Policy and Procedure No: CL 13.5	**Revision No: 5**
Division: Care Management	
Department: Claims Operations	
Title: PHC-CA State Supported Services, Family Planning and Proposition 56 Claims Processing	
Effective Date: 1/1/2017	
Supersedes Policy No: CL 13.0, CL 13.1, CL 13.2, CL 13.3 CL 13.4	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/12/2025**
Approving Committee: Compliance Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe PHC California's (the Health Plan) process for review and adjudication of claims for State Supported Services and other Proposition 56 Directed payments for Family Planning Services and initiatives.

Policy:

1. Under federal law, "a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive [family planning] services under Section 1396d (a)(4)(C) of this title…"(with limited exceptions).6 Therefore, Members must be allowed freedom of choice of family planning Providers, and may receive such services from any qualified family planning Provider, including Out-of-Network Providers, without the need to obtain prior authorization. The Department of Health Care Services (DHCS) managed care contract (Contract) specifies the requirements pertaining to family planning services in Exhibit A, Attachment 9, Access and Availability.

2. Subject to obtaining the necessary federal approvals and appropriation of funds by the California Legislature, Plans, either directly or through their Subcontractors, must pay eligible contracted and non-contracted Providers a uniform and fixed dollar add-on amount for specified family planning services (listed below) provided to a Medi-Cal managed care Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D) with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval. The directed payments shall be in addition to whatever other payments eligible providers would normally receive.

3. The Health Plan is responsible for ensuring that qualifying family planning services or medical pregnancy termination services are reported to DHCS in Encounter Data pursuant to DHCS APL 14-019, "Encounter Data Submission Requirements" using the procedure codes listed in DHCS APLs 23-008 and 23-015. Both professional and facility claims are eligible for reimbursement for payment under the program, but not both for the same service. The Health Plan is responsible for ensuring that the Encounter Data reported to DHCS is appropriate for the services being provided. The Health Plan must include oversight in their utilization management processes, as appropriate. Health The uniform dollar add-on amounts of the directed payments vary by procedure code (See Attachment "A").

4. Professional and facility claims are eligible for reimbursement for payment under the program, but not both for the same service. The Health Plan is responsible for ensuring that the Encounter Data reported to DHCS is appropriate for the services being provided.

a. The Health Plan must include oversight into our utilization management processes, as appropriate.

b. The uniform dollar amount of the directed payments varies by procedure code.

5. It is the policy of the Health Plan to reimburse State Supported Services pursuant to contractual requirements and the published Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003 for Abortion Services. The Health Plan maintains appropriate procedure codes per Medi-Cal guidelines to allow for appropriate claims processing. Procedure codes are updated monthly to ensure appropriate reimbursement and processing of claims received. Procedure codes are subject to change based on Medi-Cal updates, Current Procedural Terminology Codes (CPT) 59840 through 59857 and HCFA Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. Reference: 3 Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003, Abortion Services.

6. The Health Plan, either directly or through their Subcontractors, must pay the individual rendering Providers that are qualified to provide and bill for medical pregnancy termination services with dates of service on or after July 1, 2017, in accordance with APL 23-015. Consistent with the enacted budgets, DHCS is requiring the Plan, or their Subcontractors, to pay at least the rate for Current Procedural Terminology – 4th Edition (CPT-4) code 59840 in the amount of $400 and CPT-4 code 59841 in the amount of $700. This payment obligation applies to contracted and non-contracted Providers.

    a. The Health Plan is responsible for ensuring that the specified CPT-4 codes are appropriate for the services being provided and that this information is submitted to DHCS in Encounter Data that is complete, accurate, reasonable, and timely.

    b. In instances where a member is found to have Other Health Coverage Sources, the Health Plan must Cost Avoid or make a post-payment recovery.

7. Providers are reimbursed based on Medi-Cal fee for service fee schedule or based on contractual agreement rate with the provider. The Health Plan processes reimbursement within standard claims turnaround times. State Supported Services are outlined in the Contract and subsequent contract amendments.

8. The Health Plan shall identify eligible providers for clean claims received that qualify for this uniform dollar add-on directed payment. The state directed payments are in addition to whatever payments eligible providers normally receive from the Health Plan, or the Health Plan's Subcontractors.

    a. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), American Indian Health Service Program (AIHSP) and Cost-Based Reimbursement Clinics are not eligible to receive this uniform dollar add-on directed payment.

    b. Both professional and facility claims are eligible for reimbursement for payment under the program, but not both for the same service.

9. Turnaround times for payment of the claim are based on the published DHCS APL or are contingent on formal publishing date by the Agency. The directed payment program focuses on the following categories of family planning services:

a. Long-acting contraceptives, excluding off label use for medical benefit

b. Other contraceptives (other than oral contraceptives) when provided as a medical benefit

c. Emergency contraceptives when provided as a medical benefit

d. Pregnancy testing

e. Sterilization procedures (for females and males)

10. The Health Plan shall adhere to timely payment standards outlined in the managed care contract (Exhibit A, Attachment 8, Provision 5) for clean claims or accepted encounters that are received by the Health Plan or Subcontractor within (1) year of the date of service.

    a. The Health Plan shall publish clear policies and procedures to their network providers with respect to claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter.

    b. The Health Plan has an obligation to communicate and provide clear policies and procedures to their Network Providers with respect to the Health Plan's claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter.

    c. If the Network Provider does not adhere to the Health Plan's articulated policies and procedures, the Health Plan is not required to make payments for claims or encounters submitted one (1) year following the date of service, although timely filing requirements may be waived through an agreement in writing between the Health Plan (or the Health Plan's subcontractors) and the Network Provider.

11. Data Reporting

    a. The Health Plan must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance document available on the DHCS Directed Payment – Proposition 56 website, which is hereby incorporated herein by reference.

12. Payment and Other Financial Provisions

    a. The Health Plan shall ensure that qualifying family planning services are identified using the procedure codes listed in APLs 23-008 and 23-015.

    b. The Health Plan and its subcontractors shall not pay for any services or items, other than Emergency Services, to an excluded Provider as defined in the "Definitions" section of the DHCS' contract.

        1. This prohibition must apply to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded

Provider when the Provider knew or had reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

c. The Health Plan must have a formal procedure for the acceptance, acknowledgement, and resolution of Provider grievances related to the processing or non-payment of a directed payment as required by DHCS APLs 23-008 and 23-015.

i. The Health Plan must have a process to communicate the requirements to Providers.

1. The communication to Providers must, at a minimum, include:

a. A description of the minimum requirements for a qualifying services;

b. How payments will be processed;

c. How to file a grievance;

d. How to identify the responsible payer;

2. The Health Plan must make available to a Provider an itemization of payments made to the Provider in accordance with DHCS APLs 23-008 and 23-015.

a. The itemization must include sufficient information to uniquely identify the qualifying services for which payment was made, be provided upon the Provider's request unless the Health Plan has an established a periodic dissemination schedule and be made available in electronic format when feasible.

13. The projected value of the directed payments will be accounted for in the Health Plan's actuarially certified, risk-based capitation rates.

14. The Health Plan is responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by the Health Plan to all applicable. Subcontractors and Network Providers. DHCS may impose corrective action plans, as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see DHCS APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements DHCS APL's may result in a Corrective Action Plan and subsequent Sanctions.

Procedure:

1. Initial reimbursement: clean claim received for services are processed based on the Health Plan's Policies and Procedures:

    a. PHC-CA Claims Compliance Timeliness, and

    b. PHC-CA Provider Reimbursement

2. Directed Payments (Proposition 56)

    a. The Health Plan identifies dates of service where clean claims qualified as State Supported Services.

    b. Identified clean claims are reviewed by Claims Department for direct payment processing.

        i. When applicable, the National Drug Code (NDC) is reviewed to confirm the billed procedure code(s) for "unspecified" drugs is related to a contraceptive. Claims with NDC's not related to DHCS APL 23-008 are excluded from directed payment reprocess if no other service line qualifies for the direct payment.

    c. The original claim is adjusted to allow for additional direct payment to provider at the rate specified in the published DHCS APL.

    d. The adjustment claim is left in an allowed status for processing on the Health Plan's next scheduled check run, which occurs twice a week.

3. Provider Grievances

    a. The Health Plan shall follow the Provider Grievance procedure outlined in the Provider Manual and described on the PHC California website.

4. Provider Communications

    a. The Health Plan's Provider Relations Department shall communicate the requirements of DHCS APLs 23-008 and 23-015 and subsequent iterations to ensure compliance with regulatory and contractual requirements.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Care Management Compliance Committee.

Definitions:

1. Clean Claim: means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A "clean claim" is defined in 42 CFR section 447.45(b).

2. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

3. Directed Payment Initiative: means a payment arrangement that directs certain expenditures made by the Health Plan under this Contract and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

4. Eligible Provider: 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. See Title 22 California Code of Regulations (CCR), Section 51200.

5. Grievance: means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Health Plan's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Health Plan to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Health Plan processes. If Health Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.

6. Member or Enrollee: means a Potential Member who has enrolled with the Health Plan.

7. Network Provider: means any Provider or entity that has a Network Provider Agreement with Health Plan, Health Plan's Subcontractor, or Health Plan's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

8. State Supported Services: means Medi-Cal services that are funded entirely by the State, and for which the State does not receive matching federal funds. These services are covered by the Health Plan through their Secondary Contract with DHCS for State Supported Services.

9. Subcontractor: means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

References:

1. DHCS Managed Care Contract

2. Medi-Cal Provider Manual for Abortion Services

3. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003, Abortion Services, published March 29, 2024 (supersedes APL 22-022)

5. Department of Health Care Services (DHCS) All Plan (APL) 23-008, Proposition 56 Directed Payments for Family Planning Services, published June 26, 2023 (supersedes APL 22-011)

6. Policy and Procedure PHC-CA Claims Compliance Timeliness

7. Policy and Procedure PHC-CA Provider Reimbursement

4. Title 42 of the United States Code (U.S.C.), Section 1396a (a)(23)(B)

5. 42 U.S.C. Section 1396d (a)(4)(C)

6. Prop 56 Directed Payments Expenditures File Technical Guidance is available at: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Proposition-56-Directed-Payments-Expenditures-File-Technical-Guidance.pdf

Superseded APL's for reference

7. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-022, Abortion Services, published October 28, 2022 (supersedes APL 15-020)

8. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-020, Abortion Services, published September 30, 2015.

9. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008 (supersedes APL 22-011), Proposition 56 Directed Payments for Family Planning Services, dated June 27, 2023.

10. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-015 (supersedes APL19-013), Proposition 56 Directed Payments for Private Services, dated June 9, 2023

ATTACHMENT A

Procedure Code	Description	Uniform Dollar Add-on Amount	Dates of Service
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	$301.00	1/1/2022 – Ongoing
J7295	CONTRACEPTIVE VAGINAL RING: ETHINYL ESTRADIOL AND ETONOGESTREL	$301.00	1/1/2022 – Ongoing
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00	7/1/2019 – Ongoing
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00	7/1/2019 – Ongoing
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00	
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00	7/1/2019 – Ongoing
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00	7/1/2019 – Ongoing
J7303	CONTRACEPTIVE VAGINAL RING	$301.00	7/1/2019 – 12/31/2021
J7304	CONTRACEPTIVE PATCH	$110.00	7/1/2019 – 12/31/2021
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00	7/1/2019 – Ongoing
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00	7/1/2019 – Ongoing
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00	7/1/2019 – Ongoing

J3490U8	DEPO-PROVERA	$340.00	7/1/2019 – Ongoing
11976*	REMOVE CONTRACEPTIVE CAPSULE	$399.00	7/1/2019 – Ongoing
11981	INSERT DRUG IMPLANT DEVICE	$835.00	7/1/2019 – Ongoing
55250*	REMOVAL OF SPERM DUCT(S)	$521.00	7/1/2019 – Ongoing
58300*	INSERT INTRAUTERINE DEVICE	$673.00	7/1/2019 – Ongoing
58301*	REMOVE INTRAUTERINE DEVICEDEVICE	$195.00	7/1/2019 – Ongoing
58340*	CATHETER FOR HYSTEROGRAPHY	$371.00	7/1/2019 – Ongoing
58555*	HYSTEROSCOPY DX SEP PROC	$322.00	7/1/2019 – 12/31/2019
58565*	HYSTEROSCOPY STERILIZATION	$1,476.00	7/1/2019 – 12/31/2019
58600*	DIVISION OF FALLOPIAN TUBE	$1,515.00	7/1/2019 – Ongoing
58615*	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00	7/1/2019 – Ongoing
58661*	LAPAROSCOPY REMOVE ADNEXA	$978.00	7/1/2019 – Ongoing
58670*	LAPARASCOPY TUBAL CAUTERY	$843.00	7/1/2019 – Ongoing
58671*	LAPARASCOPY TUBAL BLOCK	$892.00	7/1/2019 – Ongoing
58700*	REMOVAL OF FALLOPIAN TUBE	$1,216.00	7/1/2019 – Ongoing
59840	INDUCED ABORTION (BY DILATION AND CURETTAGE)	$400.00	July 1, 2017 – Ongoing
59841	INDUCED ABORTION (BY DILATION AND EVACUATION)	$700.00	July 1, 2017 - Ongoing
81025	URINE PREGNANCY TEST	$6.00	7/1/2019 - Ongoing

* Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 55250, 58300, 58301, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

"Ongoing" means the directed payment is in effect, subject to CMS approval and future appropriation of funds by the California Legislature, until discontinued by DHCS via an amendment to this APL.