Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program
February 28, 2018

Purpose

- The Department of Health Care Services (DHCS) is hosting this webinar regarding proposed changes to the Medi-Cal Program. This webinar will provide information and allow for feedback on State Plan Amendments (SPA) and Waiver Renewals/Amendments proposed for submission to Centers for Medicare and Medicaid Services (CMS).

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

- This webinar is one way for DHCS to provide information about the Medi-Cal program and get feedback verbally and writing.

Agenda

Topics	Presenters
Welcome/Overview	Corinne Chavez, Department of Health Care Services (DHCS), Indian Health Program (IHP) Coordinator
SPAs Scheduled for Submission by March 30, 2018	
Medi-Cal Fee-For-Service (FFS) SB 523: Ground Emergency Medical Transport Quality Assessment Fee SPA 18-004	Angel Rodriguez DHCS Provider Rates Division
Alternative Benefit Plan (ABP) Update to Add Marriage and Family Therapists (MFTs) as Billable Mental Health Providers in FQHCs and RHCs SPA 18-002	Kailey Hackbarth, AGPA DHCS Benefits Division
Marriage and Family Therapist Services and Reimbursement Policies Proposed Changes SPA 18-003	Corinne Chavez DHCS Primary, Rural, and Indian Health Division Jim Burkhardt DHCS Audits & Investigation Ralph Zavala DHCS Health Care Financing Division
Feedback/Closing	All

State Plan Amendment Overview

Medicaid State Plan Overview

State Plan: The official contract between the state and federal government by which a state ensure compliance with federal Medicaid requirements to be eligible for federal funding.

The State Plan describes the nature and scope of Medicaid program and gives assurance that it will be administered in accordance with the specific requirements of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and State law/regulations.

California's State Plan is over 1400 pages and can be accessed online at:

http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

State Plan Amendment (SPA) Overview

SPA: Any formal change to the State Plan.

Approved State Plans and SPAs ensure the availability of federal funding for the state's program (Medi-Cal).

The 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.

Department of Health Care Services (DHCS)

Angel Rodriguez

Provider Rates Section Chief, Fee for Service Rate Development Division

Ground Emergency Medical Transport Quality Assurance Fee (GEMT QAF) Program

SPA 18-004

GEMT QAF Program

The Program is a result of SB 523 (Chapter 773, Statutes of 2017) which was chaptered on October 13, 2017.

- Data reports due to DHCS by October 15, 2017
- GEMT QAF Program effective **July 1, 2018**

Affected Service Codes

A0429: Basic Life Support

A0427: Advanced Life Support, Level 1

A0433: Advanced Life Support, Level 2

What is QAF?

- **A fee assessed on all ground emergency transports**
  - Medi-Cal, Medicare, all other payers
  - Paid by all providers
- **Benefit to providers**
  - QAF revenue is matched with federal funds
  - Allows for increased reimbursements in the form of an add-on to current Medi-Cal ground emergency transport rates

How is the QAF Calculated?

The QAF is based on data submitted by all GEMT service providers.

- All GEMT transports
- All gross receipts for GEMT transports

Data Collection Process

- DHCS GEMT webpage was developed to provide:
  - Background,
  - Provider requirements,
  - Data submission form,
  - Deadlines

- Individual provider letters were mailed
- **Final due date: January 31, 2018**

Next Steps

- DHCS will submit a state plan amendment to seek federal approval
  - Public Notice
  - 30-day public input
  - SPA submission

Upcoming Dates to Remember

June 15, 2018:

- DHCS will post QAF & rate add-on amounts

July 1, 2018:

- QAF collections begin (for April - June 2018 transports)
- Increased reimbursements for Medi-Cal GEMT services begin

Resources

- **GEMT QAF website:** http://www.dhcs.ca.gov/provgovpart/Pages/GEMTQAF.aspx
- **SB 523:** http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB523
- **GEMT QAF email address:**

  GEMTQAF@dhcs.ca.gov

Contact Information

Angel Rodriguez
Department of Health Care Services
Fee-for-Service Rate Development Division
1501 Capitol Avenue, MS4600
P.O. BOX 997417
Sacramento, CA 95899-7417
GEMTQAF@dhcs.ca.gov

Alternative Benefit Plan (ABP) Update to Add Marriage and Family Therapists (MFTs) as Billable Mental Health Providers in FQHCs and RHCs SPA 18-002

Kailey Hackbarth, AGPA
DHCS Benefits Division
February 28, 2018

Background: MFTs

Medi-Cal services provided at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid on a “per visit” basis. A visit is defined as a face-to-face encounter between a patient of a FQHC or RHC and specified health care professionals. (Welfare and Institutions Code, Section 14132.100(g)(1).) Currently, MFTs provide mental health services at FQHCs and RHCs, but services are not reimbursable on a per visit basis. SPA 18-002 will add MFTs to the list of specified health care professionals whose services are payable by Medi-Cal on a per visit basis in the Alternative Benefit Plan for the new adult group.

Proposed MFT Changes

According to AB 1863, Medi-Cal will add MFTs to the list of health care professionals whose services are payable on a per visit basis at FQHCs and RHCs. Mental health services are a covered Medi-Cal benefit for all eligible beneficiaries. MFT benefits provided under the Medi-Cal ABP will be the same schedule of benefits provided to Medi-Cal beneficiaries. (Welfare and Institutions Code, Section 1432.02(a).)

Mental health services, when provided by MFTs, will be payable to FQHCs and RHCs, to the extent that federal financial participation is available and necessary federal approvals are obtained. In order for a FQHC or RHC to bill MFT services as a separately reimbursable visit, a mandatory change of scope of services request (CSOSR) must be submitted after MFT services have been provided by the FQHC or RHC for one full fiscal year.

Background: Allergy Injections

Additionally, the ABP sets a limit of up to eight injections for allergy treatment within 120 days without requiring approval of a treatment authorization request (TAR). If a patient's medical condition warrants additional injections, a TAR is required.

Proposed Allergy Injection Changes

Medi-Cal intends to eliminate the TAR requirement for more than eight medically necessary allergy injections within 120 days to reflect current medical practice.

- Effective date of **January 1, 2018**

Impact

Tribal Health Programs:

- SPA 18-002 will allow MFT services to be reimbursed by Medi-Cal when provided at FQHCs and RHCs. DHCS anticipates no impact to Tribal Health Programs (THPs), since THPs are currently paid for mental health services provided by MFTs. (Senate Bill x1-1 (Hernandez, Chapter 4, Statutes of 2013).)

- Providers at THPs do not submit TARs, so removing the TAR requirement for allergy injections will not impact them.

Impact

Federally Qualified Health Centers (FQHCs):

- FQHCs may have an increase in Medi-Cal patients seeking MFT services. If a FQHC chooses to bill for MFT services the FQHC must submit a CSOSR to DHCS. A CSOSR may increase or decrease the FQHC's payment rate.

- Providers at FQHCs/RHCs do not submit TARs, so removing the TAR requirement for allergy injections will not impact them.

Indian Medi-Cal Beneficiaries:

- There may be an increase in MFT services available for eligible Indian beneficiaries as FQHCs would be able to bill for the service.

Contact Information

Jim Elliott
Department of Health Care Services
Benefits Division
1501 Capitol Avenue, MS 4601
PO Box 997413
Sacramento, CA 95899-7413
Jim.Elliott@dhcs.ca.gov

Marriage and Family Therapist Services and Reimbursement Policies Proposed Changes SPA 18-003

Corinne Chavez, Jim Burkhardt &
Ralph Zavala
Department of Health Care Services

Public Notice Information

- Public Notice released 12/26/2017
  - Link to the Public Notice
- Draft State Plan Amendment (SPA) Language
  - Open for public comment until 5:00pm on 3/23/2018
  - Link to the SPA Language
- Please note, there are various other proposed technical updates to the State Plan that are not highlighted in this presentation. DHCS recommends reviewing the entire proposed SPA Language and submitting any comments/questions to the following email address:
  - PublicInput@dhcs.ca.gov

Marriage and Family Therapist (MFT)

- MFT services provided at FQHCs and/or RHCs are billable on a "per-visit" basis
  - Reminder, a FQHC or RHC can bill up to two visits per day:
    1) one Dental
    2) either one Medical or one Mental Health visit

- Effective January 1, 2018, if a FQHC or RHC decides to bill for MFT services as separate visits, the clinic must first submit a change in scope-of-service (CSOSR) to be eligible to receive reimbursement

- Prior to submitting a CSOSR, the FQHC or RHC must provide MFT services for a full fiscal year

Scope of Service Rate Adjustment

FQHCs and RHCs that eliminate or add a service, may require a rate adjustment to their Prospective Payment System (PPS) rate through a Change of Scope of Services Requests (CSOSR)

- Definition of the change in type, intensity, duration or amount of services
- Provider must wait a full fiscal year from the scope of service change before a CSOSR is submitted
- When the scope of service change occurs, the change will be compared to the preceding fiscal year
- Circumstances when CSOSR for an Electronic Health Record system (medical or dental) cost can be submitted
- Dental Hygienist (DH) or Dental Hygienist in Alternative Practice (DHAP)
  - In order to bill DH or DHAP services on a per visit basis, clinic must submit a CSOSR

Services Provided Outside the Clinic Facility ("Four Walls")

FQHC or RHC services are provided in the clinic's established place of business; however, there are exceptions when FQHC or RHC services may be provided outside the clinic facility "four walls" in order to receive reimbursement:

- Inpatient Services
- Dental Services
- Telehealth Services
- Homeless Services
- Mobile units and intermittent clinics
- Other locations outside of the clinic facility

Minimum Productivity Standards

- Applies to Rate Setting and CSOSR audits
- Minimum Visits per Physician Full Time Equivalent (FTE) (Employed or Contracted)
  - 3,200 Visits
- Minimum Visits per Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife FTE (Employed or Contracted)
  - 2,600 Visits

Rate Setting Effective Date

Proposed SPA language clarifies the effective date for rate setting purposes for the following entities below:

- New Clinic
- Relocated Clinic
- Intermittent Clinic
- Mobile Clinic

Rate Setting Effective Date cont.

- Effective dates are based upon the following:
  - The date DHCS first receives the Rate Setting Audit Application or
  - The date the FQHC or RHC is first certified by the applicable federal agency
    - In order to receive a retroactive date, the FQHC or RHC must submit a complete rate setting application package within 90 days from the date from the federal agencies written notification of approval as a FQHC or RHC for the new, relocated, intermittent, or mobile site

Contact Information

Ralph Zavala
Department of Health Care Services
Health Care Financing Division
1501 Capitol Avenue, MS 4050
PO Box 997413
Sacramento, CA 95899-7413
Ralph.Zavala@dhcs.ca.gov

Feedback