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Department of Health Care Services



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FAQs- All Plan Rate Meeting for Assembly Bill 97, July 21, 2011

Dear Plan Partner:

Although the Department of Health Care Services has statutory authority to implement the different sections of AB 97, the statutes cannot be implemented until DHCS receives approved State Plan Amendments or a Waiver Amendment from the federal government. As part of the reiterative process, contracting health plans were encouraged to submit questions to DHCS in anticipation of the implementation of AB 97. The document below summarizes the questions submitted and DHCS responses.

Will it be possible to share the SPA access study on the DHCS website?

The SPA access analyses are now available online on the DHCS website at the following link: <http://www.dhcs.ca.gov/pages/RateReductions.aspx>

How will DHCS account for Emergency Department services utilized at a non-contract hospital?

When calculating the Emergency Room component of the capitation rate, DHCS generally uses the average cost of these services and does not differentiate as to whether the service is provided at a contract or noncontract hospital.

Will any line items in the Provider Payment Reductions (PPR) exceed 10 percent?

Individual categories of service will not be reduced by more than 10 percent.

Will there be different PPR implementation dates for Fee-For-Service (FFS) and Managed-Care?

DHCS will implement the PPR retroactive to July 1, 2011, for managed care plans. FFS PPR will be implemented retroactive to June 1, 2011.

Can DHCS provide a comprehensive list of “included” categories of service (COS) as with “excluded” COS?

The legislation addresses excluded categories of service and as such DHCS will not be providing a list of included categories of service. Each plan should consult their respective legal counsel when making a determination as to whether a category of service is excluded or included.

How will the rate reduction affect FQHCs?

DHCS will be reducing this category of service by the actuarial equivalent of 10 percent. DHCS will continue its discussions with plan partners on an implementation strategy. The FQHCs will continue to be made whole through the interim payment process.

Will there be retroactive changes to the Managed-Care and FFS fee schedule?

AB 97 calls for retroactive changes in terms of rate freezes and payment reductions of up to 10 percent, effective July 1, 2011 for Managed Care rates and June 1, 2011 for FFS fees.

Will DHCS schedule a follow-up meeting for implementation of AB 97?

DHCS will host an All Plan Conference Call on November 18, 2011, from 9:45 am to 11:30 am, to address plan issues related to the implementation of AB 97.

SEVEN VISIT SOFT CAP

DHCS currently does not have federal approval to implement the Seven Visit Soft Cap. As a result, an actuarial equivalent has not been applied to the managed care rates. If approval to implement caps is granted by CMS, DHCS will evaluate the applicability to managed care and whether an actuarial equivalent rate reduction is appropriate. In addition, DHCS will work with plan partners and stakeholders to address caps in the managed care environment in a fair and equitable manner.

Will these caps apply to dual-eligibles?

Not Applicable

How do we track 7 Visits with soft cap? What if a visit is medically necessary?

Not Applicable

Is preventative care exempt from the soft caps?

Not Applicable

Who will notify beneficiaries of cap?

Not Applicable

Will timing of implementation affect number of beneficiaries “tripping” cap?

Not Applicable

Is Urgent Care the same as ER; is urgent care subject to caps?

Not Applicable

Do caps apply to developmentally disabled visits?

Not Applicable

Do caps apply to services provided at FQHCs?

Not Applicable

What will DHCS do to ensure that ER utilization does not increase as an unintended consequence of the caps?

Not Applicable

Can DHCS provide a comprehensive calendar or timeline for Soft Cap implementation?

Not Applicable

How will Soft Caps be rolled out? How much lead time will be provided?

Not Applicable

How can caps be tracked if member switches plans?

Not Applicable

Does a beneficiary’s Initial Health Assessment count under cap since it is required?

Not Applicable

Will increased admin costs be considered?

Not Applicable

COPAYMENTS

Although the DHCS has statutory authority to impose copayments on Medi-Cal beneficiaries receiving services through a managed care plan, the statute cannot be implemented until DHCS receives an approved Waiver amendment. As a result, an actuarial equivalent for copayments has not been applied to the managed care rates. If a Waiver amendment to implement copayments is granted, DHCS will convene a plan stakeholder group to address the plan questions posed, as well as to secure additional input from its plan partners. The questions provided by the managed care plans are provided for the record and for information purposes.

Do copayments apply to dual-eligibles?

Not Applicable

Can DHCS provide legal support on provider outpatient care refusals of service, if copays are not paid?

Not Applicable

Will there be copayment maximums? Was a waiver for this requirement submitted to CMS?

Not Applicable

What if a beneficiary cannot pay?

Not Applicable

What if beneficiaries change health plans. Who will keep track of copayments paid, if there is a limit?

Not Applicable

Will a 90-day pharmacy refill copayment be applied once or three times?

Not Applicable

Some providers require office visit to refill which may result in financial hardship for beneficiary. How will DHCS address this concern?

Not Applicable

Is there a policy recommendation regarding the variability / flexibility of copays with the use preferred/non-preferred prescriptions (or generic versus non-generic)?

Not Applicable

How will DHCS deal with the possible unfair competition advantage that may occur if some plans choose not to implement copayments?

Not Applicable

How will this affect those in Share-of-cost Medi-Cal?

Not Applicable

Will Roger's rate be reduced accordingly if copays are implemented?

Not Applicable

Who pays for foster kids?

Not Applicable

PHARMACY

Is there a policy or recommendation on how plans will undertake the move from Average Wholesale Price (AWP) to Actual Acquisition Cost (AAC)?

The Medi-Cal Managed Care plan's contract with the DHCS does not require that the plans reimburse pharmacies at the Medi-Cal Fee-For-Service rate, therefore the move from AWP to AAC is not applicable to Managed Care plans.

How will plans quantify AWP vs. AAC? How will plans impose acquisition costs if PBM considers this information confidential and isn't willing to share this information with the department?

The Medi-Cal Managed Care plan's contract with the DHCS does not require that the plans reimburse pharmacies at the Medi-Cal Fee-For-Service rate, therefore the move from AWP to AAC is not applicable to Managed Care plans.

Medi-Cal Managed Care contracts require the plans report pharmacy reimbursement costs to the DHCS, the contract does not require that the Managed Care plan disclose specific methodology or values. A similar example occurs today in how pharmacy benefit managers (PBMs) establish the Maximum Acquisition Costs (MAC) for generic drugs, in this example, the calculation methodology is proprietary but the value is not.

Can you provide more information on the policy change in use of Enterals?

Effective October 1, 2011, the enteral nutrition product benefit is limited to products administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. Beneficiaries eligible for Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT) services shall be exempt from this limitation. As a result, beneficiaries who are full scope Medi-Cal and under 21 years of age remain eligible for oral enteral products when medically necessary. Plans should not confuse EPSDT and EPSDT-SS (supplemental services), when a patient is eligible for oral enteral products, the payer remains the responsible entity and continues to be Medi-Cal Fee-For-Service, the plan, or the CCS program.

In addition to beneficiaries eligible for oral enteral products as EPSDT services, enteral nutrition products not administered through a feeding tube remain a benefit for patients with diagnoses, including, but not limited to, specified malabsorption, and specified inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

Initial and reauthorization TARs approved prior to October 1, 2011 for enteral nutrition products, will be valid for the number of days specified on the TAR and product must be dispensed during the valid “from-through” period.

Plans should review the Medi-Cal FFS provider bulletins and Manual Pages for the latest information.

Would a policy for providers requiring office visit to refill prescriptions be addressed?

No, managed care plans will need to develop their own policies in this area and submit them to DHCS for approval.