Assembly
California Legislature

ASSEMBLY COMMITTEE ON HEALTH
DR. RICHARD PAN, CHAIR
ASSEMBLYMEMBER, NINTH DISTRICT

Background

Informational Hearing:
Medi-Cal: When Reimbursement Policies Interfere with the Standard of Care

Tuesday, August 12, 2014
1:30 p.m.

State Capitol, Room 4202

Introduction

This hearing is being held to examine issues related to utilization rules and restrictions in the Medi-Cal program that interfere with providing quality care. Utilization controls are used to prevent overuse of services, but if not carefully developed, can prevent healthcare providers from providing necessary care. Concerns have been raised that Medi-Cal payment policies are inappropriately limiting access to care and Medi-Cal is insufficiently responsive to evidence of inappropriate utilization controls. In particular, this hearing will examine access to allergy testing for Medi-Cal patients with allergies and asthma that prevent timely diagnosis and treatment. This hearing will also explore the factors and process the Department of Health Care Services (DHCS) uses when developing rules and restrictions on utilization.

The committee is planning additional oversight hearings on the Medi-Cal program to examine barriers to care.

The Medi-Cal Program

Medi-Cal is a joint federal-state program which provides federal funds to pay part of the state cost in providing health care services for most low-income persons. Medi-Cal covers a core set of services, including doctor visits, hospital care, and pregnancy-related services, as well as nursing home care for individuals age 21 or older through either a fee-for-service or managed care delivery system. The estimated Medi-Cal budget for 2014-15 is over $90 billion and enrollment has reached approximately 10.5 million individuals.

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The Medi-Cal program has undergone marked changes in the last several years; many of the changes came about because of the enactment of the federal Patient Protection and Affordable Care Act (ACA). Until the implementation of the ACA, Medi-Cal eligibility was limited to low-income families with children, seniors and persons with disabilities, and pregnant women. The ACA expanded eligibility to additional low-income populations, including childless adults. Under the ACA, Medi-Cal coverage expanded in 2014, making 1 million to 2 million new people eligible. In addition, with the beginning of implementing the ACA and the attendant publicity surrounding purchasing insurance, many formerly eligible individuals have applied and have been enrolled in the program. The number of new applicants was so great that there is currently a backlog of approximately 500,000 applications. The state also acted to phase out the Healthy Families program and shifted 853,000 of these children into Medi-Cal. These are the precise changes that have led to the dramatic growth in the overall Medi-Cal program.

Those enrolled in Medi-Cal can receive their health care services in two different ways. One is fee-for-service. Beneficiaries in Medi-Cal fee-for-service generally may obtain services from any provider who has agreed to accept Medi-Cal fee-for-service payments. The other model is managed care. In managed care, DHCS contracts with managed care plans to provide health care coverage for Medi-Cal beneficiaries. Managed care enrollees may obtain services from providers who accept payments from the managed care plan; these providers are commonly referred to as being in the plan's network.

Another significant change in the Medi-Cal program is the dramatic growth in managed care enrollment. Total enrollment reached 7.7 million beneficiaries last month. In managed care, the plan establishes utilization controls for allergy testing and diagnosis for those Medi-Cal beneficiaries enrolled in managed care and is responsible for ensuring there are an adequate number of specialists, including allergists.

This hearing is focused on the DHCS policies for allergy testing and diagnosis in fee-for-service. Although 75% of beneficiaries are in managed care, there are still large numbers in fee-for-service. In particular, DHCS estimates there are approximately 700,000 children in Medi-Cal fee-for-service.

Asthma and Allergies

Asthma is a chronic inflammatory disease of the airways. Asthma is widespread; in California an estimated 2.5 million adults have asthma along with about 700,000 children. It is one of the most common chronic diseases of childhood. The exact cause of asthma is unknown and it cannot be cured. Asthma can be controlled with self-management education, appropriate medical care and avoiding exposure to environmental triggers. Allergen exposure is a significant trigger that can worsen symptoms for many patients with asthma.

The National Asthma Education and Prevention Program Expert Panel guidelines for the management of asthma recommend that patients who require daily asthma medications have allergy testing for perennial indoor allergens. The guidelines also recommend that when triggers are found, exposure to allergens and pollutants be controlled through avoidance and abatement. For patients whose symptoms are not controlled adequately with these interventions and who are candidates for immunotherapy, the guidelines recommend referral to an allergist.

Medical guidelines are documents compiled with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare. They are based on an examination of current evidence. The first release of the National Asthma Education and Prevention Program clinical practice guidelines was in 1991. Progress has been made since then in the treatment of asthma. The number of deaths due to asthma has declined, even in the face of an increasing prevalence of the disease. Fewer patients who have asthma report limitations to activities and an increasing proportion of people who have asthma receive formal patient education. Hospitalization rates have remained relatively stable over the last decade, with lower rates in some age groups but higher rates among young children up to four years of age. Asthma disproportionately affects low-income Californians, who miss more days of work and school, are more likely to have frequent asthma symptoms, and are more likely to go to the emergency department or be hospitalized for asthma care.

Food allergies are an immune-based disease that has become a serious health concern in the United States. A recent study estimates that food allergy affects 5% of children under the age of five years and 4% of teens and adults, and its prevalence appears to be on the increase. The symptoms of this disease can range from mild to severe and, in rare cases, can lead to anaphylaxis, a severe and potentially life-threatening allergic reaction. There are no therapies available to prevent or cure food allergies. The only prevention option for the patient is to avoid the food allergen. Treatment involves the management of symptoms as they appear. Because the most common food allergens—eggs, milk, peanuts, tree nuts, soy, wheat, crustacean shellfish, and fish—are prevalent in our diets, avoiding the food allergens is challenging and difficult. The development of the Guidelines for the Diagnosis and Management of Food Allergy in the United States began in 2008 to identify the best clinical practices related to food allergy across medical specialties.

Testing for allergies

Identifying the specific allergen is an essential step in effectively preventing and treating the symptoms. Allergy testing can identify the specific substance that triggers the allergic reaction. Testing can be done either through skins tests or blood tests.

There are two types of skin tests. In the first type of skin test, a drop of suspected allergens are pricked or scratched on the surface of the skin. The test spot will swell if the patient reacts to the

allergen placed. The second type of skin test involves injecting a solution of allergen into the skin. Generally, skin tests are performed under the supervision of allergists.

There are situations where skin tests cannot be used. Because they involve multiple injections, young children may not tolerate skin tests. Some medications can interfere with the tests. In addition, in some people with dark skin or skin conditions, it may be hard to read the tests. Also, the skill of the tester can affect the results, and skin tests should be done only by professionals with appropriate training. Occasionally, a patient may develop a severe reaction to the skin test requiring treatment.

Blood tests are performed by a clinical laboratory upon the order of a physician, including primary care physicians. Medications and skin conditions do not interfere with the results. Because blood tests, in contrast to skin tests, do not require visits to a specialist, they may be more economical and much more accessible. Patients do not have to wait to see a specialist and avoid the time and effort involved in additional appointments for specialty care.

Neither skin nor blood test results alone diagnose allergies. All test results, from either type of test, must be interpreted together with the medical history.

DHCS has developed a policy for the allergy blood test. The policy does not require prior authorization. The process requires the provider, in this case the clinical laboratory, to submit relevant information to the fiscal intermediary with the claim for reimbursement. There are two available options for submitting relevant information with the claim: 1) upload an attachment or scanned document to accompany the claim, or mail the attachment to Xerox; or 2) provide medical justification on the claim form where an explanation limited to 80 characters is available. DHCS added the second option within the last year after working with the labs on their concerns about easing administrative burdens.

The fiscal intermediary is a private entity who DHCS contracts with. The fiscal intermediary employs a clinical laboratory reviewer who adjudicates claims based on established medical policy and coverage criteria. This is a standard practice not only in the area of allergy testing, but for other laboratory services as well.

Issues for the Committee to consider

Does the Department's policy regarding reimbursement for blood allergy tests make it more difficult to diagnose allergies in Medi-Cal patients? The policy puts in place additional requirements for reimbursement for clinical labs for a blood test than for screening tests, such as skin testing for allergies. A path is provided for reimbursement but the concern has been raised that the administrative burden discourages either the physician or laboratory (who must get information from the physician) from conducting tests.

Moreover, does the DHCS policy ignore the advantages of blood tests, which can be ordered by a primary care physician without a Medi-Cal patient having to make an extra visit to an allergist at additional expense to the state and inconvenience to the patient? If a primary care physician is able to order a blood test and accurately diagnoses the patient, the patient is likely to receive medical treatment sooner. This can be vital for life-threatening asthma and food allergies.

Is there adequate access to allergists in the Medi-Cal program? In Medi-Cal it is simpler for an allergist to be reimbursed for a skin test. However, most people who suffer from allergies receive care for them from their primary care physician. Further, Medi-Cal has had historic issues with adequate access to specialists in the fee for service program. DHCS has been asked about the number and distribution of allergists enrolled in the program and the reimbursements associated with diagnosis and testing.