blue california
Promise Health Plan

Network Provider Update

To: Medi-Cal Network Providers

August 2024

From: Finance Department
Blue Shield of California Promise Health Plan

Subject: **California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) Supplemental Payment Notification**

We are writing to share with you the Blue Shield of California Promise Health Plan (Blue Shield Promise) processes for managing and making supplemental payments in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56).

If you meet qualifying requirements, you or your IPA/MSO may receive supplemental payment(s) and details regarding the eligible services rendered under one or more of the following All Plan Letters (APLs):

- APL 23-008: Proposition 56 Directed Payments for Family Planning Services; See Appendix B
- APL 23-014: Proposition 56 Value-Based Payment Program Directed Payments; See Appendix C
- APL 23-015: Proposition 56 Directed Payments for Private Services; See Appendix D
- APL 23-016: Proposition 56 Directed Payments for Developmental Screening Services; See Appendix E
- APL 23-017: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services; See Appendix F
- APL 23-019: Proposition 56 Directed Payments for Physician Services; See Appendix G

See Appendix A of this letter for a summary of our processes for managing payments, electronic funds transfer (EFT), questions and inquiries, and disputes related to these Proposition 56 payments. We recommend signing up for EFT to receive payments faster and avoid mail delays.

Please note that the California Department of Health Care Services (DHCS) has indicated that the Proposition 56 supplemental payment program will continue until further notice.

We will send you any additional updated Proposition 56 information as it becomes available.

Should you have any questions about Proposition 56 supplemental payments, please contact us by email at Prop56inquiries@BlueShieldca.com or call (800) 468-9935 from 6 a.m. to 6:30 p.m., Monday through Friday.

Appendix A: Proposition 56 Additional Requirements and Information

See specific approved APLs for a detailed listing of the requirements.

A.1.a: Typical Payment Process Summary

Blue Shield Promise makes Proposition 56 payments to providers directly or through independent physician associations (IPAs) or managed service organizations (MSOs) in accordance with timely payment standards for clean claims or accepted encounters described in our contract. All eligible payments are calculated based on the specific APL criteria. These payments are validated based on the receipt of a qualifying clean fee-for-service (FFS) claim or encounter from the provider or the provider's IPA/MSO. The payments are made based on the date of qualifying service. The payments are processed and issued within 30 days from the end of the month following receipt of a clean claim or an accepted encounter from the IPA/MSO and as per the related APL.

Blue Shield Promise asks IPAs and MSOs to downstream Proposition 56 payments to rendering providers within 60 days of receiving the funds from Blue Shield Promise.

Blue Shield Promise will pay IPAs/MSOs an administrative fee of one percent (1%) of the total Proposition 56 funds distributed. To qualify for this fee, IPAs/MSOs must return the Proposition 56 Distribution Summary Excel file to Blue Shield Promise within 90 days of the Proposition 56 funds check date.

Proposition 56 payments are issued with a detailed cover letter describing the payments, whom to contact with any questions, and how to file an appeal and grievance. Along with the payment cover letter, you will also receive a detailed claims/encounter report showing the data upon which the payments were calculated. In the case of payments made to IPAs or MSOs, the letter will contain detailed information about which providers should receive downstreamed payments from the IPA/MSO. IPAs and MSOs must provide the claims/encounter details for which the payments are issued to the respective providers and communicate expectations for the timing of these payment distributions to the providers.

IPAs and MSOs must maintain records of all provider payments, consistent with regulatory record retention standards (42 C.F.R. § 422.504). Blue Shield Promise may request evidence of payments (check numbers, etc.) downstreamed to providers by the IPAs/MSOs as part of Proposition 56 program compliance and/or DHCS audit, or upon an inquiry or dispute from the providers.

A.1.b: Instructions for Electronic Funds Transfer (EFT)

Blue Shield of California Promise Health plan uses Paymode-X to facilitate electronic funds transfer (also known as EFT or direct deposit) for faster and more efficient payments. To enroll in the Paymode-X Basic no-fee solution:

1) Go to www.paymode.com/blueshieldofcalifornia and click "Join Now."
2) Enter the following enrollment code: **G-TQNSAR9AA**
3) Follow the on-screen instructions.
4) Reply to VendorMaintenance@blueshieldca.com (copied) with a current W9 **(W9 tax ID must match the tax ID entered on your Paymode account).**

If you are already a Paymode-X member, please log in to your account, select the "Payers" tab and click "accept" for Blue Shield of California.

For enrollment assistance please call 1-800-331-0974 Monday through Friday 8:00 AM – 5:00 PM EST or email enrollment@paymode-x.com.

To learn more about Paymode-X, go to www.paymode-x.com/get-paid and click "Watch the video."

A.2: Provider Questions and Inquiries

Providers can communicate questions and inquiries regarding Proposition 56 supplemental payments to Blue Shield Promise by email at Prop56inquiries@BlueShieldca.com or call (800) 468-9935. Please provide missing claim or encounter records, including the date of service, billing NPI, CPT codes, and patient information, when you contact Blue Shield Promise.

A.3: Provider Disputes Policy and Procedure

Providers may submit a formal, written dispute regarding the processing or non-payment of directed payments required by Proposition 56 to the Provider Dispute and Resolution Department at:

Blue Shield of California Promise Health Plan
ATTN: FirstSource – BSCPHP PDR
PO Box 8309
Chico, CA 95927-8309

Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen (15) working days of receiving the written dispute, and a resolution letter will be sent within forty-five (45) working days.

All provider disputes must be submitted in writing within three hundred sixty-five (365) days from the last date of action on the issue. If a provider attempts to file a provider dispute via telephone, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing. Information about how to file a dispute can be found at Blue Shield Promise's website at Blueshieldca.com/promise. You will find the information in the section titled *Policies, Guidelines, Standards and Forms*. All provider disputes are forwarded to the appropriate department for processing.

APPENDIX B: Additional Details Regarding All Plan Letter 23-008

Proposition 56 Directed Payments for Family Planning Services

In accordance with All Plan Letter (APL) 23-008 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments that are funded by Proposition 56 for family planning services. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-008.pdf

- An eligible provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a member.
- For dates of service on or after June 27, 2023, both professional and facility claims are eligible for reimbursement for payment, but not both for the same service on the same date of service under this program.
- Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics are not eligible for these directed payments.

Qualifying services

Please refer to the list of qualifying family planning services contained in APL 23-008. Note that the dates of service may affect eligibility for payment, because the list of qualifying services has been modified since the Proposition 56 directed payments began.

In compliance with federal regulations, Blue Shield Promise members have free access to confidential family planning services from any family planning provider or agency without obtaining authorization for these services.

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APPENDIX C: Additional Details Regarding All Plan Letter 23-014

Proposition 56 Value-Based Payments Program Directed Payments

In accordance with All Plan Letter (APL) 23-014 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand the supplemental payments that were funded by Proposition 56 for the value-based payments (VBP) program. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-014.pdf

Qualifying services

Value-based directed payments were made to eligible providers for specific qualifying services tied to performance across four domains and their specified measures as set forth in the VBP program specifications guide and the valuation summary.

The four domains included:

- Prenatal and postpartum care
- Early childhood prevention
- Chronic disease management
- Behavioral health care

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics were not eligible for value-based directed payments.

Program end date

The Proposition 56 Value-Based Program ended on **June 30, 2022**. The program was originally authorized by Centers for Medicare and Medicaid Services (CMS) and the California State Legislature to operate from July 1, 2019, through June 30, 2022.

Blue Shield Promise paid claims for services rendered prior to June 30, 2022, that were submitted within one year of the service date.

APPENDIX D: Additional Details Regarding All Plan Letter 23-015

Proposition 56 Directed Payments for Private Services

In accordance with All Plan Letter (APL) 23-016 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for the provision of specified state-funded medical pregnancy termination services. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-015.pdf

Qualifying services

- Induced abortion (by dilation and curettage)
- Induced abortion (by dilation and evacuation)

In compliance with federal regulations, Blue Shield Promise members have free access to confidential family planning services (including abortion) from any family planning provider or agency without obtaining authorization for these services.

APPENDIX E: Additional Details Regarding All Plan Letter 23-016

Proposition 56 Directed Payments for Developmental Screening Services

In accordance with All Plan Letter (APL) 23-016 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for developmental screening services. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-016.pdf

Requirements for a qualifying screening

A qualifying developmental screening service is one provided by a Network Provider, in accordance with the AAP/Bright Futures periodicity schedule and through use of a standardized tool that meets the criteria specified below, to a Member enrolled in the MCP who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).

- Developmental screenings must be provided in accordance with the AAP/Bright Futures periodicity schedule and guidelines at 9 months, 18 months, and 30 months of age and when medically necessary based on developmental surveillance. For purposes of directed payments, a routine screening will be considered to have been done in accordance with AAP guidelines and eligible for payment if done on or before the first birthday, after the first birthday and before or on the second birthday, or after the second birthday and on or before the third birthday. Screenings done when medically necessary, in addition to the routine screenings, are also eligible for directed payments.

A qualifying developmental screening service must be performed using a standardized tool that meets all of the following CMS criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The CMS Technical Specifications and Resource Manual includes a list of standardized tools that are cited by AAP/Bright Futures and meet the above criteria.* The list is updated regularly as new tools meeting the CMS criteria are developed.

Providers must document all of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; discussion with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request by the Member and/or the Member's parent(s)/guardian(s).

The provider must document completion of the developmental screening with CPT code 96110 without the modifier KX. Additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX. See reference located below.

*A link to the CMS Technical Specifications and Resource Manual can be found at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

APPENDIX F: Additional Details Regarding All Plan Letter 23-017

Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

In accordance with All Plan Letter (APL) 23-017 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for adverse childhood experiences (ACE) screening services. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-017.pdf

Requirements for a qualifying screening

A qualifying ACE screening service is one provided by a Network Provider through the use of either the PEARLS (Pediatric ACE and Related Life-events Screener) tool or a qualifying ACE questionnaire to a Member enrolled in the MCP who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).

- To qualify, the ACE questionnaire must include questions on the 10 original categories of ACE.
- Providers may utilize either an ACE questionnaire or the PEARLS tool for Members 18 or 19 years of age; the ACE screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACE screenings among adults ages 20 years and older.
- Providers must calculate the score for the billing codes using the questions on the 10 original categories of ACE.

To be eligible for the directed payment, the Network Provider must meet the following criteria:

1. The Network Provider must use either the PEARLS tool or a qualifying ACE questionnaire, as appropriate;
2. The Network Provider must bill using one of the (2) HCPCS codes G9919 or G9920, based on the screening score from the PEARLS tool or ACE questionnaire used; and
3. The Network Provider that rendered the screening must be on DHCS' list of Providers that have completed a certified core ACEs Aware training. The training requirement will be waived for dates of service prior to July 1, 2020. However, commencing July 1, 2020, Network Providers must have taken a certified training and self-attested to completing the training to receive the directed payment for ACE screenings. Please visit https://www.acesaware.org/ for more information about the ACEs Aware Initiative and details about provider training opportunities.

Providers must document all of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; what was discussed with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request by the Member and/or the Member's parent(s)/guardian(s).

Frequency of payments for screenings

Providers may screen Members utilizing a qualifying ACE questionnaire or PEARLS tool as often as deemed appropriate and medically necessary. However, each MCP is only required to make the $29.00 required minimum payment to a particular Network Provider once per year per Member screened by that Provider, for a child Member assessed using the PEARLS tool, and once per lifetime per Member screened by that Provider, for an adult Member (through age 64) assessed using a qualifying ACE questionnaire.

APPENDIX G: Additional Details Regarding All Plan Letter 23-019

Proposition 56 Directed Payments for Physician Services

In accordance with All Plan Letter (APL) 23-019 published by the Department of Health Care Services, Blue Shield of California Promise Health Plan is including these additional details to help providers understand how they may qualify for supplemental payments funded by Proposition 56 for specified physician services. For more information, please view the letter at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-019.pdf

- Eligible providers are network providers that are the individual rendering providers qualified to provide and bill for the Current Procedural Terminology (CPT) codes specified in Table A of APL 23-019.

- Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics are not eligible for these directed payments.

Qualifying services

Please refer to the list of qualifying physician services contained in Table A of APL 23-019. Note that the dates of service may affect eligibility for payment and payment amounts, because the list of qualifying services and payment amounts has been modified since the Proposition 56 directed payments began.

Program end

APL 24-007 Targeted Provider Rate Increases incorporates applicable Proposition 56 physician services supplemental payments into the Targeted Rate Increase (TRI) fee schedule. APL 24-007 is applicable to all the procedure codes under Proposition 56 APL 23-019. Therefore, once Blue Shield Promise begins paying the TRI rates, all add-on payments for physician services identified in APL 23-019 will cease. In addition, because the TRI rates are retroactive to dates of service since January 1, 2024, after TRI payment adjustments are made Blue Shield Promise will need to recoup any Proposition 56 add-on payments issued for the procedure codes under APL 23-019 for the dates of service on or after January 1, 2024.