

Department of Health Care Services (DHCS)



Indian Grinding Rock

**CMS-IHS I/T/U Outreach & Education Training
Medi-Cal Overview and Update
September 14, 2011**

What is Medicaid?

- An entitlement program created in 1965 under Title XIX of the Federal Social Security Act.
- Makes available medically necessary health care services for low income families, children, pregnant women, seniors and persons with disability who meet criteria for program services.
- Is a federal-state partnership which plays a key role in health care delivery systems.
- Makes available federal funding, known as federal financial participation (FFP) for programs that are in compliance with applicable federal Medicaid statutes, regulations and policies.

What is Medicaid? (cont.)

- States are able to receive FFP, based on their federal medical assistance percentage (FMAP), for program administration and covered medical services through federally approved:
 - State Plan and State Plan Amendments (SPAs), which are the formal “contracts” with the federal government in administering Medicaid programs; and
 - Federal waivers, which allow states to “waive” certain rules pertaining to program implementation.

So What is Medi-Cal?

- Medi-Cal is California's version of Medicaid established in 1966 under the Welfare & Institutions Code, starting at Section 14000
 - Program regulations are found under the California Code of Regulations, Title 22, Division 3.
- Is administered by DHCS, which serves as the Medicaid Single State Agency and is responsible for ensuring the program is administered in accordance with applicable federal and state statutes, regulations and policies.

So What is a State Plan?

- The **State Plan** - the official contract between the state and federal government by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding.
- Is developed by the Single State Agency and is submitted to and approved by the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid partners.
- Describes the nature and scope of Medicaid programs and gives assurances that it will be administered in accordance with the specific requirement of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and other applicable official issuance of the applicable State.
- California's State Plan is over 1400 pages and can be accessed online at:
<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>

What is a State Plan Amendment?

- State Plan Amendment (SPA) - any formal change to the State Plan.
- Approved State Plans and SPAs ensures the availability of federal funding for the state's program.
- CMS reviews all State Plans and SPAs for compliance with:
 - Federal Medicaid statutes and regulations
 - State Medicaid Manual
 - Most current State Medicaid Directors' Letters which serve as policy guidance.

What Are Medicaid Waivers?

- They are not part of the State Plan. In general, Medicaid Waivers allow:
 - The federal government to waive specified provisions of Medicaid law (Title XIX of the Social Security Act (SSA) by the Secretary of the U.S. Department of Health and Human Services (HHS)).
 - Flexibility and encourage innovation in administering its Medicaid program to meet the health care needs of its populations.
 - Ability to provide medical coverage to individuals who may not otherwise be eligible and/or provide services that may not otherwise be allowed under the regular Medicaid rules.

Types of Medicaid Waivers

- Two sections of the SSA, Sections 1115 (Research and Demonstration Waivers) and 1915 (Program Waivers), allow states to apply to the federal government to obtain an exemption (i.e. “waiver) from particular Medicaid statutes.
- The three categories of federal Medicaid waivers are:
 - Section 1115: Research and Demonstration Projects
(e.g. Bridge to Healthcare Reform)
 - Section 1915 (b): Managed Care/Freedom of Choice Waivers
(e.g. County Organized Health Systems (COHS) – Health Insuring Organizations of California)
 - Section 1915 (c): Home and Community-Based Services Waivers
(e.g. Nursing Facility / Acute Hospital (NF/AH))

Medi-Cal Indian Health Clinic Data

Merced River-Cathedral Rock

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#yose40036

Indian Health Clinic Medi-Cal Providers

- 62 primary care clinic sites serving AI/AN
 - 6 Tribal Federally Qualified Health Centers (FQHC) sites
 - 49 Indian Health Services Memorandum of Agreement (IHS/MOA).
 - 7 Urban Indian FQHC Clinics sites

Number of Med-Cal Visits by Age at Indian Health Clinics (includes Duplicate Users) 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	% of 21 yrs. and older
Users	26,797	33,656	3,800	64,253	37,456	58%
Visits	75,600	54,180	6,118	135,898	60,298	44%
Visits per User	2.82	1.61	1.61	2.12	1.61	

Source: DHCS-Research and Analytical Studies Section. 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.' 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 Per Quarter for IHS/HCFA (CMS)
MOA Clinics
Calendar Year 2010
(All Age Groups – includes Duplicate Users)**

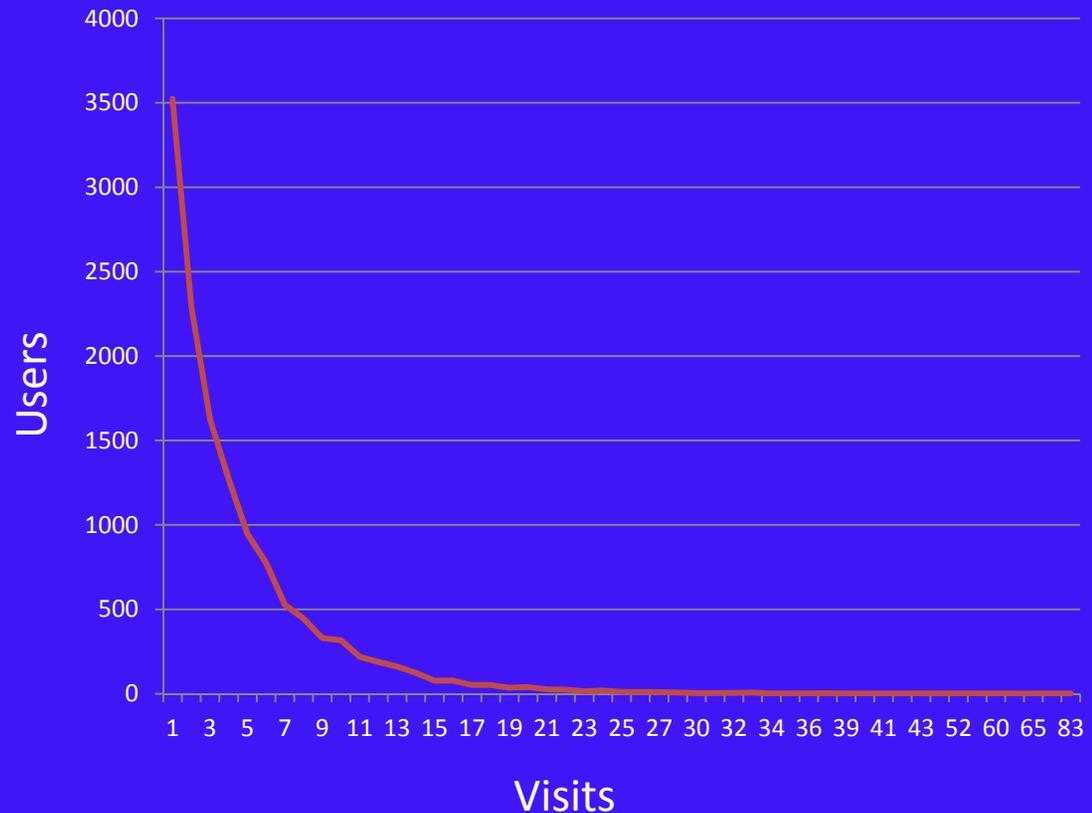
QUARTERLY	NUMBER OF INDIAN MATCH	TOTAL AMOUNT PAID	\$289/VISIT	NUMBER ESTIMATED VISIT PER USER
JAN 2010 - MAR 2010	16,506	\$ 3,914,841.07	13,546	0.82
APR 2010 - JUN 2010	16,076	\$ 3,874,375.65	13,406	0.83
JULY 2010 - SEPT 2010	12,374	\$ 2,784,213.98	9,634	0.78
OCT 2010 - DEC 2010	24,795	\$ 5,985,799.24	20,712	0.84
TOTAL	69,751	\$ 16,559,229.94	57,298	0.82

Based on data received from the Federal Indian Health Services, California Rural Indian Health Board, Inc, and Redding Rancheria data match.

*Indian defined as any member of a federally recognized Indian tribe; any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is living in California, is a member of the Indian community served by a local program of the Indian Health Service, and is regarded as an Indian by the community in which such descendant lives; any Indian who holds trust interest in public domain, national forest, or Indian reservation allotments in California; any Indian in California who is listed on the plans for distribution of the assets of California Rancherias and reservations under the Indian Self Determination Act (Public Law 93-638)

Number of Indian Health Clinic Visits per Unduplicated User Ages 21 and Older July 2010 – June 2011

- Users 13,240
- Visits 59,474
- Range 1 to 83
- Mean 4.50
- Median 3
- Mode 1
- 10,963 of 13,240 had 7 or less visits



Source. Fee-For-Service, DHCS administered, Medi-Cal '35' file paid claims, July 2010 - June 2011 months of service. July 2010 - June 2011 months of service have claim lags ranging from 0 to 11 months. Users were counted using CINs. Users are unduplicated and defined as individuals who utilized an IHC at least once throughout the fiscal year.

Note. Excludes claims for "disorders of teeth and jaw" (ccs_prim '136'). Totals do not include 162 paid claims that were missing a CIN.

Indian Health Clinic Payments July 2009 – June 2010

- Tribal Indian Health Clinics (FQHC & MOA)
 - Paid \$42.4 million
 - Average \$3.5 million per month
- Urban Indian Health Clinics
 - Paid \$10 million
 - Average \$832 thousand per month



Indian Health Clinic Utilization by Top Fifteen Clinical Classifications Categories by Expenditures July 2010 – June 2011

All Ages, Including "Disorders of Teeth and Jaw"

Disease Category	Users	Visits	Expenditures
Disorders of teeth and jaw	22,922	57,215	\$ 16,477,555.67
Administrative/social admission	4,549	7,000	\$ 1,940,699.22
Other upper respiratory infections	4,539	6,238	\$ 1,682,894.03
Spondylosis; intervertebral disc disorders; other	2,698	6,617	\$ 1,629,542.35
Mood disorders	1,689	4,223	\$ 1,080,974.18
Normal pregnancy and/or delivery	857	3,592	\$ 1,028,084.81
Other non-traumatic joint disorders	1,775	3,041	\$ 753,898.49
Diabetes mellitus without complication	1,567	3,349	\$ 693,955.53
Attention-deficit conduct and disruptive behavior	707	2,397	\$ 668,974.57
Medical examination/evaluation	2,248	2,370	\$ 627,860.49
Anxiety disorders	1,035	2,263	\$ 595,047.22
Residual codes; unclassified	1,533	2,063	\$ 532,573.82
Otitis media and related conditions	1,340	1,807	\$ 496,735.53
Immunizations and screening for infectious disease	1,641	1,787	\$ 489,908.56
Other connective tissue disease	1,276	1,990	\$ 480,359.95
Total	50,376	105,952	\$ 29,179,064.42

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

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

Indian Health Clinic Utilization by Top Fifteen Clinical Classifications Categories by Expenditures July 2010 – June 2011

Ages 21 and older, Excluding "Disorders of Teeth and Jaw"

Disease Category	Users	Visits	Expenditures
Spondylosis; intervertebral disc disorders; other	2,417	6,154	\$ 1,498,869.78
Normal pregnancy and/or delivery	661	2,812	\$ 803,849.86
Mood disorders	1,312	2,975	\$ 719,987.50
Diabetes mellitus without complication	1,530	3,265	\$ 669,837.68
Other non-traumatic joint disorders	1,470	2,610	\$ 632,636.28
Other upper respiratory infections	1,460	1,863	\$ 468,343.26
Essential hypertension	1,330	2,185	\$ 434,588.65
Other connective tissue disease	1,066	1,750	\$ 413,293.77
Other nervous system disorders	805	1,551	\$ 369,892.42
Anxiety disorders	748	1,389	\$ 342,576.61
Medical examination/evaluation	1,239	1,325	\$ 332,436.33
Diabetes mellitus with complications	757	1,547	\$ 325,280.73
Abdominal pain	671	1,050	\$ 253,527.29
Headache; including migraine	555	942	\$ 239,808.79
Skin and subcutaneous tissue infections	551	878	\$ 210,737.77
Total	16,572	32,296	\$ 7,715,666.72

Source: Fee-For-Service, DHCS Administered, Medi-Cal '35' file paid claims data, July 2010 - June 2011 months of payment. User, visit, and expenditure totals do not include claims with clinical classifications of "disorders of teeth and jaw" – ccs_prime '136.'

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

Tribal Medi-Cal Administrative Activities (MAA)

- The Tribal MAA program reimburses Tribes and Tribal Organizations for performing administrative activities allowed by the Tribal MAA program including, Outreach, Facilitating Medi-Cal Application Referrals to Medi-Cal Services, Non-Emergency/Non-Medical Transportation, Program and Policy Development, MAA Claims Coordination.
- Currently 18 participating providers
- Over \$1 million in paid claims since 2010

State Fiscal Year 2011-2012 Cost Containment Proposals

- Rate Reductions
- 7 Visit Soft Cap
- Adult Day Health Center Services Elimination
- Beneficiary Copayments





Rate Reductions

SPA 11-009

10% Payment
Reduction for
Outpatient Providers

SPA 11-009

10% Payment Reduction for Outpatient Providers

- Department of Health Care Services (DHCS) will implement the 10 percent payment reductions authorized by AB 97 (Welfare and Institutions Code, Section 14105.192) only to the extent that the reduced payments are determined by DHCS to comply with federal Medicaid requirements for services on or after June 1, 2011
- Impacted Providers include: physicians, clinics, optometrists, therapists, dentists, hospital outpatient departments, medical transportation, durable medical equipment, and clinical laboratories
- This SPA does not affect IHPs or UIHOs for purposes of Medi-Cal reimbursement
- This SPA does not affect Indian beneficiaries who receive outpatient services from Indian Health Clinics. Indian beneficiaries will be impacted by this SPA to the same extent as other Medi-Cal beneficiaries who receive outpatient services in non-Indian Health Clinics.
- This SPA has not yet been approved by CMS.



Yuba North Fork

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Seven Visit Soft Cap

SPA 11-013

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

SPA 11-013

Limit the Total Number of Physician Office and Clinic Visits to Seven Per 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 per beneficiary, per year are determined by DHCS to comply with federal Medicaid requirements.
- For purposes of this limit, a visit includes physician services provided at any FQHC, RHC, community clinic, outpatient clinic, and hospital outpatient department.
- 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.

SPA 11-013

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

- 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. 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)
- Stakeholder teleconference is scheduled September 28, 2011 to gather input on system.
- 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.



Weaving Materials



Adult Day Health Care Services

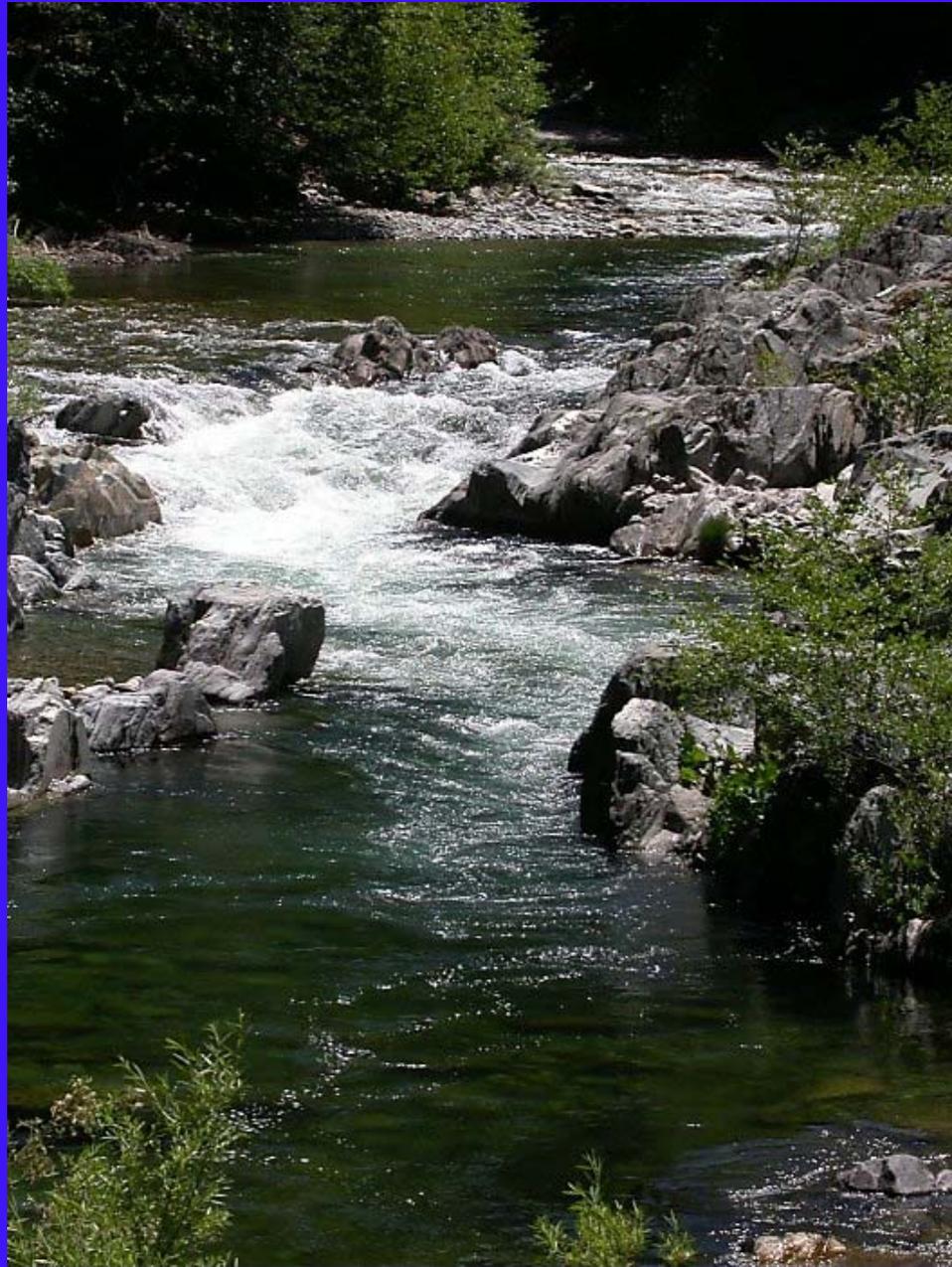
SPA 11-014 and
SPA 11-026

Eliminate Adult Day
Health Care

Elimination of Adult Day Health Care Services (ADHC)

- Adult Day Health Care (ADHC) is a licensed community-based day care program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home.
- Enacted on March 24, 2011, Assembly Bill 97, Chapter 3, Section 104 of Statutes of 2011, ADHC benefit is scheduled to term on September 1, 2011. SPA 11-014 eliminates ADHC benefit.
- July 2011-DHCS files SPA 11-026, which extends transition date to December 1, 2011.
- SPA 11-014 was approved by CMS on July 1, 2011.
- SPA 11-026 was approved by CMS on July 20, 2011.





Beneficiary Copayment

Background

- The Department of Health Care Services (DHCS) requested technical assistance from the Centers for Medicare and Medicaid Services and submitted an amendment to the 1115 Bridge to Reform Demonstration Waiver, which would allow the State to impose mandatory copayments on Medi-Cal beneficiaries.
- The mandatory copayments would be imposed on Medi-Cal beneficiaries regardless of eligibility category, age or whether they are participating in the Medi-Cal fee-for-service or enrolled in a health plan contracting with DHCS. However, a managed care health plan may establish a lower copayment or no copayment.
- Providers may collect the copayment from the beneficiary at the time of service. In the event the beneficiary does not pay the copayment at the time of service, the provider has the option to deny services, waive the copayment, or provide the service without waiving the copayment and hold the beneficiary liable for the amount owed. Providers will be reimbursed at the applicable Medi-Cal reimbursement rates less the copayment amount.

Description of Waiver Amendment (Cont'd)

Copayments would be required for the following services:

- nonemergency services received in an emergency room;
- emergency services received in an emergency room;
- each hospital inpatient day, with a maximum per admission;
- preferred drugs prescription or refill;
- non-preferred drug prescription or refill; and
- each visit for outpatient services including dental services received on an outpatient basis.



Impact

- **Impact on Indian Health Programs:**

The waiver amendment will impact Indian Health Programs because it imposes mandatory copayments on Medi-Cal beneficiaries. It will be the responsibility of the provider to collect these copayments.

- **Impact on Indian Health Beneficiaries:**

The waiver amendment will impact Indian Health beneficiaries because it imposes mandatory copayments on Medi-Cal beneficiaries.



Indian Water Basket



Yosemite

1115 Bridge to Health Care Reform Waiver Program

- Seniors and Persons with Disabilities
 - Mandatory Managed Care Enrollment
 - 16 counties
- California Children's Services Demonstration Projects
- Low Income Health Program
 - Covers adults between 19 and 64 years of age with family incomes at or below 133% of federal poverty level (FPL)
 - All 58 counties included

Other Affordable Care Act Activities

- Provider Preventable Conditions Implementation
- Medi-Cal Beneficiaries Smoking Cessation Program
- Continued Work on Establishing Health Insurance Exchange



Advisory Process

- Annual Designee Determination – September
- Continue Webinars – Mid November
- Plan to schedule statewide meeting on January/February 2012
- Developing Website





THANK YOU