Proposition 56 Funding & Payments Webinar

November 18, 2020

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

PL0939 1120

Overview

- Prop 56 Programs
  - Review of Eligibility criteria
  - Review of Programs
  - Prop 56 Resources
- Telehealth tips
- Contacting L.A. Care
  - Sample Letter
  - Sample Remittance Advice
  - Sample Explanation of Benefits
  - Checklists

What is Proposition 56?

- **California Healthcare, Research and Prevention Tobacco Tax Act** (Proposition 56) increased the excise tax rate on cigarettes and electronic cigarettes, effective 4/1/17, and other tobacco products effective 7/1/17.
  - Tax increased to $2.87 – up from $0.87 per pack of 20 cigarettes, with an equivalent rate increase on other tobacco products.
- Revenue from the additional $2.00 tax was allocated to health program.
  - DHCS developed the structure for supplemental payments (pending CMS approval)
- Funding began SFY 2017-2018 and continues for SFY 2020-2021

Prop. 56 Programs

There are multiple Prop. 56 programs, each with its own eligibility criteria*

1. Hyde Reimbursements (Medical Pregnancy Termination)
2. Physician Services Supplemental Payments
3. Developmental Screening Services
4. Adverse Childhood Experiences Screening Services
5. Value-Based Payment Program
6. Family Planning Supplemental Payments

*Services provided to members that are dual eligible for Medicare Part B are not eligible for reimbursement.

Prop. 56 Programs & Eligibility

Prop 56 Program	All Plan Letter (APL)	Provider Type	Other Criteria	FQHC/ CBRC/IHCP
Hyde Reimbursements: Medical Pregnancy Terminations	APL19-013	All Providers (inc. non-contracted)	Practicing within scope	Yes
Physician Services	APL19-015	Eligible Network Providers	Practicing within scope	No
Developmental Screenings	APL19-016	Eligible Network Providers	Clinical guidelines; Screening tool	Yes
Adverse Childhood Experiences Screenings (ACES)	APL19-018	Eligible Network Providers	Training requirement; screening tool	Yes
Family Planning Services	APL20-013	All Providers (inc. non-contracted)	Practicing within scope	No
Value-Based Payment Program (VBP)	APL20-014	Eligible Network Providers	NPI Type 1; Practicing within scope	No

1. Physician Services

Implementation Date: July 1, 2019

Eligibility	Eligible Network Providers
Exclusions	FQHCs, RHCs, IHCPs, CBRCs; Prepaid Ambulatory Health Plans
What's reimbursed	Specified physician services (23 CPT Codes) provided to members that are not dual eligible for Medicare Part B
Payment type	Supplemental payment – uniform dollar increase
Status	Already being reimbursed

1. Physician Services

Service	Population	CPT Codes	Supplemental Payment
Office/Outpatient Visit New	All	99201-99205	$18.00-$107.00
Office/Outpatient Visit Est	All	99211-99215	$10.00-$76.00
Psychiatric Diagnostic Eval	All	90791-90792	$35.00
Pharmacologic Management	All	90863	$5.00
Initial Comprehensive Preventive Med E&M	≤39 years	99381-99385	$30.00-$83.00
Periodic Comprehensive Preventive Med E&M	≤39 years	99391-99395	$27.00-$79.00

2. Adverse Childhood Experiences Screening (ACES) Services

Implementation Date: January 1, 2020

Eligibility	Eligible Network Providers - Training requirement as of 7/1/2020
Exclusions	Pre-paid Ambulatory Health Plans; Rady Children's Hospital
What's reimbursed	ACES Trauma Screenings using the appropriate PEARLS tool or a qualifying ACES questionnaire provided to members that are not dual eligible for Medicare Part B
Payment type	Supplemental payment – minimum fee schedule
Status	Already being reimbursed

Service	Population	HCPCS Code	Payment
ACES Trauma Screening (APL 19-018)	Children and Adults ≤64 years old	G9919-G9920	Min. $29.00

2. ACES Training Requirements

- Beginning July 1, 2020, providers must be on the DHCS list of providers that have completed the state-sponsored trauma-informed care training.
- Providers must take a certified training and self-attest to completing certified ACEs training on the DHCS website to receive the directed payment for ACEs screenings.
- For more information, see APL19-018 and https://www.acesaware.org/

3. Developmental Screenings

Implementation Date: January 1, 2020

Eligibility	Eligible Network Providers
Exclusions	Pre-paid Ambulatory Health Plans, Rady Childrens Hospital
What's reimbursed	Developmental Screenings provided in accordance with AAP/Bright Futures guidelines and when medically necessary to members that are not dual eligible for Medicare Part B
Payment type	Uniform dollar increase (specified code)
Status	Already being reimbursed

Service	Population	CPT Code	Payment
Developmental Screenings (APL 19-016)	Children up to age 30 months	96110 without modifier KX	$59.90

4. Family Planning Services

Implementation Date: July 1, 2019

Eligibility	All Providers (contracted and non-contracted) qualified to provide and bill for family planning services
Exclusions	FQHCS, RHCs, IHCPs, CBRCs, Pre-paid Ambulatory Health Plans; Rady Children's Hospital
What's reimbursed	Family Planning Services (26 CPT codes) provided to members that are not dual-eligible for Medicare Part B
Payment type	Uniform dollar increase (specified codes)
Status	Payment coming December 2020

4. Family Planning Services

Family Planning Service	Procedure Codes	Supplemental Payment
Long acting reversible contraceptives	J7296-J7298, J7300-J7301, J7307, 11981, 58300-58301	$195-2727
Other contraceptives (other than oral) when provided as a medical benefit	J3490U8, J7303-J7304	$110-340
Emergency contraceptives	J3490U5-J3490U6, 11976	$50-399
Pregnancy testing	81025	$6
Sterilization: male and female	55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670-58671, 58700	$322–1515

5. Hyde Reimbursement: Medical Pregnancy Termination Services

Implementation Date: July 1, 2017

Eligibility	All Providers (contracted and non-contracted) qualified to provide and bill for medical pregnancy termination services
Exclusions	Pre-paid ambulatory health plans
What's reimbursed	Medical Pregnancy Termination Services
Payment type	Minimum fee schedule: specified codes
Status	Already being reimbursed

Service	Population	CPT-4 Code	Payment
Pregnancy Termination (APL 19-013)	Pregnant women	59840	min. $400.00
	Pregnant women	59841	min. $700.00

6. Value-Based Payment Program (VBP)

- Incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations, targeting areas such as:
  - Behavioral Health Integration
  - Chronic Disease Management
  - Prenatal/Post-partum care
  - Early Childhood Prevention

6. VBP Measures: HEDIS, Telehealth & P4P

Acronym	Prop. 56 Measures	Telehealth	HEDIS	P4P (MY2020)
	Adult Influenza ('Flu') Vaccine			
CIS	All Childhood Vaccines for Two Year Olds		x	**x**
LSC	Blood Lead Screening		x	
CDC-HbA1c	Comprehensive Diabetes Care	x	x	**x**
AMR	Control of Persistent Asthma	x	x	x
CBP	Controlling High Blood Pressure	x	x	**x**
	Dental Fluoride Varnish			
AMM-Acute	Management of Depression Medication	x	x	
	Postpartum Birth Control	x		
PPC - Post	Postpartum Care Visits*	x	x	x
PPC - Pre	Prenatal Care Visit		x	**x**
PRS	Prenatal Pertussis (‘Whooping Cough’) Vaccine		x	
	Tobacco Use Screening	x		
	Screening for Clinical Depression	x		
	Screening for Unhealthy Alcohol Use	x		
W34	Well Child Visits in 3rd – 6th Years of Life	x	x	**x**
W15	Well Child Visits in First 15 Months of Life	x	x	x

x = Double-weighted for P4P; Performance on these measures has a greater role in determining performance scores, performance rankings, and incentive payments.

* Completing the measure for Prop 56 VBP fulfills the HEDIS and P4P Postpartum Care Visit measure. See *Value Based Payment Program Performance Measures* for more information: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf

6. Value-Based Payment (VBP) Program

Implementation Date: July 1, 2019

Eligibility	Eligible Network Providers practicing within their practice scope
Exclusions	FQHCs, RHCs, IHCPs, CBRCs Prepaid Ambulatory Health Plans, Rady Childrens Hospital, SCAN Health Plan
What's reimbursed	Value-Based Payment Program services provided to members that are not dual eligible for Medicare B
Payment type	Per Service Payments Tied to Quality Measures
Status	Payment coming December 2020

**Measurement Year is the calendar year in which the service is provided*

6. Prop 56 VBP: Eligibility Criteria

1. Network Providers only
   - Only contracted providers
2. NPI Type 1 only
   - Rendering, ordering, prescribing or billing provider field must be NPI Type 1
   - VBP is designed for individual providers, not clinics or health systems
   - Type 1 is for individual providers
     - includes physicians, RNs, dentists, pharmacists and other sole proprietors
   - Type 2 is for organizations
     - includes physician groups, hospitals, nursing homes and the corporation formed when an individual provider incorporates him/herself (organization NPI)

6. Value-Based Payment (VBP) Program

50% more

VBP Domain	Non-At Risk Add-On	At Risk Add-On
Prenatal/Postpartum Care	$25 – 70	$37.50 – 105
Early Childhood Prevention	$25 – 70	$37.50 – 105
Chronic Disease Management	$25 – 80	$37.50 – 120
Behavioral Health Integration	$40 - 50	$60 - 75

- **At Risk Add-on**: enhanced payments for services provided to at-risk groups
    - Substance use disorders (SUD)*
    - Serious mental illness (SMI)* or
    - Homeless (ICD-10: Z59.0 or Z59.1)
- The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement (calendar) year.
- The diagnosis of homeless should be on the encounter data for the VBP eligible service.

*Download the codes via the link on Page 11 of the VBP Specifications: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-9.30.20.pdf

6. Prop 56 VBP: Data Used to Calculate Payments

- Clean claim or accepted encounter
  - Received within one year of the date of services (DOS)
  - DOS on or after July 1, 2019 for VBP
  - No chart review
- Clean claim definition:
  - Claim that can be processed without obtaining additional information from the provider of the service or from a third party
- Accepted encounter definition:
  - Encounter data received by L.A. Care (clean data after edit process) submitted timely, formatted properly, and coded accurately in compliance with national standards.

6. VBP: Additional Tips for Coding

- Data must be coded based on VBP Specifications to be eligible for supplemental payment
  - e.g. Prenatal Care Visits should be coded ICD-10 O09 or Z34 with CPT 992xx for supplemental payment
- Diagnosis and procedures codes for services must have the same date of service on the claim

6. VBP - Prenatal/Postpartum Care: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Prenatal Pertussis (Whooping Cough) Vaccine	CPT 90715 with ICD-10 O09 or Z34 series	**1** payment per delivery per patient	$25.00	$37.50
Prenatal Care Visits	ICD-10 O09 or Z34 with CPT 992xx	**1** payment per pregnancy per plan	$70.00	$105.00
Postpartum Care Visits	ICD-10 Z39.2	**1** payment per postpartum period (2 total)	$70.00	$105.00
Postpartum Birth Control	See VBP Specifications	**1** payment per delivery	$25.00	$37.50

*Download the codes via the link on Page 4 of the VBP Specifications:
https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-9.30.20.pdf

6. VBP - Early Childhood: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Well Child Visits in First 15 Months of Life	Any of the following: **CPT:** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439 **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	**1** payment per eligible well child visit: • 6-month • 9-month • 12-month **3 total**	$70.00	$105.00

6. VBP - Early Childhood: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Well Child Visits in 3rd-6th Years of Life	Any of the following: **CPT:** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439 **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	**1** payment per eligible annual well child visit: • 3 years • 4 years • 5 years • 6 years **4 total**	$70.00	$105.00

6. VBP - Early Childhood: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Blood Lead Screening	CPT code 83655	**1** payment for each screening provided on or before the 2nd birthday • **Provider can receive more than one payment**	$25.00	$37.50

6. VBP - Early Childhood: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
All Childhood Vaccines for Two Year Olds	N/A	**1** payment for each **final** vaccine administered in a series to children turning age 2 in the measurement year: 1. DTaP – 4th 2. IPV – 3rd 3. Hep B – 3rd 4. Hib – 3rd 5. PCV – 4th 6. RV –2nd / 3rd 7. Flu – 2nd **7 total**	$25.00	$37.50

6. VBP - Early Childhood: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Dental Fluoride Varnish	CPT 99188 or CDT D1206	**1** payment for each application of dental fluoride varnish for children <6 years • Payment for the first four visits in a 12 month period **4 maximum**	$25.00	$37.50

6. VBP – Chronic Disease Management: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Controlling High Blood Pressure	• **Controlled Systolic:** – CPT 3074F – CPT 3075F • **Controlled Diastolic:** – CPT 3078F – CPT 3079F • **Hypertension:** – ICD-10: I10	**1** payment for each non-emergency outpatient visit or remote monitoring event documenting adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure	$40.00	$60.00

6. VBP – Chronic Disease Management: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Diabetes Care	– **CPT 3044F** most recent HbA1c < 7.0% **– CPT 3045F** most recent HbA1c 7.0-9.0% (through 9/30/19) **– CPT 3051F** most recent HbA1c >= 7.0% and < 8.0% (as of 10/1/19) **– CPT 3052F** most recent HbA1c 8.0-9.0% (as of 10/1/19) **– CPT 3046F** most recent HbA1c > 9.0%	**1** payment for each event of HbA1c testing that shows the results for members 18 to 75 years • **Maximum 4 payments per year.** • Dates for HbA1c results must be ≥ 60 days apart. • Diabetes diagnosis is not required for screening individuals at increased risk of diabetes.	$80.00	$120.00

6. VBP – Chronic Disease Management: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Control of Persistent Asthma	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998	**1** payment per patient per year per provider for patients 5-64 years old	$40.00	$60.00

6. VBP – Chronic Disease Management: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Tobacco Use Screening	CPT codes: 99406, 99407, 4004F, or 1036F	**1** payment per provider per patient per year for patients 12 years and older	$25.00	$37.50
Adult Flu Vaccine	N/A	**2** per year 1 payment per patient per quarter **maximum** for January-March and October-December for patients 19 years and older. If >1 provider gives a flu shot, only the first provider gets paid	$25.00	$37.50

6. VBP - Behavioral Health Integration: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Screening for Clinical Depression	CPT G8431 or G8510	1 payment per provider per patient per year for patients 12 years and older • Must be an outpatient visit	$50.00	$75.00

6. VBP - Behavioral Health Integration: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Management of Depression Medication	N/A	• 1 payment per prescribing provider for prescribing antidepressant medications during the Effective Acute Phase Treatment for patients 18 years and older with a new diagnosis of major depression 60 days before the new prescription through 60 days after • No more than one Effective Acute Phase Treatment per year	$40.00	$60.00

6. VBP - Behavioral Health Integration: Coding

Quality Measure	Coding	Maximum Allowed	Non-At Risk Add-On	At Risk Add-On
Screening for Unhealthy Alcohol Use	CPT codes: 99408, 99409, G0396,G0397, G0442, G0443, H0049, or H0050	**1** payment per provider per patient per year	$50.00	$75.00

6. Prop 56 VBP: Resources

- DHCS VBP Program Page
  - information on the program and links to program resources
  - https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx
- APL 20-014
  - program specifics, including provider eligibility and claims and encounter data
  - https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx
- Technical Specifications
  - measure specifications and coding standards
  - https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-9.30.20.pdf
- FAQs
  - https://www.dhcs.ca.gov/provgovpart/Documents/VBP-FAQ-10.01.2020.pdf

Prop. 56 Resources

Resource	Website
DHCS All Plan Letters (APLs)	https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
DHCS Prop 56 Webpage	https://www.dhcs.ca.gov/provgovpart/Pages/Proposition-56.aspx

6. VBP Measures: HEDIS, Telehealth & P4P

Acronym	Prop. 56 Measures	Telehealth	HEDIS	P4P (MY2020)
	Adult Influenza ('Flu') Vaccine			
CIS	All Childhood Vaccines for Two Year Olds		x	**x**
LSC	Blood Lead Screening		x	
CDC-HbA1c	Comprehensive Diabetes Care	x	x	**x**
AMR	Control of Persistent Asthma	x	x	x
CBP	Controlling High Blood Pressure	x	x	**x**
	Dental Fluoride Varnish			
AMM-Acute	Management of Depression Medication	x	x	
	Postpartum Birth Control	x		
PPC - Post	Postpartum Care Visits*	x	x	x
PPC - Pre	Prenatal Care Visit		x	**x**
PRS	Prenatal Pertussis (‘Whooping Cough’) Vaccine		x	
	Tobacco Use Screening	x		
	Screening for Clinical Depression	x		
	Screening for Unhealthy Alcohol Use	x		
W34	Well Child Visits in 3rd – 6th Years of Life	x	x	**x**
W15	Well Child Visits in First 15 Months of Life	x	x	x

x = Double-weighted for P4P; Performance on these measures has a greater role in determining performance scores, performance rankings, and incentive payments.

* Completing the measure for Prop 56 VBP fulfills the HEDIS and P4P Postpartum Care Visit measure. See *Value Based Payment Program Performance Measures* for more information: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf

Additional Coding for Telehealth Measures

- Telehealth services can be done by:
  - telephone only visit,
  - e-visits (via email), or
  - virtual check-ins (interactive audio and video).
- Providers should use the same codes as the in-person visits and include the appropriate telehealth codes.
- Provider does not need to specify the type of telehealth used in the medical record but should submit correct code for the method used.
- L.A. Care Guide: https://www.lacare.org/sites/default/files/la2972_telehealth_guide_for_hedis_202008%281%29.pdf

Codes for Telephonic Encounters with Physicians

TELEPHONIC | Codes that refer to phone conversations with your doctor are billed in time increments from five minutes to a half an hour	CPT
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	99443

Codes for Telephonic Encounters with Nurses, NPs, or PAs

TELEPHONIC | Codes for phone consultations with physician extenders, who are usually nurses, NPs, or PAs, usually correspond with a bill that is less than the bill for phone conversations with your doctor.	CPT
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	98968

Codes for Virtual Check-Ins (interactive audio and video)

TELEHEALTH - ESTABLISHED PATIENTS | **Add the Modifiers to specify the type of face-to-face visit.**	**CPT**
Requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	99212
Requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	99213
Requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	99214
Requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	99215

Modifiers for Virtual Check-Ins

Modifiers	CPT
Synchronous telemedicine service rendered via a **real-time interactive audio and video** telecommunications system. Append this modifier to an appropriate CPT code (listed in Appendix P in the 4/13/2020 CPT manual) for a real time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. The totality of the communication of information exchanged between the reporting provider and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Codes must be listed in Appendix P or have the symbol «next to the code.	95
Via **interactive audio and video telecommunication systems**. Use only when directed by your payer in lieu of modifier 95. NOTE *Medicare stopped the use of modifier GT in 2017 when the place of service code 02 (telehealth) was introduced. If your payers reject a telemedicine claim and the 95 modifier is not appropriate, ask about modifier GT.*	GT (Telehealth)
The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)	02 (Telehealth)

E-Visits (Via Email)

Email or some other online service to discuss a medical problem with a physician.	99444

Prop. 56 Payments

- Payments will be made quarterly, within 90 days of receipt of a qualifying clean claim or accepted encounter, if the following claims and encounter submission requirements are met:

Prop. 56 Program	APL	DOS on or after	Clean Claim or Accepted Encounter Received
Hyde Reimbursements for Medical Pregnancy Termination Services	APL19-013	7/1/2017	Timely
Physician Services	APL19-015	7/1/2019	Within 1 year of DOS
Developmental Screening Services	APL19-016	1/1/2020	Within 1 year of DOS
Adverse Childhood Experiences Screening Services (ACEs)	APL19-018	1/1/2020	Within 1 year of DOS
Family Planning Services	APL20-013	7/1/2019	Within 1 year of DOS
Value-Based Payment Program	APL20-014	7/1/2019	Within 1 year of DOS

L.A. Care Prop 56 Payment Information

Prop 56 Program	All Plan Letter (APL)	Payment Type	Payment Source	Payment Summary
Hyde Reimbursements - Medical Abortions	APL19-013	Separate check **OR** included in claims payment	Who you normally bill	Remittance Advice (if LA Care) or request Explanation of Benefits (EOB) if IPA
Physician Services	APL19-015	Separate check	IPA	Request from IPA
Developmental Screenings	APL19-016	Separate check	L.A. Care	Request from L.A. Care
ACES	APL19-018	Separate check	L.A. Care	Request from L.A. Care
Family Planning	APL20-013	Separate check	L.A. Care	Request from L.A. Care
VBP	APL20-014	Separate check	L.A. Care	Request from L.A. Care

Contacting LA Care

- Please refer to the letter accompanying the check
  - Checks do not contain memo lines
  - Letter identifies which Prop 56 program the payment is for
  - Note the date range for claims and encounters
- Use the contact listed in the letter to reach out with any questions
  - Request a payment summary report for payment details
  - Utilize the checklist(s) to obtain a quicker response
- If you have misplaced the letter, contact us at **866-522-2736**

Sample Letter

October 25, 2020

RE: PROPOSITION 56 SUPPLEMENTAL PAYMENT:
VALUE-BASED PAYMENT (VBP) PROGRAM PAYMENT #1
FUNDS ALLOCATED for State Fiscal Year 1 (2019-20) & State Fiscal Year 2 (2020-21) Q1

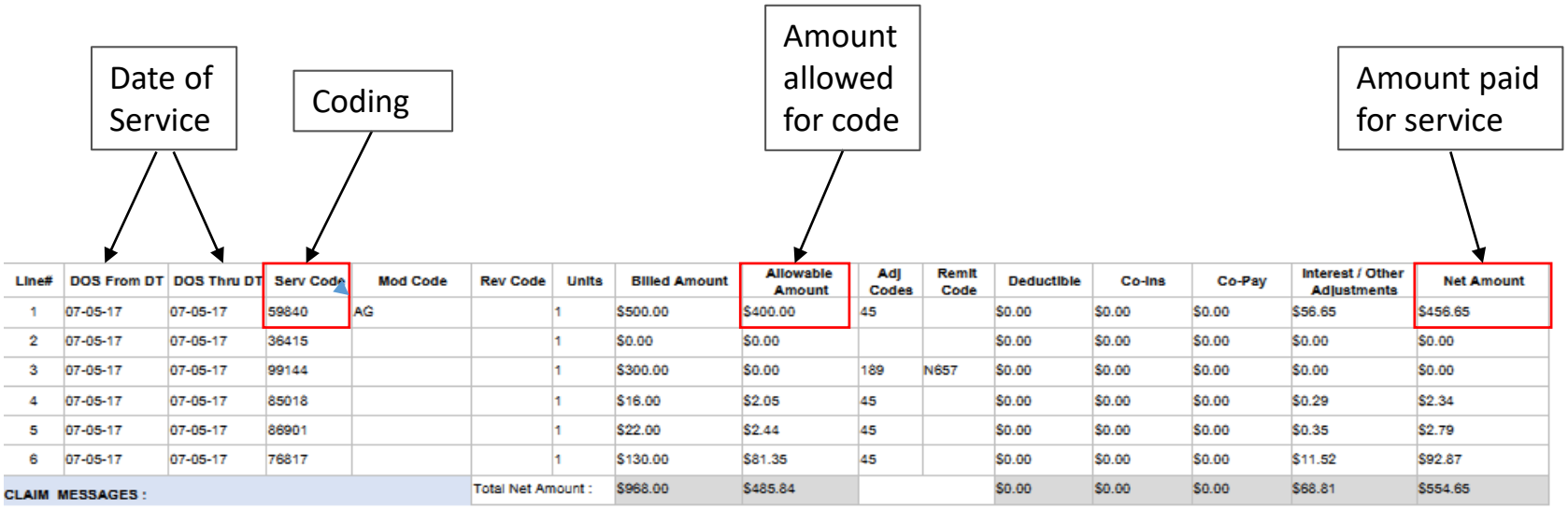
Dear Provider:

On November 8, 2016, California voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (commonly known as Proposition 56) to increase the excise tax on cigarettes and tobacco products to help fund health care expenditures. The funding appropriated for Proposition 56 by the Department of Health Care Services (DHCS) specifies the issuance of supplemental payments to Managed Care Plans for Eligible Network Providers performing qualifying Value-Based Payment (VBP) Program services. L.A. Care Health Plan (L.A. Care) will release supplemental payments to Eligible Network Providers, including remittance advice, based on the criteria below.

Payment Criteria
The Proposition 56 payments are based on **Dates of Service (DOS) July 1, 2019 to June 30, 2020 (Fiscal Year 1) and DOS July 1, 2020 to September 30, 2020 (Fiscal Year 2, Quarter 1) for clean claims or "Accepted" Encounters Received by September 30, 2020 – Payment #1**. L.A. Care defines "Accepted" Encounter data as encounter data received by L.A. Care (clean data after edit process) submitted timely, formatted properly, and coded accurately in compliance with national standards. Please reference All Plan Letter (APL 20-014) for further specifications regarding encounter submission.

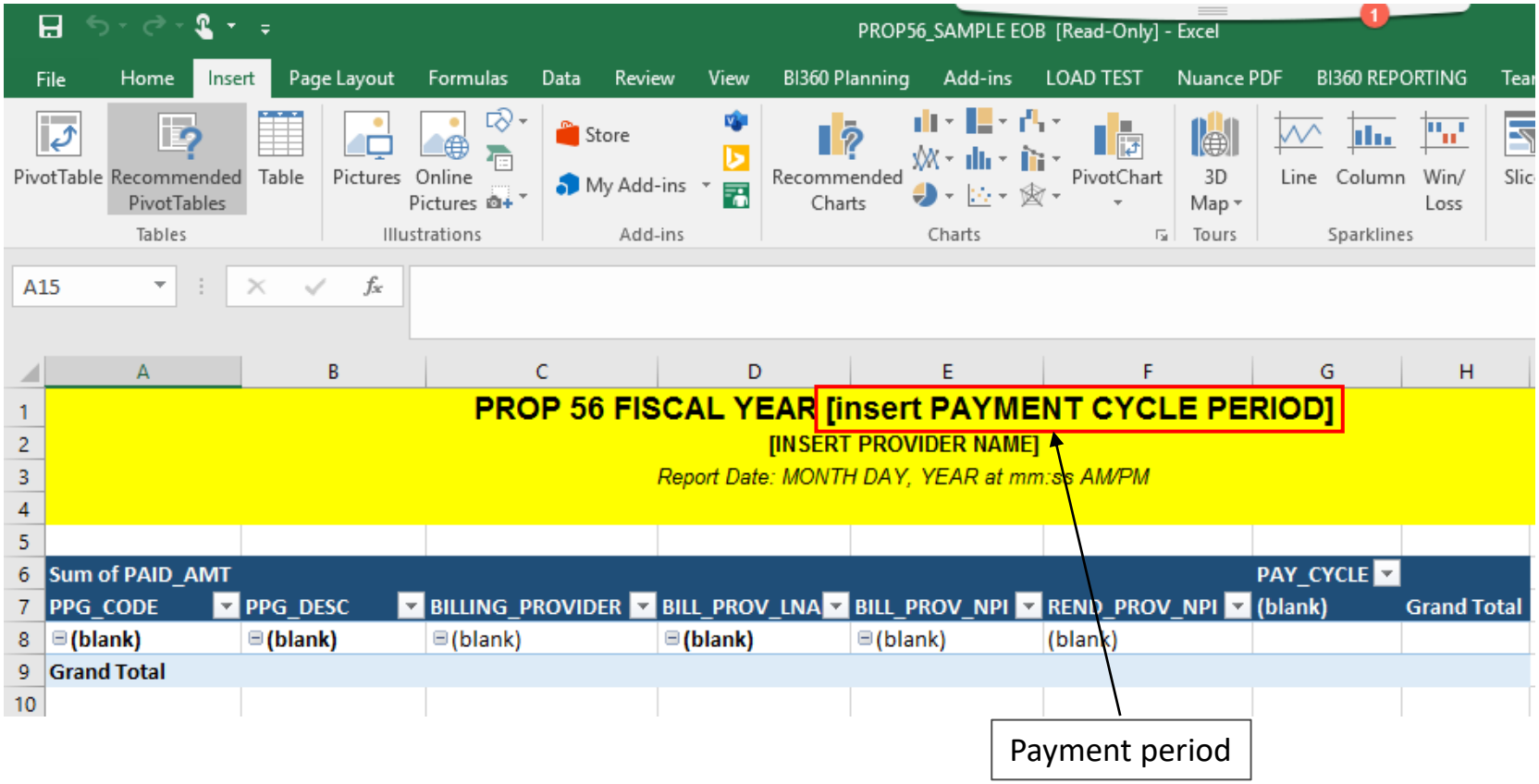
Sample Remittance Advice

Hyde Reimbursements – Medical abortions (APL 19-013) only

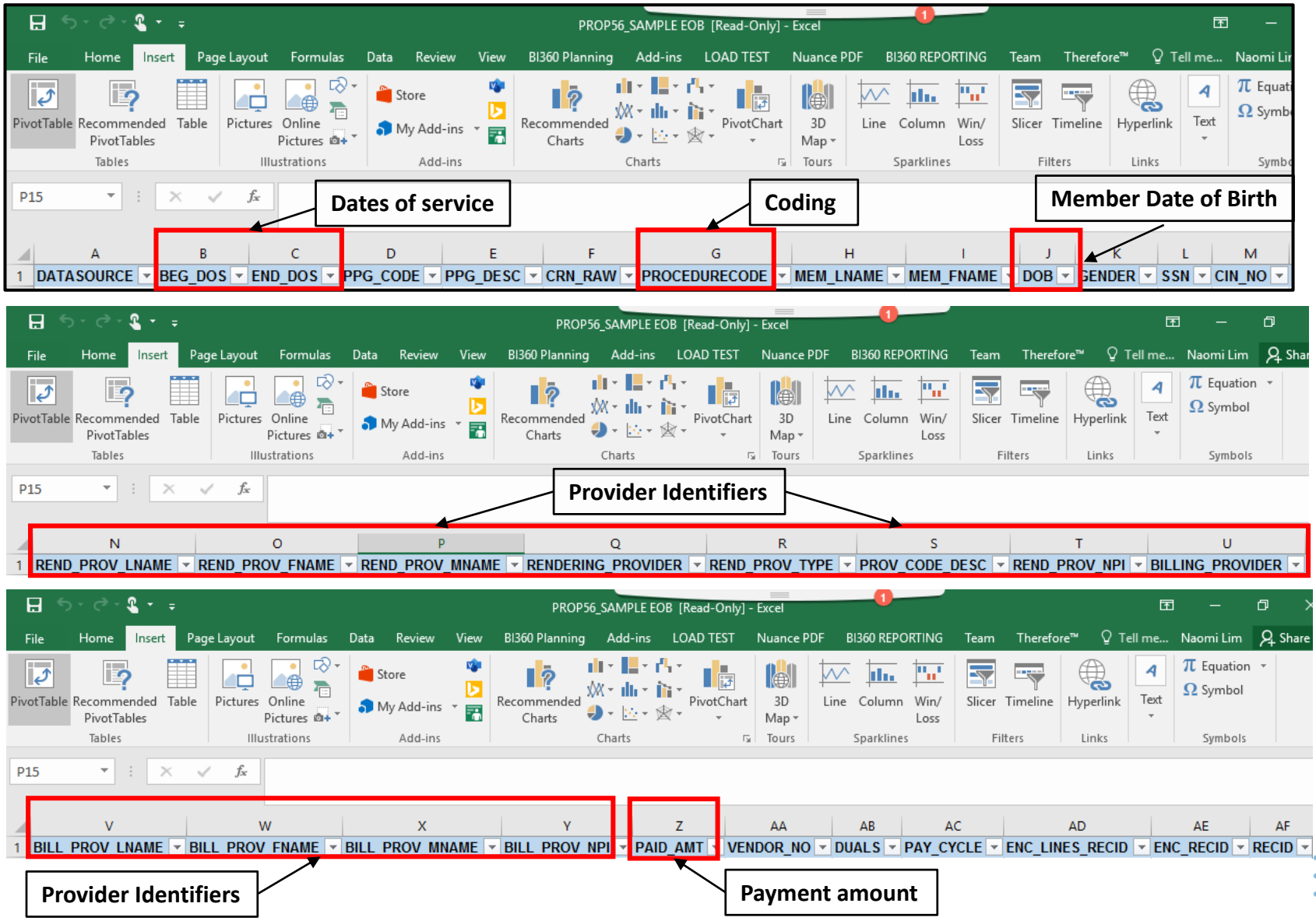


Line#	DOS From DT	DOS Thru DT	Serv Code	Mod Code	Rev Code	Units	Billed Amount	Allowable Amount	Adj Codes	Remit Code	Deductible	Co-Ins	Co-Pay	Interest / Other Adjustments	Net Amount
1	07-05-17	07-05-17	59840	AG		1	$500.00	$400.00	45		$0.00	$0.00	$0.00	$56.65	$456.65
2	07-05-17	07-05-17	36415			1	$0.00	$0.00			$0.00	$0.00	$0.00	$0.00	$0.00
3	07-05-17	07-05-17	99144			1	$300.00	$0.00	189	N657	$0.00	$0.00	$0.00	$0.00	$0.00
4	07-05-17	07-05-17	85018			1	$16.00	$2.05	45		$0.00	$0.00	$0.00	$0.29	$2.34
5	07-05-17	07-05-17	86901			1	$22.00	$2.44	45		$0.00	$0.00	$0.00	$0.35	$2.79
6	07-05-17	07-05-17	76817			1	$130.00	$81.35	45		$0.00	$0.00	$0.00	$11.52	$92.87
CLAIM MESSAGES :					Total Net Amount :		$968.00	$485.84			$0.00	$0.00	$0.00	$68.81	$554.65

Sample Explanation of Benefits



Sample Explanation of Benefits



Prop 56 Payment Inquiry Checklist

Prop. 56 Payment Inquiries

LA Care HEALTH PLAN
For All of L.A.

Checklist

If you are contacting LA Care with a question regarding your payment, include all applicable information below, in order to ensure a timely response. Inquiries missing required information will be prompted to re-submit.

Provider Information

Name of MD or Medical Group	
All NPIs	
TIN	
Address	
Phone #	
Email Address	
PPGs/IPAs	

Inquiry

Which Prop. 56 Program is your inquiry about? If you received a check, please reference the cover letter for this information.	☐ Physician Services (APL 19-015) ☐ Abortion Services (APL 19-013) ☐ ACEs Trauma Screenings (APL 19-018) ☐ Developmental Screenings (APL 19-016) ☐ Family Planning Services (APL 20-013) ☐ Value-Based Payment Program (APL 20-014)
Claims / Encounter #	
DOS	
Member Name	
Member ID	
Documentation of appropriate coding for the eligible service	
Explanation of what you believe is the payment issue	

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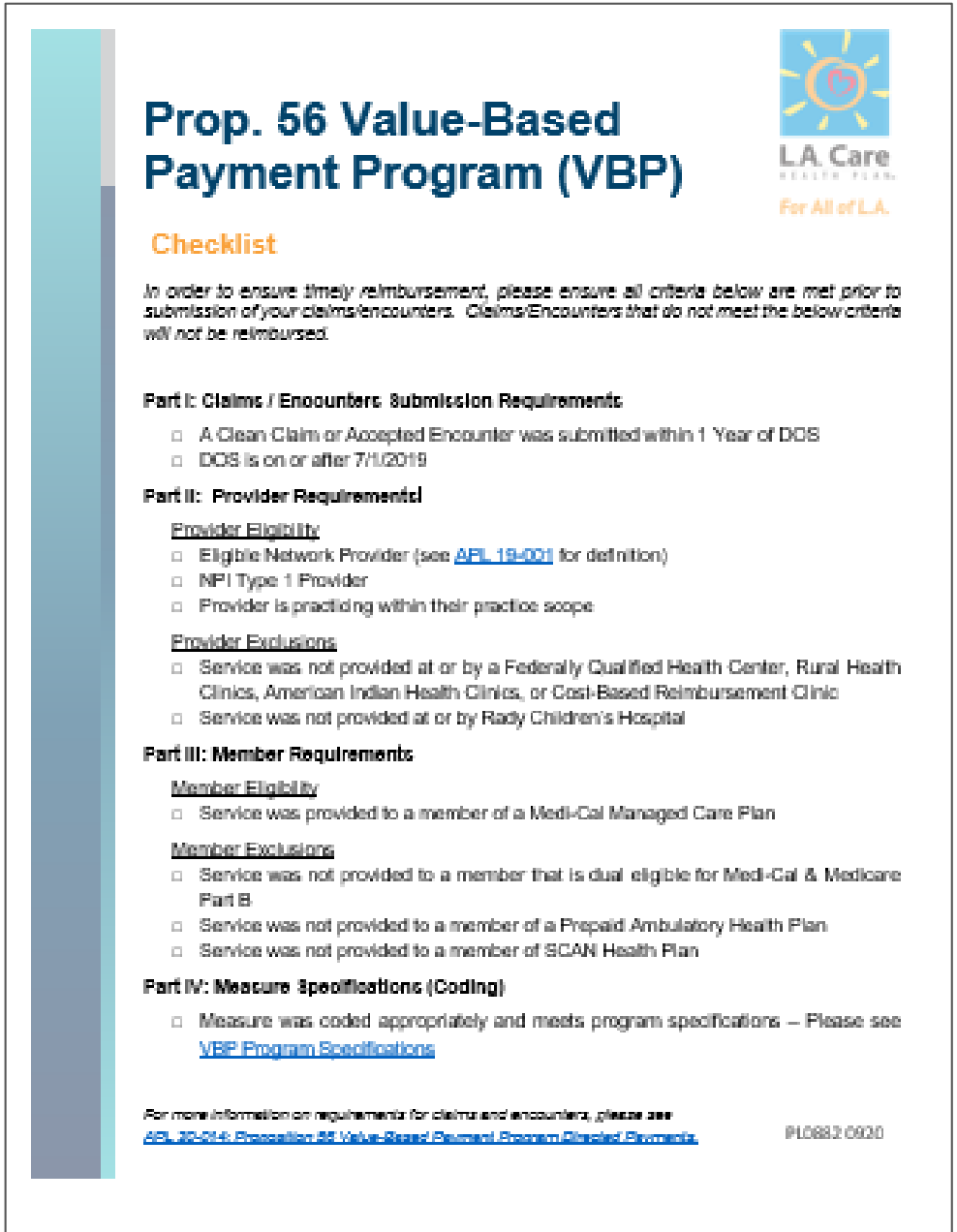
Prop 56 Payment Inquiry Checklist



Prop. 56 Value-Based Payment Program (VBP)

LA Care HEALTH PLAN
For All of L.A.

Checklist

In order to ensure timely reimbursement, please ensure all criteria below are met prior to submission of your claims/encounters. Claims/Encounters that do not meet the below criteria will not be reimbursed.

Part I: Claims / Encounters Submission Requirements

- ☐ A Clean Claim or Accepted Encounter was submitted within 1 Year of DOS
- ☐ DOS is on or after 7/1/2019

Part II: Provider Requirements

Provider Eligibility

- ☐ Eligible Network Provider (see APL 19-001 for definition)
- ☐ NPI Type 1 Provider
- ☐ Provider is practicing within their practice scope

Provider Exclusions

- ☐ Service was not provided at or by a Federally Qualified Health Center, Rural Health Clinics, American Indian Health Clinics, or Cost-Based Reimbursement Clinic
- ☐ Service was not provided at or by Rady Children's Hospital

Part III: Member Requirements

Member Eligibility

- ☐ Service was provided to a member of a Medi-Cal Managed Care Plan

Member Exclusions

- ☐ Service was not provided to a member that is dual eligible for Medi-Cal & Medicare Part B
- ☐ Service was not provided to a member of a Prepaid Ambulatory Health Plan
- ☐ Service was not provided to a member of SCAN Health Plan

Part IV: Measure Specifications (Coding)

- ☐ Measure was coded appropriately and meets program specifications – Please see VBP Program Specifications

For more information on requirements for claims and encounters, please see APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments.

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Questions?