



News Update

April 21st 2011

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April 12 ~ 14, 2012*

Medi-Cal Cuts, Caps and Co-Pays

Below are excerpts from AB 97, the budget trailer bill on health, which was signed into law by the Governor on March 24, 2011 as urgency legislation which took effect immediately. The attached excerpts pertain to the following issues:

- 1. 10% Provider Payment Reduction**
- 2. “Soft Cap” of 7 physician/clinic visits per year**
- 3. Exclusion of non-legend cough and cold products as covered benefits**
- 4. Limitation on enteral nutrition products as covered benefits**
- 5. Co-pay requirements**

To review the actual statute go to www.leginfo.ca.gov and search for AB 97.

CDC continues efforts to stop the 10% payment reduction. Also included below is our letter to CMS requesting that CMS disapprove the 10% payment reductions contained in AB 97.

Finally, CDC is also working with the Alliance for Patient Care (APC), a statewide association of provider groups, regarding the possibility of filing a lawsuit requesting the courts to enjoin these cuts.

We will have more updates for you as these issues continue to unfold.

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Next Board Meeting

May 20, 2011 ~ Oakland

For more information, on-line registration and hard copy registration forms, please visit our web site at: www.californiadialysis.org

Medi-Cal Cuts

Excerpts from AB 97, Chapter 3, Statutes of 2011

1. 10% Provider Payment Reduction
2. "Soft Cap" of 7 physician/clinic visits per year
3. Exclusion of non-legend cough and cold products as covered benefits
4. Limitation on enteral nutrition products as covered benefits
5. Co-pay requirements

1. 10% Provider Payment Reduction:

SEC. 93.5. Section 14105.192 is added to the Welfare and Institutions Code, to read: 14105.192. (a) The Legislature finds and declares the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for Medicaid in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law. (b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products. (c) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of

provider bulletins, or similar instructions, without taking regulatory action. (m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available. (1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code. (2) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements. (n) The department shall seek any necessary federal approvals for the implementation of this section. **(o) This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of subdivision (d) shall be implemented retroactively to June 1, 2011, or on such other date or dates as may be applicable.**

2. 'Soft Cap' of 7 physician/clinic visits per year:

SEC. 100.5. Section 14131.07 is added to the Welfare and Institutions Code, to read: 14131.07.

(a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), 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 shall be limited to seven visits per beneficiary per fiscal year, excepting visits that meet the conditions set forth in subdivision

(b). For purposes of this limit, a visit shall include physician services provided at any federally qualified health center, rural health clinic, community clinic, outpatient clinic, and hospital outpatient department. The department may seek input from consumer organizations and the provider community, as applicable, prior to implementation.

(b) (1) Visits exceeding seven per beneficiary per fiscal year shall be required to be certified by the physician, or other medical professional under the supervision of a physician, attesting that one or more of the following circumstances is applicable:

(A) The services will prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.

(B) The services will prevent deterioration in the beneficiary's condition that would otherwise result in inpatient admission.

(C) The services will prevent disruption in ongoing medical therapy or surgical therapy, or both, including, but not limited to, medications, radiation, or wound management.

(D) The services constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.

(E) The services are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.

(2) The certification shall consist of a written declaration by the physician, or other medical professional under the supervision of the physician, that the visit meets the requirements of any one

or more of the circumstances set forth in paragraph (1), and shall include a description of the services provided.

(3) The certification shall be maintained onsite at the physician's office or clinic location at which the medical records for the beneficiary are maintained and shall be subject to audit and inspection by the department.

(i) This section shall be implemented on the first day of the first calendar month following 180 days after the effective date of the act that added this section, or on the first day of the calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later. If the implementation date occurs after July 1, 2011, then the benefit caps described in subdivision (a) for the first year of implementation shall be applied from the implementation date to June 30 of the state fiscal year in which implementation begins. Thereafter, the benefit caps shall apply on a state fiscal year basis.

3. Exclusion of non-legend cough and cold products as covered benefits:

SEC.101. Section 14132 of the Welfare and Institutions Code is amended to read: 14132(d)(4)(A)

~~Nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.~~ *(i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.*

(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later. (iv) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from clauses (ii) and (iii).

4. Limitation on enteral nutrition products as covered benefits:

14132(ab) ~~(1) Purchase of prescribed enteral formulae nutrition products is covered, subject to the Medi-Cal list of enteral formulae nutrition products and utilization controls.~~

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomytube. Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

5. Co-payment requirements:

SEC. 101.5. Section 14134 is added to the Welfare and Institutions Code, to read: 14134. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits or imposing further reductions on Medi-Cal providers during times of economic crisis, it is crucial to find areas within the program where beneficiaries can share responsibility for utilization of health care, whether they are participating in the fee-for-service or the managed care model of service delivery.

(3) The establishment of cost-sharing obligations within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(4) As the single state agency for Medicaid in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust cost sharing responsibilities for Medi-Cal beneficiaries receiving health care services. (b) Therefore, it is the intent of the Legislature for the department to obtain federal approval to implement cost-sharing for Medi-Cal beneficiaries and permit providers to require that individuals meet their cost-sharing obligation prior to receiving care or services. (c) A Medi-Cal beneficiary shall be required to make copayments as described in this section. These copayments represent a contribution toward the rate of payment made to providers of Medi-Cal services and shall be as follows:

(1) Copayment of up to fifty dollars (\$50) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means services not required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(2) Copayment of up to fifty dollars (\$50) shall be made for emergency services received in an emergency room. For purposes of this section, "emergency services" means services required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(3) Copayment of up to one hundred dollars (\$100) shall be made for each hospital inpatient day, up to a maximum of two hundred dollars (\$200) per admission.

(4) Copayment of up to three dollars (\$3) shall be made for each preferred drug prescription or refill. A copayment of up to five dollars (\$5) shall be made for each nonpreferred drug prescription or refill. Except as provided in subdivision (g), "preferred drug" shall have the same meaning as in Section 1916A of the Social Security Act (42 U.S.C. Sec. 1396o-1).

(5) Copayment of up to five dollars (\$5) shall be made for each visit for services under subdivision (a) of Section 14132 and for dental services received on an outpatient basis provided as a Medi-Cal benefit pursuant to this chapter or Chapter 8 (commencing with Section 14200), as applicable.

(6) This section does not apply to services provided pursuant to subdivision (aa) of Section 14132. (d) The copayments established pursuant to subdivision (c) shall be set by the department, at the maximum amount provided for in the applicable paragraph, except that each copayment amount shall not exceed the maximum amount allowable pursuant to the state plan amendments or other federal approvals.

(e) The copayment amounts set forth in subdivision (c) may be collected and retained or waived by the provider. The department shall deduct the amount of the copayment from the payment the department makes to the provider whether retained, waived, or not collected by the provider. (f) Notwithstanding any other provision of law, and only to the extent allowed pursuant to federal law, a provider of service has no obligation to provide services to a Medi-Cal beneficiary who does not, at the point of service, pay the copayment assessed pursuant to this section. If the provider provides services without collecting the copayment, and has not waived the copayment, the provider may hold the beneficiary liable for the copayment amount owed.

(j) (1) This section shall become operative on the date that the act adding this section is effective, but shall not be implemented until the date in the declaration executed by the director pursuant to paragraph (2). In no event shall the director set an implementation date prior to the date federal approval is received. (2) The director shall execute a declaration that states the date that implementation of the copayments described in this section will commence and shall post the declaration on the department's Internet Web site and provide a copy of the declaration to the Chair of the Joint Legislative Budget Committee, the Chief Clerk of the Assembly, the Secretary of the Senate, the Office of the Legislative Counsel, and the Secretary of State.

Notes:

- Proposal for a "hard cap" on prescriptions at no more than 6 per month was defeated.
- Proposal for a "hard cap" on physician/clinic visits at no more than 10 per year was defeated. Alternative "soft cap" of 7 visits per year was substituted, as noted in item 2 above.



California Dialysis Council

Legislative Office

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April 21, 2011

Donald M. Berwick, M.D.

Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Subject: California Medicaid Cuts – Request for CMS to Reject

Dear Dr. Berwick:

The California Dialysis Council (CDC) urges the Centers for Medicare & Medicaid Services (CMS) to deny approval of the cuts made to the California Medicaid program by AB 97, Chapter 3, Statutes of 2011. **The cuts contained in this “budget trailer bill,” signed into law by Governor Jerry Brown on March 24, 2011, clearly violate federal law and would have a devastating impact on access to service and quality of service for Medicaid beneficiaries in California.**

AB 97 proposes billions in cuts to the Medicaid program in California. These cuts include a 10 percent reduction in provider rates, mandatory patient co-payments (including authority for providers to withhold care if the co-payment is not made), and a "soft cap" of seven physician office or clinic visits per year, in addition to other cuts. We urge CMS to stop California from implementing these cuts. Such cuts would have a devastating impact on access to quality medical services.

10% Medi-Cal Provider Payment Reduction - Background

On March 24, 2011, Governor Brown signed Assembly Bill (AB) 97, legislation enacting budget cuts to California's Health and Human Services programs. This legislation added section 14105.07 to the California Welfare and Institutions Code. This section requires the Director of the Department of Health Care Services (DHCS) to reduce provider reimbursement payments by ten percent. The section also directs DHCS to seek “any necessary federal approvals” and prohibits implementation of the section “until federal approval is obtained.”

Current Medi-Cal payment rates are already too low. Historically, every time the State of California has faced a fiscal crisis, it has raided the Medi-Cal program for funds-- taking away from the healthcare services provided to low-income and disabled residents of California. As a result, Medi-Cal beneficiaries have had more limited access to health care services. Despite the requirements of federal law, the California Legislature and the Governor have now enacted further reductions without sufficient consideration of the adverse impact these reductions will have on beneficiary access to quality health services.

Chilling Impact on Decisions to Open New Dialysis Clinics

Low reimbursement levels and slow clinic licensure and certification are already having a chilling impact on decisions by dialysis providers to locate new clinics in California. With the growth of the dialysis population, access to dialysis services will be adversely impacted by a further reduction in reimbursements which are already too low. Such reductions fall disproportionately on dialysis providers, due to the frequency of treatment and the percent of patients in dialysis clinics who rely on Medi-Cal or Medicare—with a very low ratio of “private pay patients.” Lowering the reimbursement will generally/potentially discourage additional clinic investment as economics get more and more difficult. Many California dialysis clinics, particularly in urban areas, are operating at maximum capacity already. Thus, many patients must stay in the hospital because there is no space in dialysis clinics. These “access issues” cost the system more, are bad for patients, and will be exacerbated if the 10% payment reduction takes place.

State action clearly violates Federal Law

To receive federal funds, states are required to administer their programs in compliance with individual “state plans for medical assistance” approved by the federal Secretary of Health and Human Services. (42 U.S.C. §1396) Federal law sets forth detailed requirements for state plans [*see id.* §1396a(a)(1)-(71)], including the specific provision that the State is trying to circumvent through AB 97. Under that federal provision, §1396(a)(30)(A) (“Section 30(A)), a state plan must:

Provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan...as may be necessary...to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available in the geographic area[.]

The United States District Court for the Central District of California enjoined the implementation of the State’s 2008 Medi-Cal provider rate reductions because the State of California had not properly considered “efficiency, economy, quality of care, and equality of access, as well as the effect of providers’ costs on those relevant statutory factors” when it adopted the provider rate reduction. Moreover, the Court found that Medi-Cal patients would be irreparably harmed if those cuts were not enjoined.

On behalf of California’s most vulnerable patients, we ask you to reject any plan amendment, waiver, flexibility plan or other changes in law or regulation that would allow California to reduce its already deficient provider payments. The CDC urges CMS to reject these cuts and not allow California to ignore the Section 30(A) requirements of federal law, as DHCS is apparently asking CMS to do through a new State Plan Amendment (SPA). CMS approval of California’s SPA will allow the State of California to avoid its responsibilities under the Medicaid Act and will result in further needless litigation. CMS should not allow the State to take funds away from the healthcare of the neediest residents of California to cure its budget woes.

In conclusion, the CDC requests that CMS deny approval for the provider payment reductions included in AB 97. DHCS has not shown and cannot demonstrate that the payment reductions called for in AB 97 would be in compliance with the requirements of federal law and CMS regulations.

Thank you for your consideration of this request.

Sincerely,

Dr. Thomas Paukert
CDC President

Cc: CDC Board
Members of Alliance for Patient Care
California Congressional Delegation
Cindy Mann, Deputy Administrator, CMS
Kathleen Sebelius, Secretary of Health and Human Services