

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET, Room 320, MS 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1958



September 15, 2009

TO: REGIONAL CENTER DIRECTORS AND ADMINISTRATORS

SUBJECT: FISCAL YEAR (FY) 2009-10 BUDGET REDUCTIONS IN OTHER DEPARTMENTS AND IMPACT TO REGIONAL CENTER CONSUMERS AND FUNDING

Background

The FY 2009-10, state budget includes reductions in other state departments that impact regional center consumers. The Department of Developmental Services' (DDS) budget includes offsetting funding for eliminated services based on data matches between DDS and the impacted department. It is important to note that the amount of the offset included in DDS' budget does not constitute a cap on regional center funding for services identified in the consumers' Individual Program Plans (IPP) to mitigate the loss of these generic services. Below is a summary of the program reductions in other departments and associated general fund offsets (increases) in the DDS budget.

Department of Health Care Services (DHCS)***Elimination of Optional Medi-Cal Benefits for individuals 21 years of age and older (with specified exceptions).***

Trailer Bill language (TBL) effective July 29, 2009, (ABX3 5, Chapter 20, Statutes of 2009) added Section 14131.1 to the Welfare and Institutions Code (WIC), eliminating the optional Medi-Cal (audiology, optometry, podiatry, psychology, speech therapy, acupuncture, chiropractic, optician and optical laboratory) and Denti-Cal (dental) benefits. Medi-Cal coverage for these services has been eliminated for consumers 21 years of age and older, except for those consumers living in a skilled nursing facility, who are pregnant, or receiving benefits through the California Children's Services program or a Program of All-Inclusive Care for the Elderly (PACE). Medi-Cal beneficiaries, regardless of age, who reside in intermediate care and skilled nursing facilities continue to receive Denti-Cal services.

There are a number of additional exceptions based on the type of practitioner providing the care. For example, per the enclosed Notice of Reduction of Medi-Cal Benefits (prepared by DHCS), "Most claims for excluded optional benefit services billed by a physician or physician group remain reimbursable on or after July 1, 2009. However,

"Building Partnerships, Supporting Choices"

these claims will be denied if the rendering provider is **not** a physician but one of the optional benefit providers as listed below:

- | | |
|-----------------|-----------------------|
| ◇ Acupuncturist | ◇ Dispensing Optician |
| ◇ Dentist | ◇ Podiatrist |
| ◇ Audiologist | ◇ Psychologist |
| ◇ Chiropractor | ◇ Speech Therapist" |
| ◇ Optometrist | |

Based on a regional center consumer and Medi-Cal eligibility data match with DHCS, DDS received \$11,972,000 in funding related to these reductions. The regional center may purchase services to address the discontinued Medi-Cal services pursuant to the regional center consumer's IPP. If the regional center is purchasing services through any of the Title 17 service codes listed below, the rate of payment is specified in regulations. Title 17, Section 57332(b) mandates that the maximum rate of reimbursement for each of the services and service codes listed below shall be in accordance with the Schedule of Maximum Allowances (SMA). As such, regional centers purchasing consumer services through the service codes listed below are mandated to continue to use the associated SMA established by DHCS. The funding received in the state budget also assumes payment at the SMA rate. The associated Title 17 service codes for the eliminated optional benefits are as follows:

DENTAL SERVICES

Dentistry - Service Code 715

SPEECH THERAPY SERVICES

Speech Pathology - Service Code 707

PODIATRIC SERVICES

Physician/Surgeon – Service Code 755

AUDIOLOGY SERVICES

Audiology - Service Code 706

Hearing and Audiology Facilities - Service Code 730

OPTOMETRIC/OPTICIAN SERVICES

Orthoptic Services (Orthoptic Technician and Optometrist) - Service Code 745

Other Medical Equipment or Supplies (Dispensing Optician - Service Code 755

PSYCHOLOGY SERVICES

Clinical Psychologist - Service Code 785

OTHER MEDICAL SERVICES

Service Code 760

The above referenced Title 17 service codes are not currently billable to the Home and Community-Based Services Waiver (Waiver). However, DDS is pursuing a Waiver amendment adding former optional Medi-Cal/Denti-Cal services using the same service definitions and rates (SMA) used by DHCS.

Please remember there are two alternative Waiver billable service codes (Specialized Therapeutic Services [STS], service codes 115 and 117) under which the following providers of health care services can be vendored:

Dentist	Dental Hygienist	Physician/Surgeon
Speech Therapist	Nurse Practitioner	Occupational Therapist
Physical Therapist	Marriage and Family Therapist	Occupational Assistant
Social Worker	Physical Therapist Assistant	Respiratory Therapist
Psychologist	Chemical Addiction Counselor	RN and/or LVN

STS was added as a Waiver billable service in 2004, and differs from Medi-Cal services in provider qualifications, scope and location of services. Please see the enclosed June 24, 2004 correspondence to regional centers for more specific information about the use of the STS service codes (please note that the age restriction for STS was lifted in the 2006 Waiver renewal.) New providers of STS are subject to the median rate for your regional center or the statewide median, whichever is lower.

Reduction of Adult Day Health Care Program (ADHC) to no more than three (3) days per week

As part of the recent budget reductions, the Medi-Cal Adult Day Health Care (ADHC) benefit was limited to a maximum of three days of ADHC services per week. The reduction was scheduled to become effective August 27, 2009, 30 days after the signing of the budget bill. However, DHCS was unable to assure that all beneficiaries received at least 10 days advance notice of this change. Additionally, DHCS is being sued by plaintiffs seeking class action status on behalf of Medi-Cal beneficiaries using ADHC services 4 or 5 days a week. On August 24, 2009, the plaintiffs filed a motion for a temporary restraining order to prevent implementation of the benefit reduction on August 27, 2009. The court issued an order preventing the implementation of the

reduction until September 7, 2009. On September 10, 2009, the California Departments of Aging (CDA) and Health Care Services notified ADHC providers that due to a subsequent court ruling on September 10, 2009, the reduction would not take place at this time. DDS emailed to regional centers a copy of the CDA/DHCS update on September 14, 2009. Copies of all notices released regarding ADHC benefit changes are provided on the DHCS website at <http://www.dhcs.ca.gov>. Based on a data match with DHCS, DDS received \$5,335,000 in funding related to this reduction.

To review the section of Trailer bill (ABX3 5, Chapter 20, Statutes of 2009) affecting ADHC services see SEC. 43, 54: WIC §14132; 14526.1; and Sec. 44, 52, 53, 55; 56: WIC §14132.20; 14522.4; 14525.1; 14526.2; 14550.6 Adult Day Health Care Benefits (ADHC).

Department of Social Services (DSS)

Reductions in Social Security benefits

In the state budget approved in February 2009, a Cost-of-Living Adjustment (COLA) was suspended effective May 1, 2009. SSI/SSP grants were reduced by 2.3 percent effective July 1, 2009, reducing grants from \$870 to \$850 for individuals and \$1,524 to \$1,489 for couples. The July 2009 amended budget for 2009-10 permanently eliminates automatic cost-of-living adjustments for SSI/SSP recipients and also reduces SSI/SSP grants to individuals and couples effective Nov. 1, 2009. Statewide, approximately 1 million individuals receiving SSI/SSP will see a .6 percent reduction in their monthly grant, from \$850 per month for the maximum grant to \$845 per month and approximately 245,363 couples receiving SSI/SSP will see their grants reduced to the minimum allowed under federal law, from \$1,489 per month for the maximum grant to \$1,407, a reduction of \$82 per month.

The DDS budget was augmented by \$3,032,000 to offset these reductions for regional center consumers residing in independent and supported living arrangements. Regional centers should continue to use service code 065 for making the payments to impacted consumers.

IHSS

The Amended Budget for 2009-10 includes a range of efforts to address fraud in the IHSS program. In addition, to address the state fiscal crisis, the enacted budget reduces and eliminates IHSS services to individuals with the lowest needs, eliminates the state's supplemental payment of recipients' Medi-Cal share-of-cost requirements, and reduces administrative funding to public authorities. Below are

some excerpts from the California Health and Human Services Blue Book which can be found at <http://www.chhs.ca.gov/initiatives/Documents/BBFinal.pdf>.

SERVICE REDUCTIONS

The enacted budget for FY 2009-10 eliminates all IHSS services to an estimated 36,179 recipients with Functional Index scores of 1.99 or below. Certain exemptions may apply. A person's Functional Index Score is determined by DSS using a uniform assessment process that assesses the individual's functioning on 11 activities of daily living (ADL), these individual ranks by ADL are weighted by importance and combined to provide an overall functional index congregate score.

The Amended Budget for 2009 eliminates or reduces IHSS services to individuals with the lowest needs:

Domestic and related services including housekeeping, meal preparation, food shopping and errands will be eliminated for individuals whose needs are assessed at a functional index (FI) rank of 1, 2 or 3. Those demonstrating a moderate to high level of need with scores of 4 and 5, will continue to receive domestic and related services.

Assessed Functional Index rankings range from 1-5. A rank of 1 means the individual can perform the activities above independently and does not require services; a rank of 2 means verbal reminders are needed; and a rank of 3 means the person needs some assistance with performance of the above activities.

DSS is working toward the implementation of the changes above and will be releasing implementation information to the public as soon as available. The enacted budget did not include an offset to the DDS budget for this change. DDS and DSS are doing a data match to determine the fiscal impact to DDS associated with this service reduction once implemented.

ELIMINATION OF STATE PAYMENT OF RECIPIENTS' SHARE-OF-COST

An individual is required to pay a Medi-Cal deductible, or "share of cost". IHSS, as a Medi-Cal program, is required to assess the Medi-cal approved share of cost. In 2004, IHSS received a federal waiver shifting individuals from the state funded programs using SSI/SSP share of cost to the Medi-Cal standard. The supplemental payment was

designed to assist recipients during the transition into Medi-Cal. Individuals are required to pay a share of cost if their income is in excess of the Medi-Cal benefits requirements. The state elected to make those supplemental share-of-cost payments for a small number of IHSS recipients.

Under the Amended Budget for 2009-10, effective October 1, 2009, the state will no longer make this payment for 9,277 IHSS recipients, meaning they will be required to cover their Medi-Cal share of cost in the program, consistent with the obligations of other Medi-Cal beneficiaries. In February 2009, this supplemental DSS share-of-cost payment was eliminated for new recipients effective July 1, 2009.

WAGES

No changes to wages are included in the Amended Budget for 2009-10. A reduction in state participation in IHSS wages from \$12.10/hr. to \$10.10/hr. enacted in February 2009 was enjoined by the U.S. District Court on June 26, 2009. This case is on appeal.

MAJOR REFORMS TO ADDRESS FRAUD

Fingerprinting and Background Check Requirements

Under the Amended Budget for 2009-10, recipients of IHSS services will be fingerprinted at assessment beginning April 1, 2010. DSS will consult with county welfare departments to develop protocols and procedures for obtaining fingerprints to ensure that recipients do not receive duplicate aid in more than one county, under more than one name or at multiple addresses.

Current providers will be required to complete a new enrollment form, pay for fingerprinting and a background check, and complete an orientation between Nov. 1, 2009, and June 30, 2010, as a condition of continued employment.

Effective immediately, new providers applying through a public authority will be required to pay for fingerprinting and background checks prior to providing IHSS services. New providers applying through a county will be required to do this by Nov. 1, 2009.

Any individual convicted in the last 10 years of three specific crimes -- defrauding a government health care or supportive service programs, felony child abuse or felony elder abuse -- will be excluded from the program.

Face-to-Face Enrollment

Effective immediately, new providers of IHSS services will be required to enroll face-to-face with county social workers or public authorities, providing original identification documentation that must be photocopied and retained.

New Civil Penalties and Timecard Improvements

Until the Amended Budget of 2009-10, there were no provisions in law for civil penalties for fraud in the IHSS program. Under the new law, providers will be subject to civil penalties of \$500 to \$1,000 following a criminal conviction for fraud. In addition, the new law requires that timecards indicate that these civil penalties may apply if the information on the timesheet is found not to be true and correct. In addition, effective July 1, 2011, time cards will include the index fingerprints of both the provider and the recipient.

Funding for Targeted Mailings

The Amended Budget provides funding to send information to recipients and providers about program integrity concerns.

Limiting Use of P.O. Boxes

Effective immediately, providers may not list P.O. Boxes on enrollment forms but must use their physical residential address. Paychecks shall not be sent to P.O. Boxes unless the county approves circumstances that make it necessary.

NEW AUTHORITY TO ENFORCE COMPLIANCE WITH PROGRAM REQUIREMENTS

The Amended Budget authorizes 78 positions for counties to conduct program integrity activities including unannounced home visits to recipients to ensure that services are necessary and being provided as intended.

NEW RESOURCES AND AUTHORITY TO INVESTIGATE AND SHARE INFORMATION ABOUT IHSS FRAUD

Under the Amended Budget, counties will be authorized to investigate fraud and will be able to coordinate and share data with DSS and DHCS in those investigations. In addition, the budget provides funding to counties to investigate and prosecute suspected fraud.

Regional Center Directors and Administrators
September 15, 2009
Page eight

If you have any questions regarding this correspondence, please contact Brian Winfield, Chief, Regional Center Operations Section at (916) 654-1958.

Sincerely,

Original Signed By

RITA WALKER
Deputy Director
Community Operations Division

Enclosures

cc: Robert Baldo, ARCA
Regional Center Chief Counselors
Regional Center Administrators
Karyn Meyreles, DDS

State of California - Health and Human Services Agency
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850

June 2009

Notice of Reduction of Medi-Cal Benefits

Dear Beneficiary:

The California Department of Health Care Services has sent this notice to let you know of a change in the law contained in Welfare and Institutions Code section 14131.10. Starting July 1, 2009, Medi-Cal will no longer pay for some benefits. This change will affect only Medi-Cal beneficiaries age 21 and older. If you are age 21 and older, you can still get all of these benefits through June 30, 2009.

What benefits will Medi-Cal no longer pay for?

Medi-Cal will no longer pay for the following benefits and services for most adults (there are some exceptions):

- Dental services
- Speech therapy services
- Podiatric services
- Audiology services
- Chiropractic services
- Acupuncture services
- Optometric and optician services (ophthalmology [doctor services for the eyes] will continue to be covered)
- Psychology services (psychiatry services, and all services through county mental health programs will continued to be covered)
- Incontinence creams and washes

What are the exceptions?

The above benefits and services will NOT change for Medi-Cal beneficiaries who are:

- Under the age of 21; or
- Living in a skilled nursing facility (Level A or B; this includes subacute care facilities); or
- Pregnant. (If you are pregnant, you can continue to receive pregnancy-related benefits and services. You can also receive other benefits and services listed above to treat conditions that, if left untreated, might cause difficulties for the pregnancy. This includes dental exams, cleanings, and gum treatment. Dental and other benefits and services may also be available up to 60 days after the baby is born;) or
- Receiving benefits through the California Children's Services program; or
- Receiving benefits through a Program of All-Inclusive Care for the Elderly.

If I do not meet the above exceptions, can I still receive the reduced benefits?

You can still receive some or all of the reduced benefits, and certain dental services if you are:

- Receiving the services through the Genetically Handicapped Persons Program; or
- Receiving the benefits through the county mental health program; or
- Receiving the benefits through the Medicare Part B program; or
- Receiving the services directly from a physician.

You should contact your physician or dentist if you have any questions about these changes.

Are there any benefits and services listed above that I can still get if I do not meet the exceptions? Yes.

- You can receive the benefits and services listed above if an emergency condition occurs and the benefit is required to treat the emergency condition.
- Some medical and surgical services provided by a dentist will continue to be covered. Check with your dentist for more information.
- Some of these benefits and services may be provided in hospital outpatient clinics, Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services, adult day health care centers, or through home health agencies. Check with your primary health care provider for a referral.
- Some of these benefits and services may be continued if you are currently receiving them or if you move from an exempt group, such as under 21 years of age, to a non-exempt group, such as turning 21 years of age. Check with your primary health care provider for more information.
- Your county health department may be able to provide you some of the benefits and services no longer covered by Medi-Cal.

Where can I go for more information?

We will provide more answers on the Department of Health Care Services website at <http://www.dhcs.ca.gov> and on the Medi-Cal website at <http://www.medi-cal.ca.gov/>.

If you have more questions about these changes, you may call the Medi-Cal Beneficiary Services Line at **1-888-284-0623**.

DEPARTMENT OF DEVELOPMENTAL SERVICES

1600 NINTH STREET, Room 320, MS 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1954



DATE: JUNE 24, 2004

TO: REGIONAL CENTER EXECUTIVE DIRECTORS

SUBJECT: Centers for Medicare and Medicaid Services (CMS) approved Home and Community-based Services Waiver Amendment

CMS has approved the addition of Specialized Therapeutic Services (STS) to the list of available Waiver services for **consumers twenty-one years of age and older**. STS includes services to address the oral, physical and/or behavioral/social-emotional health needs of the consumer following a determination that there are no appropriate, available generic services (including MediCal) to meet the consumer's need. The Department has established Miscellaneous Service Code 117 (Enclosure A) specifically to be used for the STS services as defined in the Waiver amendment for consumers twenty-one years of age and older.

Conceptually, the STS services approved in the Waiver are different from medical, dental, and behavioral/social-emotional health services provided through the MediCal and Denti-Cal programs in the following areas:

- Provider qualifications;
- the scope of the service (what is provided); and,
- in some instances, the location of the service delivery.

Generally, it is anticipated that private insurance or MediCal will be the appropriate generic service, but this amendment recognizes that there are times and situations in which the impact/complexities of the individual's developmental disability on the delivery of physical, oral and/or behavioral/social-emotional health services is such that specialized therapeutic services are required. The addition of the STS Waiver service should assist regional centers in meeting the unique needs of individuals they serve and promote positive health outcomes for consumers.

"Building Partnerships, Supporting Choices"

To be vendored as a provider under Miscellaneous Service code 117, providers must:

- Hold a current State license or certificate to practice in the respective clinical field;
- have at **least one year of experience** providing direct care in the field of licensure with persons with developmental disabilities; and,
- be one of the following professionals consistent with Enclosure C:

Physician/Surgeon	Dentist
Speech Therapist	Dental Hygienist
Occupational therapist or Occupational Therapist Assistant	Licensed Clinical Social Worker
Physical Therapist or Physical Therapist Assistant	Psychologist
Nurse (RN) or Nurse Practitioner	Marriage and Family Therapist
Certified Chemical Addiction Counselor	Licensed Vocational Nurse
	Respiratory Therapist

Regional centers must obtain validation of the one year of experience providing direct care in the field of licensure prior to vendorization and maintain this information in the regional center vendor file.

Also, there are several key criteria that must be considered by the consumer's individual planning team in the determination regarding the purchase of these services through the Waiver. Below is an excerpt from the CMS approved Waiver amendment (Enclosure B) to which regional centers must strictly adhere:

The need for a Specialized Therapeutic Service must be identified in the Individual Program Plan, also known as a Plan of Care, and is to be provided only when the individual's regional center planning team has:

- 1. Determined the reason why other generic or State Plan services can not/do not meet the unique oral health, behavioral/social-emotional health, physical health needs of the consumer as a result of his/her developmental disability and the impact of the developmental disability on the delivery of therapeutic services;***
- 2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e., a provider of State Plan services does not have the appropriate qualifications to provide the service;***
- 3. Determined that the individual's needs cannot be met by a State Plan provider delivering routine State Plan services; and***

- 4. Determined that the Specialized Therapeutic Service is a necessary component of the overall Plan of Care that is needed to avoid institutionalization*
- 5. Consulted with a Regional Center clinician.*

The need to continue the Specialized Therapeutic Service will be evaluated during the mandatory annual review of the individual's IPP in order to determine if utilization is appropriate and progress is being made as a result of the service being provided.

Since the above text is merely an excerpt from the approved Waiver amendment, regional centers should carefully review the enclosed CMS approved service description for Specialized Therapeutic Services (Enclosure B), as well as the corresponding description and matrix listing of approved providers of this service (Enclosure C). Regional centers may only vendorize providers under this service code that meet the qualifications articulated in the approved Waiver amendment.

The newly established Miscellaneous Service Code 117 for this Waiver service should be used whenever purchasing specialized therapeutic services for any consumer twenty-one years of age or older. A corresponding change has been made to existing Miscellaneous Service Code 115 to limit use of that service code to consumers over three years of age and under 21 years of age (Enclosure D). No changes have been made to Miscellaneous Service Code 116 – Specialized Therapeutic Services for consumer's birth to three years of age. Regional centers should pay close attention to their use of the now three (3) distinct service codes for Specialized Therapeutic Services to ensure proper coding and Waiver billing, consistent with the CMS approved Waiver amendment.

CMS also approved changes to the service code descriptions for the DDS Licensed - Specialized Residential Facility in the Waiver. The corresponding Miscellaneous Service Code 113 has been revised accordingly and is enclosed for regional center use (Enclosure E). These revisions clarify the regional center's monitoring role and the application of Title 17, Section 56919 (a) regarding payment for services.

Regional Center Executive Directors
June 24, 2004
Page four

If you have any questions about the revisions to Miscellaneous Service Code 113 - Specialized Residential Facility service description, please contact Shelton Dent at (916) 654-1958. Questions regarding the use of the Miscellaneous Service Code 117- Specialized Therapeutic Services for Consumers twenty-one years of age and older, should be directed to Rita Walker at (916) 654-1958.

Sincerely,

A handwritten signature in black ink, appearing to read 'DALE SORBELLO', with a horizontal line extending to the right.

DALE SORBELLO
Deputy Director

Enclosures

cc: RC Chief Counselors
RC Waiver Coordinators
RC Administrators
ARCA
Glenda Davis, DDS
Julia Mullen, DDS
Barbara Ogata, DDS
MaryLou Azevedo, DDS