

California's Elimination of Medi-Cal Optional Benefits

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Assembly Bill 5 (Noreen Evans, Democrat, Santa Rosa)

- Added Welfare & Institutions Code sec. 14131.10, which stated that "[n]otwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590). . . [t]he following optional benefits are excluded from coverage under the Medi-Cal program:"
 - (A) Adult dental services.
 - (B) Acupuncture services.
 - (C) Audiology services and speech therapy services.
 - (D) Chiropractic services.
 - (E) Optometric and optician services, including services provided by a fabricating optical laboratory.
 - (F) Podiatric services.
 - (G) Psychology services.
 - (H) Incontinence creams and washes.
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Exceptions:

- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.
 - The optional benefit exclusions do not apply to either of the following:
 - (1) Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.
 - (2) Beneficiaries receiving long-term care in a nursing facility that is a SNF or ICF that is licensed as a “nursing facility” under Health & Safety Code section 1250(k).
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Exceptions:

- Welfare & Inst. Code sec. 14131.10(d) states that “[t]his section shall be implemented to the extent permitted by federal law.”
 - There is an exception for “pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy” – don’t rely on this unless you have prior written guidance from DHCS regarding how to obtain prior approval for these services.
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When is it effective?

- AB 5 was signed into law on March 3, 2008.
 - The elimination of “optional” benefits in 14131.10 goes into effect on “the first day of the month following 90 days after the operative date of this section.”
 - In English, this means that optional benefits are eliminated effective July 1, 2009.
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**What’s the Bottom Line for
Community Clinics?**

- In general, on July 1st, community clinics will need to stop billing Medi-Cal for the following services, unless the patient is an EPSDT beneficiary:
- Adult Dental (dentists, dental hygienists, RDHAPs);
 - Acupuncture services;
 - Audiologists;
 - Speech Therapy (speech pathologists);
 - Chiropractic services;
 - Optometric and optician services;
 - Podiatric services;
 - Psychologists; and
 - Incontinence creams and washes.
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What's the Bottom Line for FQHCs and RHCs?

- In general, on July 1st, and unless CMS and/or DHCS confirm prior guidance relating to the meaning of "physician," FQHCs/RHCs will need to stop billing Medi-Cal for the following services, unless the patient is an EPSDT beneficiary:
 - Adult Dental (dentists, dental hygienists, RDHAPs);
 - Acupuncture services;
 - Audiologists;
 - Speech Therapy (speech pathologists);
 - Chiropractic services;
 - Optometric and optician services; and
 - Podiatric services.
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Termination of Professional Services Agreements

- Identify services that will be eliminated on July 1, 2009 and determine if EPSDT patient volume or other exceptions will allow continuation of services;
 - Review your provider agreements to determine the length of time needed to terminate the Professional Services Agreements;
 - Determine whether or not termination of the provider agreements is necessary.
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Impact on Rural Health Clinics and Federally Qualified Health Centers

- For FQHCs and RHCs, psychology services are still covered as part of the “mandatory” FQHC/RHC services benefit even after July 1, 2009;

 - How do we know this?
 - Look at 42 U.S.C. §§ 1396a(bb), 1396d(a)(2)(C), 1396d(l)(2) and 1395x(aa)(1)(B); or
 - HRSA Policy Information Notice 2004-05, which says that the services of clinical psychologists part of the mandatory FQHC/RHC services benefit so long as the practitioner is licensed, and they are practicing within the scope of their practice under state law.
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Impact on Rural Health Clinics and Federally Qualified Health Centers

- Aren't the services of dentists, podiatrists, optometrists, and chiropractors part of the mandatory FQHC/RHC services benefit? **Possibly**, and here's why:

 - DHCS has interpreted federal law as requiring it to reimburse FQHCs/RHCs for “physicians” services, and has acknowledged means services provided by medical doctors, osteopaths, dentists, podiatrists, optometrists and chiropractors (Welf. & Inst. Code § 141321.100(g); HCFA Pub. 27, section 123; 42 U.S.C. § 1395x(aa)(1)(A) and (r)).

 - CMS Region VIII has provided guidance to North Dakota clarifying that if optional dental services were cut by the state, Medicaid reimbursement for FQHC/RHC services, including dental, must still continue as a result of federal law.
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Impact on Rural Health Clinics and Federally Qualified Health Centers

- Things to consider if you're an FQHC/RHC while DHCS and CMS are deciding the issue:
 - Provider Services Agreement Termination Provisions – 30, 60 or 90 days customary for “without cause” termination;
 - Patient abandonment issues – you need to consider limiting new course of treatment for patients – particularly dental services;
 - FTCA or Malpractice Coverage – Notice to HRSA or purchase of tail coverage if required by provider agreement.
 - HRSA Scope of Project Notice and Approval Requirement.
 - Medi-Cal Scope of Service Rate Adjustments – mandatory for elimination (not reduction) of dental, or decrease of more than 2.5% of per-visit rate.
 - Joint Commission or AAAHC – Prior Notice of Changes in Sites and Services.
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Department of Public Health, Licensing & Certification

- Health & Safety Code section 1212(b)(1) requires licensed nonprofit community and free clinics to “notify the department, in writing, of the change in service or physical plant no less than 60 days prior to adding the service or remodeling or modifying an existing primary care clinic site.”
 - No notice to Licensing & Certification is required for deleting a service, but it's not a bad idea to notify your district office.
 - DPH's Licensing & Certification *incorrectly* says that “[a]ll other changes (besides a [change in ownership] CHOW) must also be reported to the L&C District Office (DO) in writing within 10 days of the change, pursuant to Section 75025 of Title 22 of the CCR.
 - However, that regulation in fact only requires notices to L&C of changes in “the principal officer such as chairperson, president, or general manager of the governing board” or the administrator
 - Unless your provider is one of these, no notice to L&C of the termination is required.
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Medi-Cal: FQHC/RHC Scope of Service Changes

- Welfare & Inst. Code section 14132.100(e)(5) and 14132.101(a) **require** FQHCs/RHCs to file cost reports in two circumstances:
 - If an FQHC or RHC discontinues providing onsite pharmacy or dental services.
 - If, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate.
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Medi-Cal: FQHC/RHC Scope of Service Changes

- **When do you file?**
 - Within 150 days of the first day of the fiscal year following (see Welf. & Inst. Code sec. 14132.100(e) and 14132.101(a)):
 - The discontinuation of on-site dental or pharmacy services;
 - A year in which the FQHC/RHC experienced a decrease in the scope of services" that you "knew or should have known would have resulted in a significantly lower per-visit rate" – defined as "an average per-visit rate decrease in excess of 2.5 percent."
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Medi-Cal: FQHC/RHC Scope of Service Changes

- Eliminating a service does not necessarily mean your rate will go down.
 - Eliminating low-cost, highly productive providers may result in a higher per-visit rate.
 - Some costs may need to be borne even after services are discontinued/reduced – high cost and lower visit count.
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Outstanding Policy Issues

- The primary outstanding issue is whether or not CMS will issue guidance confirming that for purposes of the mandatory FQHC/RHC services benefit, “physician” is defined the same for both Medicare and Medicaid – that is to include MDs, osteopaths, dentists, podiatrists, optometrists and chiropractors (42 USC sec. 1395x(aa) and (r)).
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Suggestions

- ❑ Make sure that your Congressional representatives, your State legislators, HRSA, CSRHA, CARHC, CPCA, NRHA, NACHO, NACHC, etc., know how this provision of the budget will impact your patients and your ability to sustain medical services at your clinic, FQHC or RHC.
 - ❑ Participate in every opportunity to make your voice heard, and to let HRSA, CMS and your Congressional representatives know that you need CMS to provide this guidance to California's Medi-Cal program.
 - ❑ Don't panic, and don't act prematurely.
 - ❑ Ask for help if you need it. Ask questions if you don't understand.
 - ❑ Stay tuned, and more importantly, keep your providers informed as CMS, DHCS and HRSA evolve their policies regarding the "physician" definition applicable to FQHCs/RHCs under Medi-Cal.
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