

**Department of Health Care Services
Benefits, Waiver Analysis and Rates Division
State Plan Amendment Number 11-013 to Limit the Total Number of
Physician Office and Clinic Visits to Seven Per Fiscal Year**

Background:

State Plan Amendment (SPA) Number 11-013 will amend the State Plan to implement Welfare and Institutions (W&I) Code Section 14131.07. W&I Code Section 14131.07 limits the total number of physician office and clinic visits for physician services provided by a physician, or a medical professional under the direction of a physician, that are a covered benefit under the Medi-Cal program to seven visits per beneficiary per fiscal year. W&I Code Section 14131.07 also exempts certain services and beneficiaries from the limitation. For purposes of this limit, a visit includes physician services provided at any federally qualified health center, rural health clinic, community clinic, outpatient clinic, and hospital outpatient department. The limit will be implemented only to the extent permitted by federal law. DHCS plans to submit the SPA to seek federal approval for implementation of the limit.

Description of SPA:

DHCS plans to submit SPA 11-013 no later than July 29, 2011, to amend the State Plan and establish a physician office and clinic visit limit. SPA 11-013 will limit the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that are a covered benefit under the Medi-Cal program to seven visits per beneficiary per fiscal year. For visits in excess of the seven visit cap, a physician, or other medical professional under the supervision of a physician, must certify in a written declaration that the services meet one or more of the following circumstances:

1. Prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.
2. Prevent deterioration in a beneficiary's condition that would otherwise result in an inpatient admission.
3. Prevent disruption in ongoing medical and/or surgical therapy, including, but not limited to, medications, radiation, or wound management.
4. Constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.
5. Are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.

The written declaration must include a description of the services and be maintained onsite at the physician's office or clinic location at which the medical records for the beneficiary are maintained. The records will be subject to audit and inspection by DHCS.

The following services and beneficiaries are not subject to the limitation:

- Specialty mental health services.
- Any pregnancy-related visits, or any visit for the treatment of any other condition that might complicate a pregnancy.
- Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
- Beneficiaries receiving long-term care in a nursing facility that is both of the following:
 - A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the program established by Section 14132.20 of the Welfare and Institutions Code.
 - Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.
- Beneficiaries receiving contracted managed care through Senior Care Action Network (SCAN), AIDS Healthcare Foundation, or the Program of All-Inclusive Care for the Elderly (PACE).

The cap is scheduled to take effect either October 1, 2011 (the first day of the first month following 180 days after enactment of the law), or the first day of the first month following 60 days after DHCS receives all federal approvals, whichever is later. In the first state fiscal year of implementation, the full amount of seven visits will be available from the Department's implementation date through June 30, 2012.

Impact on Indian Health Programs or Urban Indian Organizations:

- **Impact on Indian Health Programs**
This SPA affects all Indian health care facilities that provide physician services to Medi-Cal beneficiaries.

For providers who are physicians, or other medical professionals under the direction of a physician, this SPA will limit physician visits to seven per beneficiary per fiscal year, unless the Medi-Cal patient meets one of the above exemptions. A reservation system will be developed to allow providers to check a beneficiary's usage of visits against this cap. A provider will be able to check the system, and if the cap has not been met, the provider will be able to reserve the service facilitating payment when it is billed. If the cap has been met, the physician, or other medical professional under the direct supervision of a physician, will be required to certify that at least one of the exempted conditions exists for visits that exceed the seven visits cap.

- **Impact on Indian Medi-Cal Beneficiaries**

This SPA affects beneficiaries who receive physician services at Indian health care facilities. This SPA will impact Indian Medi-Cal beneficiaries, if:

- The beneficiary has received seven or more physician visits in a fiscal year; and,
- The requested service does not meet one or more of the exempted conditions noted above.

Response Date:

Indian Health Programs and Urban Indian Organizations may submit written comments, questions concerning this SPA, and request a copy of the full text of the SPA by email to Kathryn.Waje@dhcs.ca.gov or by mail to the address below within 30 days from the receipt of this notice.

Contact Information:

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