State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: December 31, 2021

TO: Medi-Cal Managed Care Plans, Public and Private Transplant Providers

FROM: Department of Health Care Services

SUBJECT: Information on Major Organ Transplant Reimbursement Requirements

The Department of Health Care Services (DHCS) is in the process of operationalizing the provider reimbursement requirements associated with the transition of organ and bone marrow transplants that are currently covered in the fee-for-service (FFS) delivery system to managed care, effective January 1, 2022, as part of the CalAIM initiative. Reference APL 21-015 for published guidance on benefit standardization and the CalAIM initiative.[1] Ahead of the final All Plan Letter (APL) updates and publication of finalized directed payment rates for public hospitals, DHCS is providing interim information to assist affected plans in planning for the transitioning of this benefit including contracting efforts. Please note, this information does not substitute for or replace formal APL guidance, including but not limited to APL 21-015 and any subsequent revisions, and plans will be required to comply with all applicable contract or APL terms.

[1] APL 21-015 is available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf. Attachment 2 of the APL, specific to Major Organ Transplant requirements, is available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015-Attachment-2-MOT.pdf.

Scope of Reimbursement Requirement

- WIC § 14184.201(c)(2) states, in part:

  > *For contract periods from January 1, 2022, to December 31, 2024, inclusive, … each applicable Medi-Cal managed care plan shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102.*

- State law obligates Medi-Cal managed care plans to pay providers of organ or bone marrow transplant surgeries, and obligates such providers to accept, no more and no less than the State directed payment rates for applicable services, as set forth below.
- DHCS will operationalize this reimbursement requirement through a directed payment arrangement in accordance with 42 CFR 438.6(c), subject to CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.
- This requirement will apply ONLY to newly transitioning transplant events. It will not apply to COHS counties where all organ and bone marrow transplants are already managed care covered services, nor to single-organ kidney and corneal transplants that are already covered in managed care statewide, nor to California Children's Services (CCS) pediatric transplants in non-Whole Child Model (WCM) counties.
- This directed payment requirement will apply to both in-network and out-of-network providers, as well as out-of-state providers, furnishing organ or bone marrow transplant surgeries.
- The requirement will apply to the transplant event itself, consisting of the following:
  - The costs of the organ or bone marrow acquisition and related donor costs.
  - The transplant surgery event.
  - The associated uninterrupted inpatient stay beginning the day of transplant through discharge.
- The transplant event will not include services not listed above, such as but not limited to:
  - Pre-transplant event services, except organ or bone marrow acquisitions as indicated above.

  - Professional services that are not billed on a facility claim for the transplant event.
  - Post-transplant services.
  - Costs associated with readmission after the initial inpatient discharge.

  Note: These excluded services are not subject to the directed payment but are payable by plans to providers under the terms of their contracts or agreements, and the projected costs associated with these services will be captured in capitated rate development associated with organ and bone marrow transplants.

- Medicaid is the payer of last resort. For members with Medicare or other health coverage, plans must follow standard cost-avoidance protocols specified in the contract. The amount the plan must reimburse the provider shall be offset accordingly; e.g., for the same scope of services, if the directed payment amount is $150,000, and a member's other health coverage pays $140,000, the plan must only pay $10,000 to satisfy the directed payment obligation.
- As with all directed payment arrangements, plans must ensure that the provider receives the directed payment amount regardless of any delegation or sub-capitation arrangements. Plans are responsible for ensuring that their delegates comply with all applicable directed payment requirements.

Reimbursement for Private Hospitals[2]

- In order to determine the FFS-equivalent payment levels for the organ acquisition costs, plans must follow billing instructions as outlined in the provider manual.[3]
- In order to determine the FFS-equivalent payment levels for the surgery and associated inpatient stay of a transplant, plans must follow the diagnosis related group (DRG) pricing resources on DHCS' website.[4]
- DHCS encourages plans and providers to enter into network provider agreements for the purpose of furnishing organ or bone marrow transplant surgeries to Medi-Cal beneficiaries. Compensation under such agreements must adhere to the reimbursement requirements in State law.

[2] These reimbursement requirements also apply to out-of-state providers.
[3] Instructions are available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf.
[4] Pricing resources for SFY 2021-22 are available at https://www.dhcs.ca.gov/provgovpart/Pages/DRG-Pricing-Resources-for-SFY-2021-22.aspx.

Reimbursement for Public Hospitals/UCs

- DHCS anticipates publishing a directed fee schedule of FFS-equivalent reimbursement rates for the University of California (UC) system facilities furnishing organ and bone marrow transplant surgeries.
- The directed fee schedule will include case rates for each transplant type by each UC system facility, with a supplemental per-diem rate for "outlier" cases in the event there is an extended inpatient admission beyond defined length of stay thresholds. The directed fee schedule will address single-organ transplants as well as multi-organ transplants, such as simultaneous pancreas-kidney transplants.
- DHCS understands that, due to time limitations associated with the fee schedule not being published prior to January 1, 2022, plans may be unable to update their systems to pay the directed rates by January 1, 2022, and will need to make payments using interim rates initially. Although DHCS is not directing the amount of the interim payments, plans may consider the DRG methodology indicated for private hospitals as an interim approach. DHCS will require that these interim payments for applicable services be reprocessed and paid in a timely manner according to the final directed payment rates, retroactive to dates of services beginning on or after January 1, 2022, once the final directed rates are published by DHCS in an APL.
- DHCS encourages plans and providers to enter into network provider agreements for the purpose of furnishing organ or bone marrow transplant surgeries to Medi-Cal beneficiaries. Compensation under such agreements must adhere to the reimbursement requirements in State law. Although the final directed fee schedule is yet to be finalized, the compensation methodology is prescribed in State law as quoted above.

Plan Risk Corridor

A two-sided, symmetrical risk corridor will be in place between DHCS and each plan in each county for the transitioning transplant services for the CY 2022 rating period, except for Cal MediConnect.

- The risk corridor will apply only to those costs subject to the reimbursement requirements (i.e., the transplant event as defined above for transitioning services only).
- The risk corridor will be centered on 100% of the applicable gross medical expense component within the rates, with a single ±5% risk band in both directions.
- The risk corridor does not change or modify in any way the provider reimbursement requirements in accordance with State law.

Sincerely,

DocuSigned by:
Rafael Davtian
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Rafael Davtian
Capitated Rates Development Division
Department of Health Care Services