State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
*DIRECTOR*

EDMUND G. BROWN JR.
*GOVERNOR*

JUL 2 8 2011

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 11-013

Dear Dr. Nagle:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 11-013, as mandated by California Welfare and Institutions (W&I) Code Section 14131.07, enacted on March 24, 2011.

The legislation requires DHCS to limit the total number of physician office and clinic visits for physician services provided by a licensed physician, or other medical professional under the direction of a licensed physician, that are covered benefits under the Medi-Cal program, to seven visits per beneficiary, per fiscal year. For purposes of this limit, a visit shall include physician services provided at any:

- Federally qualified health center (FQHC);
- Rural health clinic (RHC);
- Community clinic;
- Outpatient clinic; and,
- Hospital outpatient department.

For visits in excess of the seven visit limit, a physician, or other medical professional under the supervision of a physician, must attest in a written declaration that the services meet one or more of the following conditions:

- Prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.
- Prevent deterioration in a beneficiary's condition that would otherwise result in an inpatient admission.

- Prevent disruption in ongoing medical and/or surgical therapy, including, but not limited to, medications, radiation, or wound management.
- Constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.
- Are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.

The following are exempt from the seven visit limit:

- Specialty mental health services provided via the 1915(b) waiver for these services.
- Pregnancy-related visits and visits for the treatment of other conditions that might complicate the pregnancy.
- Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.
- Beneficiaries receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).
- Beneficiaries receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including an ICF/DD Habilitative and ICF/DD Nursing.
- Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE).
- Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation.

DHCS calculated the Federal Budget Impact of $41,041,000, as indicated in block 7 of form HCFA-179, as follows:

- Prepared a data run to identify past reimbursement totals paid out for all physician office visits during the state fiscal year 2008-09;
- Removed reimbursements that exceeded a cap of seven per fiscal year per beneficiary;
- Estimated the total savings by assuming the cap would result in a 15 percent reduction of visits beyond the cap; and,
- Multiplied the total savings by an FMAP value of 50 percent to determine the Federal Budget Impact.

DHCS is submitting the following revised or added SPA pages to implement the W&I Code Section 14131.07:

- Revised Limitations on Attachment 3.1-A Page 2 – added reference under service type "2a Hospital outpatient department services and community hospital outpatient clinic."
- Revised Limitations on Attachment 3.1-B Page 2 – added reference under service type "2a Hospital outpatient department services and community hospital outpatient clinic."
- Revised Limitations on Attachment 3.1-A Page 3 – added reference under service type "2b Rural Health Clinic (RHC) services."
- Revised Limitations on Attachment 3.1-B Page 3 – added reference under service type "2b Rural Health Clinic (RHC) services."
- Revised Limitations on Attachment 3.1-A Page 3A – changed numbering to bullet points.
- Revised Limitations on Attachment 3.1-B Page 3A – changed numbering to bullet points.
- Revised Limitations on Attachment 3.1-A Page 3C – added reference under service type "2c and 2d Federally Qualified Health Center (FQHC) services."
- Revised Limitations on Attachment 3.1-B Page 3C – added reference under service type "2c and 2d Federally Qualified Health Center (FQHC) services."
- Revised Limitations on Attachment 3.1-A Page 3D – changed numbering to bullet points.
- Revised Limitations on Attachment 3.1-B Page 3D – changed numbering to bullet points.
- Revised Limitations on Attachment 3.1-A Page 10a – added content under service type "5a Physician's Services continued."
- Revised Limitations on Attachment 3.1-B Page 10a - added content under service type "5a Physician's Services continued."
- Added Limitations on Attachment 3.1-A Page 10a.1 – moved content from page 10a Limitations on Attachment 3.1-A.
- Added Limitations on Attachment 3.1-B Page 10a.1 – moved contact from page 10a Limitations on Attachment 3.1-B.
- Revised Attachment 4.19-B Page 6B – changed content under letter C1(a) to reference location in the State Plan where FQHC and RHC services are detailed.
- Revised Attachment 4.19-B Page 6B.1 – changed content under letter C1(b) to reference location in the State Plan where covered FQHC and RHC services are detailed.

On May 16, 2011, DHCS notified Indian Health Programs and Urban Indian Organizations of SPA 11-013 in compliance with the American Recovery and Reinvestment Act of 2009 (ARRA). In addition, DHCS held a webinar on May 31, 2011, for Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations. DHCS revised the notification and send it to Indian Health Programs and Urban

Indian Organizations on June 22, 2011, providing an additional 30-days for comments and questions to be submitted to DHCS. DHCS will be sending the comments received and its responses under separate cover.

On July 26, 2011, DHCS requested the California Office of Administrative Law (OAL) to publish a public notice regarding potential rate changes for FQHCs and RHCs related to this SPA. OAL will publish the public notice on August 5, 2011.

In an effort to expedite the review process, also enclosed are answers to five standard funding questions requested by the Centers for Medicare & Medicaid Services on previous State Plan Amendments.

If you have any questions regarding the information provided, please contact Ms. Vickie Orlich, Chief, Medi-Cal Benefits and Waiver Analysis Division, at (916) 552-9400.

Sincerely,

FOR Vanessa Baird
Toby Douglas
Director

Enclosures

cc: Donald A. Novo
Medicaid Program Branch Manager
Division of Medicaid and Children's Health Operations
San Francisco Regional Office
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300(5W)
San Francisco, CA 94103

Vanessa M. Baird
Deputy Director
Health Care Benefits and Eligibility
Department of Health Care Services
P.O. Box 997413, MS 4000
Sacramento, CA 95899-7413

cc: Continued on next page.

cc: Vickie Orlich, Chief
Benefits and Waiver Analysis Division
Department of Health Care Services
P.O. Box 997417, MS 4600
Sacramento, CA 95899-7417

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **11-013**

2. STATE: California

3. PROGRAM IDENTIFICATION: Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396a, 42 CFR Part 440

7. FEDERAL BUDGET IMPACT:
FFY 12 -$41,041,000 (Reduction)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Limitations on Attachment 3.1-A Page 2
Limitations on Attachment 3.1-B Page 2
Limitations on Attachment 3.1-A Page 3
Limitations on Attachment 3.1-B Page 3
Limitations on Attachment 3.1-A Page 3A
Limitations on Attachment 3.1-B Page 3A
Limitations on Attachment 3.1-A Page 3C
Limitations on Attachment 3.1-B Page 3C
Limitations on Attachment 3.1-A Page 3D
Limitations on Attachment 3.1-B Page 3D
Limitations on Attachment 3.1-A Page 10a
Limitations on Attachment 3.1-B Page 10a
Limitations on Attachment 3.1-A Page 10a.1
Limitations on Attachment 3.1-B Page 10a.1
Attachment 4.19-B Page 6B
Attachment 4.19-B Page 6B.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Limitations on Attachment 3.1-A Page 2
Limitations on Attachment 3.1-B Page 2
Limitations on Attachment 3.1-A Page 3
Limitations on Attachment 3.1-B Page 3
Limitations on Attachment 3.1-A Page 3A
Limitations on Attachment 3.1-B Page 3A
Limitations on Attachment 3.1-A Page 3C
Limitations on Attachment 3.1-B Page 3C
Limitations on Attachment 3.1-A Page 3D
Limitations on Attachment 3.1-B Page 3D
Limitations on Attachment 3.1-A Page 10a
Limitations on Attachment 3.1-B Page 10a
Attachment 4.19-B Page 6B
Attachment 4.19-B Page 6B.1

10. SUBJECT OF AMENDMENT:
Implementation of physician office and clinic visit limits for physician services to seven per Medi-Cal beneficiary per State fiscal year.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Vanessa M Baird

13. TYPED NAME:
**Toby Douglas**

14. TITLE:
**Director**

15. DATE SUBMITTED: JUL 2 8 2011

16. RETURN TO:

**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, Suite 71.3.26**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

FORM HCFA-179 (07-92)

## Standard Funding Questions for SPA 11-013

The following questions are being answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, these questions must be answered for all payments made under the state plan for such service.

**Question #1:** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**Response:** SPA 11-013 is limited in scope to changing benefits. Pages 6B and 6C of Attachment 4.19-B are being amended only to make conforming amendments to the references to federally qualified health center (FQHC) and rural health clinic (RHC) services that are eligible for reimbursement under Pages 6 through 6S.

SPA 11-013 does not change the methods and standards used for setting payment rates. The amounts that are used in the rate setting methodologies and formulas may be impacted, but the formulas and other prescribed calculations are not being changed. FQHCs and RHCs are required to submit scope-of-service changes when a change in their scope of service results in an average per visit rate decrease in excess of 2.5 percent. A scope-of-service change could result in changes to the FQHC's or RHC's prospective payment system (PPS) reimbursement rate per visit, but would not result in changes to any applicable methods or standards for setting rates.

Accordingly, this question #1 is not applicable to this SPA submission.

**Question #2:** Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

i. a complete list of the names of entities transferring or certifying funds;
ii. the operational nature of the entity (state, county, city, other);
iii. the total amounts transferred or certified by each entity;
iv. clarify whether the certifying or transferring entity has general taxing authority; and,
v. whether the certifying or transferring entity received appropriations (identify level of appropriations).

**Response:** Please refer to the response for Question 1.

**Question #3:** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**Response:** Please refer to our response for Question 1.

**Question #4:** For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned

or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**Response:** Please refer to our response for Question 1.

**Question #5:** Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**Response:** Please refer to our response for Question 1.

| TYPE OF SERVICE | PROGRAM COVERAGE** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|
| 2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan. | Services provided by the following at a Federally Qualified Health Center (FQHC) are covered under this state plan:<br>• Physician services: a licensed physician is a doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license. Refer to Type of Service "5a Physician's Services" for covered physician services provided by a licensed physician, visit limitation, and exemptions to the visit limitation.<br>• A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.<br>• A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.<br>• A doctor of chiropractic authorized to practice chiropractic by the State and who is acting within the scope of his/her license.<br>• A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.<br>• A Physician Assistant (PA) who is authorized to practice PA services by the State and who is acting within the scope of his/her license.<br>• A Nurse Practitioner (NP) who is authorized to practice NP services by the State and who is acting within the scope of his/her license. | FQHCs do not require Treatment Authorization Request (TAR) before rendering services; however, FQHCs must provide documentation in the medical record that the service was provided.<br><br>Refer to Type of Service "5a Physician's Services" for other requirements for physician services. |


* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

| | | |
|---|---|---|
| 2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued). | • A Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license.<br>• A visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license.<br>• Comprehensive Perinatal Services Program (CPSP) practitioner services.<br>• A licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license.<br>• A clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license.<br>Acupuncture, audiology, chiropractic, dental, podiatry, speech therapy, are covered optional benefits only for the following beneficiaries:<br>1. Pregnant women if the optional benefit is part of their pregnancy-related services or for services to treat a condition that might complicate the pregnancy. | |


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STATE PLAN CHART

(Note: This chart is an overview only.)

| TYPES OF SERVICE | PROGRAM COVERAGE** | AUTHORIZATION AND OTHER REQUIREMENTS* |
|---|---|---|
| 5a Physician's Services (continued). | The total number of physician office and clinic visits for physician services provided by a licensed physician, or other medical professional under the direction of a licensed physician, that are covered benefits are limited to seven visits per beneficiary, per fiscal year. The following are not subject to the seven visit limit:<br>• Specialty mental health provided via the 1915(b) waiver for these services.<br>• Pregnancy-related visits and visits for the treatment of other conditions that might complicate the pregnancy.<br>• Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.<br>• Beneficiaries receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).<br>• Beneficiaries receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including an ICF/DD Habilitative and ICF/DD Nursing.<br>• Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE).<br>• Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation. | Other requirements include:<br><br>For physician office and clinic visits in excess of the seven visit limit, a licensed physician, or other medical professional under the direction of a licensed physician, must attest in a written declaration that the services meet one or more of the following circumstances:<br>• Prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.<br>• Prevent deterioration in a beneficiary's condition that would otherwise result in an inpatient admission.<br>• Prevent disruption in ongoing medical and/or surgical therapy, including, but not limited to, medications, radiation, or wound management.<br>• Constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.<br>• Are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services. |

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| TYPE OF SERVICE | PROGRAM COVERAGE** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
|---|---|---|
| | | All services, including physician's services are subject to the same requirements as when provided in a non facility setting.<br><br>Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system |
| 2b Rural Health Clinic services and other ambulatory services covered under the state plan. | Services provided by the following at a Rural Health Clinic (RHC) are covered under this state plan:<br><br>• Physician services: a licensed physician is a doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license. Refer to Type of Service "5a Physician's Services" for covered physician services provided by a licensed physician, visit limitation, and exemptions to the visit limitation.<br>• A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.<br>• A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.<br>• A doctor of chiropractic authorized to practice chiropractic by the State and who is acting within the scope of his/her license. | Rural health clinics do not require Treatment Authorization Request (TAR) before rendering services; however, RHCs must provide documentation in the medical record that the service was provided.<br><br>Refer to Type of Service "5a Physician's Services" for other requirements for physician services. |


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| 2b Rural Health Clinic services and other ambulatory services covered under the state plan (continued). | • A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.<br>• A Physician Assistant (PA) who is authorized to practice PA services by the State and who is acting within the scope of his/her license.<br>• A Nurse Practitioner (NP) who is authorized to practice NP services by the State and who is acting within the scope of his/her license.<br>• A Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license.<br>• A visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license.<br>• Comprehensive Perinatal Services Program (CPSP) practitioner services.<br>• A licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license.<br>• A clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license. | |


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| TYPE OF SERVICE | PROGRAM COVERAGE** | PRIOR AUTHORIZATION OR OTHER REQUIREMENTS* |
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| 2a Hospital outpatient department services and community hospital outpatient clinic. | The following services are covered:<br>1. Physician<br>2. Optometric<br>3. Psychology<br>4. Podiatric<br>5. Physical therapy<br>6. Occupational Therapy<br>7. Speech pathology<br>8. Audiology<br>9. Acupuncture<br>10. Laboratory and X-ray<br>11. Blood and blood derivatives<br>12. Chronic hemodialysis<br>13. Hearing aids<br>14. Prosthetic and orthotic appliances<br>15. Durable medical equipment<br>16. Medical supplies<br>17. Prescribed drugs<br>18. Use of hospital facilities for physician's services<br>19. Family planning<br>20. Respiratory care<br>21. Ambulatory surgery<br>22. Dental | Refer to appropriate service section for prior authorization requirements<br><br>Refer to Type of Service "5a Physician's Services" for other requirements. |



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| 2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued). | • A Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license.<br>• A visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license.<br>• Comprehensive Perinatal Services Program (CPSP) practitioner services.<br>• A licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license.<br>• A clinical psychologist who is authorized to practice psychology services by the State and who is acting within the scope of his/her license.<br>Acupuncture, audiology, chiropractic, dental, podiatry, speech therapy, are covered optional benefits only for the following beneficiaries:<br>1. Pregnant women if the optional benefit is part of their pregnancy-related services or for services to treat a condition that might complicate the pregnancy. | |


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