

**Department of Health Care Services
Proposed May Revision Trailer Bill Legislation**

**Medi-Cal Cost Containment Proposal: Institute Copayments for
Physician/FQHC/RHC Office Visits, Dental Office Visits, Pharmacy,
Emergency and Nonemergency ER Visits, and Hospital Inpatient Days**

FACT SHEET

Background:

This proposal will impose mandatory copayments of up to \$5 for physician and Federally Qualified Health Center/Rural Health Centers (FQHC/RHC) office visits; up to \$5 for dental office visits; up to \$3 for Preferred Drug categories and up to \$5 for Not Preferred Drug categories; up to \$50 for emergency and nonemergency ER visits; and up to \$100 per Hospital Inpatient Day with a maximum of up to \$200 per admission. The Department of Health Care Services (DHCS) will set the amount of the copayments subject to approval from the federal Centers for Medicare and Medicaid Services.

This proposal will affect all Medi-Cal beneficiaries receiving these services without regard to eligibility category, age, or place of service, and regardless of whether in a fee-for-service or Medi-Cal managed care provider setting. The proposed copayments are mandatory, and providers will be able to deny service if the beneficiary does not provide the payment. DHCS will provide managed care capitation rates that reflect the actuarial equivalent of this policy for all of the affected benefits.

This proposal will require federal approval of a State Plan Amendment and a waiver of federal laws and regulations regarding the types of populations affected, their Federal Poverty Levels (FPLs), the types of services provided, and the maximum amount of copayments that can be charged.

This proposal will impose mandatory copayments on Medi-Cal beneficiaries for the following services:

\$5 Copayments for Physician and FQHC/RHC Office Visits

This proposal requires all Medi-Cal beneficiaries to pay up to a \$5 copayment for visits to physician offices and FQHCs/RHCs at the point of service. DHCS will implement this proposal without exemptions and regardless of place or type of service.

This proposal will change the source of provider reimbursement, but the reimbursement rates will remain unchanged. In the case of a \$5 copayment, the DHCS fiscal intermediary (FI) contractor will reimburse providers at the appropriate Medi-Cal reimbursement rate less the \$5 copayment, and the

provider will collect the \$5 copayment from the beneficiary at the time of service. In the event of a beneficiary's inability to pay the copayment at time of service, the provider will be allowed to deny service.

\$5 Copayments for Dental Office Visits

This proposal requires all Medi-Cal beneficiaries to pay up to a \$5 copayment for billable visits to Dentists and Dentist Offices at the point of service. DHCS will implement this proposal without exemptions and regardless of place or type of service.

This proposal will change the source of provider reimbursement, but the reimbursement rates will remain unchanged. In the case of a \$5 copayment, the DHCS dental FI will reimburse providers at the appropriate Medi-Cal reimbursement rate less the \$5 copayment, and the provider will collect the \$5 copayment from the beneficiary at the time of service. In the event of a beneficiary's inability to pay the copayment at time of service, the provider will be allowed to deny service.

\$3 and \$5 Pharmacy Copayments (Preferred/Not Preferred Drug Categories)

This proposal requires all Medi-Cal beneficiaries to pay up to a \$3 copayment for preferred drugs and up to a \$5 copayment for non-preferred drugs. "Preferred drug" has the same meaning as referred to in Section 1916A of the Social Security Act (42 U.S.C 1396o-1). This section of the Act defines "preferred drugs" as drugs identified by the states as the most cost effective drugs within a class of drugs as defined by each State. For example, in California, those drugs may include drugs on the contract drug list, drugs with an established Maximum Allowable Ingredient Cost (MAIC), or drugs with a Federal Upper Limit (FUL). DHCS will implement this proposal without exemptions and regardless of place or type of service. As with all of the affected services in this proposal, DHCS will provide Medi-Cal managed care rates that reflect the actuarial equivalent of this policy; however, in the case of pharmacy copayments, managed care plans will have flexibility in how they implement the policy to achieve the savings.

This proposal will change the source of pharmacy reimbursement, but the reimbursement rates will remain unchanged. In the fee for service system and in the case of the respective \$3 and \$5 copayments, the DHCS FI contractor will reimburse pharmacies at the appropriate Medi-Cal reimbursement rate less the \$3 or \$5 copayment, and the pharmacy will collect the \$3 or \$5 copayment from the beneficiary at the time of service. In the event of a beneficiary's inability to pay the copayment at time of service, the pharmacy will be allowed to deny service. Pursuant to the Deficit Reduction Act (DRA), states are currently permitted to allow pharmacy providers to require the receipt of the copayment from the beneficiary when dispensing a prescription and to deny service if the beneficiary is unable to pay.

\$50 Copayments for Nonemergency ER Visits and \$50 Copayments for Emergency ER Visits

This proposal requires all Medi-Cal beneficiaries to pay up to a \$50 copayment for emergency or non-emergency use of ERs at the point of service. DHCS will implement this proposal without exemptions and regardless of place or type of service. The hospitals may waive the \$50 copayments in the event of an actual hospital admission, in which case \$100 copayments per day will apply.

This proposal will change the source of hospital reimbursement, but the reimbursement rates will remain unchanged. In the case of a \$50 copayment, the DHCS FI contractor will reimburse hospitals at the appropriate Medi-Cal reimbursement rate less the \$50 copayment, and the hospital will collect the \$50 copayment from the beneficiary at the time of service. In the event of a beneficiary's inability to pay the copayment at time of service, the provider will be allowed to deny service. An exception to deny care or services is made for situations that are governed by the Emergency Medical Treatment and Active Labor Act, as specified in federal regulations at 42 CFR 489.24.

\$100 Copayments per Hospital Inpatient Day Maximum \$200 per Admission

This proposal requires all Medi-Cal beneficiaries to pay a copayment of up to \$100 per day with a cap of up to \$200 per admission for any inpatient hospital services. DHCS will implement this proposal without exemptions and regardless of place or type of service.

The hospital will request the copayment from the beneficiary for inpatient care services in accordance with the hospital's collection policy for all copayment clients. The hospital will retain all Medi-Cal copayments collected. The hospital may refuse service due to the beneficiary's inability to pay the required copayment. An exception to deny care or services is made for situations that are governed by the Emergency Medical Treatment and Active Labor Act, as specified in federal regulations at 42 CFR 489.24.

When processing a hospital's final payment for inpatient services, the DHCS FI will automatically deduct from each hospital reimbursement claim the amount of the copayment. The DHCS FI will perform this payment adjustment for non-contract hospitals and hospitals participating in the Selective Provider Contracting Program.

Why is this change needed?

California is facing a multi-billion dollar shortfall, and Medi-Cal, as the second largest General Fund expenditure after education, must be part of the effort to reduce state costs. Imposition of these various beneficiary copayments will

reduce Medi-Cal expenditures for these services. The proposal shall only be implemented to the extent permitted by federal law.

Potential for opposition, if yes, why.

There will be opposition to this proposal by consumer advocates and providers. Opponents may argue that mandatory copayments may result in some beneficiaries going without care in some instances and will have the biggest impact on beneficiaries who utilize services the most

Is there a BCP associated with this language (yes or no)? There is not a BCP associated with this language; this item has been included in the May Estimate.

Any other brief information that is relevant/important to highlight so that one can fully understand the issue that is being presented.

This proposal provides no exemptions for children, pregnant women, or residents of nursing homes.