

# Department of Health Care Services (DHCS)



**California Area Office, Indian Health Service-  
Program Directors Meeting  
July 22, 2011**



# Budget Overview

## The 2011-2012 Budget Act

- Enacted June 30, 2011
  - General Fund (G.F.) Only
    - State of California \$85.9 billion
    - DHCS \$14.9 billion (17% of total G.F. budget)

- \$26.6 billion budget gap

- To close the budget gap

\$15.0 billion Expenditure Reductions

(DHCS Medi-Cal = \$2 billion,  
about 13% of G.F. cuts)

\$.9 billion Revenues

\$2.9 billion Other Solutions

\$8.3 billion in Natural Changes

\$27.2 billion

This will leave the state with a reserve of \$543 million.





Background: Executive Orders and statutes recognize the unique relationship of Tribes with the federal government and emphasize the importance of States to work with Tribes and Designees of Indian Health programs on matters that may impact Indian health.

# Tribal Advisory Process

- DHCS is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on Medi-Cal matters having a direct effect on Indians, Indian Health Programs or Urban Indian Organizations per the Section 5006 (e) of Public Law 111-5, the American Recovery and Reinvestment Act of 2009 (ARRA).
- DHCS uses various methods to seek advice.  
The methods of communication include, but are not limited to the following:
  - Written communication (Notices)
  - Electronic (Webinars and teleconferences)
  - Face-to-Face Meetings
  - DHCS will host one annual Tribal meeting
  - DHCS may also convene other meetings if further discussion is needed or requested
  - DHCS will also participate in federal meetings as needed

# Indian Health Clinic Data Review



# Number of Med-Cal Users by Age at Indian Health Clinics During July 2010 - May 2011

	Age Group			Totals	
	0-20 yrs.	21-64 yrs.	65 yrs. or older	Grand Total	Total 21 yrs. and older
<b>Users</b>	26,797	33,656	3,800	64,253	37,456
<b>Visits</b>	75,600	54,180	6,118	135,898	60,298
<b>Visits per User</b>	2.82	1.61	1.61	2.12	1.61

Source: Fee-For-Service, DHCS Administered, Medi-Cal '35' file paid claims data, July 2010 - May 2011 months of service.

User, visit, and expenditure totals do not include claims with clinical classifications of "disorders of teeth and jaw" – ccs\_prime '136.' 6

Note: Data represent incomplete counts. Totals included less than a twelve-month lag.

# Number of Registered Indians, Paid Claims and Estimated Number of Visits Per Beneficiary for IHS/HCFA (CMS) MOA Clinics Calendar Year 2010 (All Age Groups)

QUARTERLY	NUMBER OF INDIAN MATCH	TOTAL AMOUNT PAID	\$289/VISIT	NUMBER ESTIMATED VISIT PER USER
JAN 2010 - MAR 2010	16,506	\$ 3,914,841.07	13,546	0.82
APR 2010 - JUN 2010	16,076	\$ 3,874,375.65	13,406	0.83
JULY 2010 - SEPT 2010	12,374	\$ 2,784,213.98	9,634	0.78
OCT 2010 - DEC 2010	24,795	\$ 5,985,799.24	20,712	0.84

# Indian Health Clinic-Most Frequently Billed Clinical Classifications Ages 21 Years and Older July 2010 – May 2011 (Excludes Dental Services)

	Clinical Classification	Users	Visits	Total Expenditures
1	Administrative/social admission	4,075	6,037	\$ 1,669,600
2	Other upper respiratory infections	4,110	5,501	\$ 1,489,286
3	Spondylosis; intervertebral disc disorders; other	2,458	5,667	\$ 1,391,814
4	Mood disorders	1,508	3,585	\$ 920,916
5	Normal pregnancy and/or delivery	773	3,127	\$ 891,600
6	Other non-traumatic joint disorders	1,593	2,672	\$ 663,735
7	Diabetes mellitus without complication	1,452	2,955	\$ 610,352
8	Attention-deficit conduct and disruptive behavior	656	2,063	\$ 574,730
9	Medical examination/evaluation	2,004	2,098	\$ 554,270
10	Anxiety disorders	920	1,934	\$ 509,387
11	Residual codes; unclassified	1,350	1,787	\$ 459,408
12	Immunizations and screening for infectious disease	1,494	1,618	\$ 443,355
13	Otitis media and related conditions	1,191	1,560	\$ 429,614
14	Other connective tissue disease	1,133	1,717	\$ 415,553
15	Essential hypertension	1,231	1,947	\$ 389,396
	<b>Totals</b>	<b>25,948</b>	<b>44,268</b>	<b>\$ 11,413,016</b>

Source: Fee-For-Service, DHCS Administered, Medi-Cal '35' file paid claims data, July 2010 - May 2011 months of service.

User, visit, and expenditure totals do not include claims with clinical classifications of "disorders of teeth and jaw" – ccs\_prime '136.'8

Note: Data represent incomplete counts. Totals included less than a twelve-month lag.

# **DHCS Proposed SPA to Limit the Total Number of Physician Office and Clinic Visits to Seven Per Year**



	<b>Seven Visit Soft Cap (SPA 11-013) Indian Health Advisory Process</b>
January 2011-March 2011	Legislative hearings, IHS Program Directors Meeting, IHS Tribal Leaders Meeting
May 16, 2011	DHCS releases tribal and designee notice on proposed SPA 11-013
May 31, 2011	DHCS hosts quarterly webinar on proposed changes to the Medi-Cal program
June 13, 2011	DHCS alerted to comparability issues with proposed SPA
June 17, 2011	DHCS holds teleconference to alert tribes and designees of change in impact of SPA
June 22, 2011	DHCS releases revised SPA 11-013 tribe and designee notice that no longer exempts Indian Health Services/Memorandum of Agreement Providers
July 19, 2011	DHCS held requested tribe and designee meeting
July 22, 2011	DHCS presents at IHS Program Directors Meeting  Written comments due to DHCS

## SPA 11-013

# Limit the Total Number of Physician Office and Clinic Visits to Seven Per Year

### Background

- On March 23, 2011, the Legislature enacted Assembly Bill (AB) 97 (Chapter 3, Statutes of 2011), Section 100.5 to 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.
- DHCS will implement the limit as authorized by (Welfare and Institutions Code, Section 14131.07) only to the extent that the seven office visits are determined by DHCS to comply with federal Medicaid requirements.
- For purposes of this limit, a visit includes physician services provided at any FOHC, RHC, community clinic, outpatient clinic, and hospital outpatient department.

## SPA 11-013

# Limit the Total Number of Physician Office and Clinic Visits to Seven Per Year

- The cap is scheduled to take effect either October 1, 2011 (the first day of first month following 180 days after AB 97 was signed), or the first day of the first month following 60 days after DHCS receives all federal approvals, whichever is later.
- Certain services and beneficiaries are not subject to the limitation.
- 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.

# SPA 11-013 Exemptions to Seven Visit Limit

- Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
  - EPSDT is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided.
  - EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additionally medically necessary services.
- Any pregnancy-related visits, or any visit for the treatment of any other condition that might complicate a pregnancy
- 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; and
  - A licensed nursing facility pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.
- Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation, and through the Program of All-Inclusive Care for the Elderly (PACE).

# Exemptions to Seven Visit Limit Cont'd

- Specialty mental health services are those provided through the Specialty Mental Health Services (SMHS) waiver
  - A. Services Provided Under the SMHS Waiver are:
    - Rehabilitative mental health services, including
      1. Mental health services
      2. Medication support services
      3. Day treatment intensive
      4. Day rehabilitation
      5. Crisis intervention
      6. Crisis stabilization
      7. Adult residential treatment services
      8. Crisis residential treatment services
      9. Psychiatric health facility services
  - B. Psychiatric inpatient hospital services
  - C. Targeted case management (TCM): TCM is an optional Medi-Cal Program funded by federal and local funds. The TCM Program provides specialized case management services to Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. TCM services include: Needs assessment, Development of an individualized Service Plan , Linkage and Consultation, Assistance with accessing services, Crisis assistance planning, and periodic review
  - D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services

# 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. (In development)
- Physicians will not need to forward a copy of the certification with the claims. Must maintain certification in medical records. Certifications are subject to audit. (In development)
- DHCS will issue a provider bulletin to outline these requirements and will issue a beneficiary notice informing them of the limitations and conditions for exceeding the soft 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.

# Questions Received on Proposed SPA 11-013 and Responses



# Written Questions Received To Date

1. Does the 7 visit apply to I/T/U's with an MOA?

**DHCS Response:** Yes, the 7-visit limit applies to all Indian health care facilities that provide physician services to Medi-Cal beneficiaries.

2. What form is needed to approve a visit over the 7 –visit limit? Is it a CMS form or is this something the clinic documents in their file?

**DHCS Response:** The written declaration for visits in excess of 7 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.

3. How will the clinic know that the patient has reached the limit of hospital visits or walk-in visits at other facilities?

**DHCS Response:** A reservation system will be developed by DHCS 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 from AB 97 exists for visits that exceed the seven visits cap. (In development)

## Written Questions Received To Date Continued

4. Does this SPA affect all beneficiary's? Children also?

**DHCS Response:** No, the physician visit limit does not apply to individuals under the age of 21 who have full scope Medi-Cal Eligibility. For additional information please refer to California Welfare and Institutions Code Section 14131.07 (e) which states that the physician visit limit does not apply to beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The EPSDT program is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility.

5. Will visits in excess of 7 required prior authorization through a Treatment Authorization Request (TAR)?

**DHCS Response:** No, a TAR will not be required for visits in excess of 7. Patients must meet 1 or more of the 5 established criteria for exceeding the visit cap. The written declaration for visits in excess of 7 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. (In development)

## Written Questions Received To Date Continued

6. The State is required by Federal Law to "**CONSULT**" with tribes on matters that affect Indians and Medicaid (Medi-Cal). When and where did this consultation take place????

**DHCS Response:** DHCS notified Tribes and Designees of the proposed change to the Medi-Cal Program on May 16, 2011 in accordance with DHCS' approved SPA 10-018. In addition, DHCS hosted a webinar on May 31, 2011 to present and receive feedback on all SPAs and Waiver Renewals that were proposed for submission by June 30, 2011. During the comment period, DHCS received information that required a revision to the initial notice that was sent on May 16, 2011. DHCS immediately convened a teleconference to present the information. The teleconference was held on June 17, 2011. On June 22, 2011, DHCS issued a revised summary document for SPA 11-013, which allowed for an additional 30 days for comments/feedback.

# Proposed Co-Payments Welfare and Institutions Code 14134

## Visit Copayments:

- Copayment for Physician and FQHC/RHC Visits
- Copayment for Dental Office Visits
- Pharmacy Copayments
- Copayments for Nonemergency ER visits
- Copayments for Emergency ER visits
- Copayment per Hospital Inpatient Day/Max \$200 per Admission

# Contact Information:

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Thank You