



Department of Health Care Services



Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program February 29, 2012

Purpose

- The Department of Health Care Services (DHCS) is hosting this webinar regarding proposed changes to the Medi-Cal Program. This webinar will provide information and allow for feedback on State Plan Amendments (SPA) and Waiver Renewals/Amendments proposed for submission to Centers for Medicare and Medicaid Services (CMS).
- Background: Executive Orders recognize the unique relationship of Tribes with the federal government and emphasize the importance of States to work with Tribes on matters that may impact Indian health.
- This webinar is one way for DHCS to provide information about the Medi-Cal program and get feedback verbally and writing.

Agenda

Topic	Presenter
Webinar Logistics	Lori Gonzalez, Go to Meetings
Welcome/Overview	Andrea Zubiata, Indian Health Program (IHP)Coordinator
State Plan and State Plan Amendment (SPA) Overview	Andrea Zubiata, IHP Coordinator
SPA's Scheduled for Submission by March 31, 2012	
Review of Proposed SPA 12-004	Jim Elliott, Medi-Cal Benefits, Waiver Analysis Division (BWAD)
Review of Proposed SPA 12-006	Arlene Sakazaki, Fee-For-Service Rates Division
Review of Proposed SPA 12-007	James Clark, BWAD
Review of Proposed SPA 12-008	Maria Ochoa, Provider Enrollment Division
Review of Proposed SPA 12-010	Betsi Howard, Long-Term Care Division
Review of Proposed SPA 12-012	Sonny Bains, Fee-For-Services Rates Division
Review of Proposed SPA 12-014	Teresa Miller, Pharmacy Benefits Division
Review of Proposed SPA 12-002	Andrea Zubiata, IHP Coordinator
Medicaid Waiver Overview	Andrea Zubiata, IHP Coordinator
Waiver Scheduled for Submission by March 31, 2012	
Amendment of the Section 1915(b) Freedom of Choice Waiver —Medi-Cal Specialty Mental Health Services (SMHS) Waiver	Teresa Castillo, BWAD
Feedback/Closing	All

State Plan Amendment (SPA) Overview



Medicaid State Plan Overview

- State Plan: The official contract between the state and federal government by which a state ensure compliance with federal Medicaid requirements to be eligible for federal funding.
- The State Plan describes the nature and scope of Medicaid program and gives assurance that it will be administered in accordance with the specific requirements of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and State law/regulations.
- California's State Plan is over 1400 pages and can be accessed online at:

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>

State Plan Amendment (SPA) Overview

- SPA: Any formal change to the State Plan.
- Approved State Plans and SPAs ensure the availability of federal funding for the state's program (Medi-Cal).
- The CMS reviews all State Plans and SPAs for compliance with:
 - Federal Medicaid statutes and regulations
 - State Medicaid manual
 - Most current State Medicaid Directors' Letters, which serve as policy guidance.

Provider Preventable Conditions (PPC) SPA 12-004



Background

- The federal Affordable Care Act section 2702 prohibits Medicaid programs from paying for “provider-preventable conditions” (PPCs).
- Medicare is already denying payments for PPC-related services.
- DHCS intends to submit the SPA on April 2, 2012 with an implementation date of July 1, 2012
- Providers must report all PPCs, even if they do not intend to bill Medi-Cal for treating the condition.
- Medi-Cal will limit nonpayment to the extent that the State can reasonably isolate the portion of the payment directly related to treatment for the PPC.
- Medi-Cal will not deny payment for a PPC-related claim when the provider notes that the PPC existed before he or she initiated treatment for that patient.
- PPCs are described in the Code of Federal Regulations, Title 42, part 447 as:
 - Health Care Acquired Conditions (HCACs)
 - Other Provider-Preventable Conditions (OPPCs)

Provider-Preventable Conditions

Health Care Acquired Conditions (inpatient hospital only)	Other Provider-Preventable Conditions (all health care settings)
<ul style="list-style-type: none">• Foreign object retained after surgery• Air embolism• Blood incompatibility• Stage III and IV pressure ulcers• Falls and trauma• Manifestations of poor glycemic control• Catheter-associated urinary tract infection (UTI)• Vascular catheter-associated infection• Surgical site infection following certain procedures• For non-pediatric/obstetric population, deep vein thrombosis (DVT)/pulmonary embolism (PE) resulting from total knee replacement or hip replacement	<ul style="list-style-type: none">• Wrong surgical or other invasive procedure performed on a patient,• Surgical or other invasive procedure performed on the wrong body part• Surgical or other invasive procedure performed on the wrong patient.

Impact

Impact on Indian Health Programs

- If an Indian Health Program submits a claim for a PPC that did not exist prior to that provider treating the patient, DHCS will deny payments for what would otherwise be a higher amount. The denial will happen to the extent that DHCS can reasonably isolate the portion of the payment directly related to treatment for the PPC.
- Indian Health Programs will need to report to DHCS the occurrence of any PPCs in any Medi-Cal patient that did not exist before treatment by the Indian Health Program. The Indian Health Program shall report to DHCS regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the PPC.

Impact

Impact on Indian Medi-Cal Beneficiaries

- This SPA will not impact American Indian Medi-Cal beneficiaries.



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Amendments to 10% Outpatient Provider Rate Reduction SPA 11-009 - SPA 12-006



Background

- The CMS approved SPA 11-009 on October 27, 2011, to reduce Medi-Cal payments by 10 percent for dates of service on or after June 1, 2011, as specified in Assembly Bill 97 (Chapter 3, Statutes of 2011). Upon approval of SPA 11-009, CMS requested that the DHCS respond to issues that were identified in a separate companion letter.
- DHCS is amending portions of the SPA 11-009 to make minor changes to the general reimbursement methodology section for outpatient services and the section for Home Health Agencies. The minor changes include adding the outpatient service categories to the reimbursement methodology section and adding the link to the Medi-Cal Rates website to the Home Health Agency section. SPA 12-006, which proposes to amend SPA 11-009, will be submitted to CMS by March 25, 2012. The effective date of SPA 12-006 is January 1, 2012.

Impact

Impact on Indian Health Programs

- DHCS does not anticipate that this SPA will have an effect on the Indian Health Programs because it is only adding information to make the two sections identified above more comprehensive.

Impact on Indian Medi-Cal Beneficiaries

- DHCS does not anticipate that this SPA will impact Indian Medi-Cal beneficiaries.



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Religious Nonmedical Health Care Institutions (RNHCI) SPA 12-007



Background

- The CMS requested that the DHCS submit a SPA to update the type of service from “Christian Science Practitioners” to “ Services furnished in Religious Nonmedical Health Care Institutions.” Effective date is March 25, 2012.
- SPA 12-007 will amend the State Plan by replacing “Christian Science Practitioners” and “Christian Science sanitaria care and services” with “Services furnished in RNHCI.”
- DHCS intendeds to submit this SPA to CMS by March 25, 2012.



Impact

Impact on Indian Health Programs

- DHCS does not anticipate that this SPA will have an effect on the Indian Health Programs because it is only adding information to make the two sections identified above more comprehensive.
- All existing Christian Scientist Sanitaria services will remain available under the renamed “RNHCI” services

Impact on Indian Medi-Cal Beneficiaries

- DHCS does not anticipate that this SPA will impact Indian Medi-Cal beneficiaries.

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**Patient Protection and Affordable Care Act (ACA)
and Code of Federal Regulation (CFR)
Compliance: Provider Screening and Enrollment:
SPA 12-008**



Background

- SPA 12-008 will amend the State Plan for Medi-Cal, to be consistent with Sections 6401, 6402, and 10603 of the ACA, and the 42 CFR, Subpart E, §455.400 through §455.470. These Federal provisions establish new provider screening and enrollment requirements for Medi-Cal.
- DHCS is required to submit SPA 12-008 by April 1, 2012, to the CMS. This is to confirm California's intent to comply with the new Federal provider screening and enrollment requirements.
- Effective date -
 - April 1, 2012 – DHCS is compliant only with one provision, since full compliance requires legislative changes.
 - January 1, 2013 – DHCS' intent to be in full compliance along with all impacted State departments by January 1, 2013.

Impact

Impact on Indian Health Programs

- DHCS has identified areas of impact to Indian health programs as outlined below. Medicare has these same requirements for their enrolled providers and has moved forward with implementation. Indian health programs may be fully aware of these requirements, and may have already complied with Medicare. As such, the impact may be minimized.

Enrollment of Ordering or Referring Providers

- All ordering and referring providers enrolled as participating providers (physicians and other health care professionals)
- Effective January 1, 2013, in order for Medi-Cal to reimburse claims

Impact

Impact on Indian Health Programs (continued)

Revalidation of Clinics and Providers

- Clinics and ordering/referring providers subject to revalidation at least every 5 years
- Medi-Cal may rely on Medicare revalidation/screening
 - Will be required to submit new disclosures and other documentation if screened by Medicare
- Additional information will be made available as DHCS implements
- Effective January 1, 2013



Impact

Impact on Indian Health Programs (continued)

Application Fee

- Federally Qualified Health Centers and Rural Health Centers may be subject to submit an application fee at time of application and/or revalidation.
- Ordering/referring providers are not subject to application fee
- Calculated annually by CMS
 - Fee for 2012 is \$523
- Paid either to Medicare or Medicaid
- Waivers can be requested – all are to be approved by CMS
 - Provider may initiate request
 - States may request for a specific provider type or in a regional area
 - » Based on access to care issues
- Effective January 1, 2013

Impact

Impact on Indian Medi-Cal Beneficiaries

- This SPA may impact Medi-Cal beneficiaries receiving primary care in Indian health programs, unless all ordering or referring providers are enrolled with Medi-Cal.
- Medi-Cal may not pay for prescriptions if the ordering or referring provider is not enrolled as a participating provider, and/or the provider's National Provider Identifier is not listed on the claim.
 - This could lead to beneficiaries not receiving essential care and/or medications in a timely manner.



Contact Information

- Comments may be sent by email to PEDACA@dhcs.ca.gov or by mail to the address listed below:
 - Provider Enrollment Division, Policy Unit
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Attn: PEDACA
Maria Ochoa 916-319-8129

**Implementation of Twenty Percent Reduction
in Authorized Hours for Personal Care Services
Program (PCSP), In-Home Supportive
Services (IHSS) Plus Option, and Community
First Choice Option (CFCO) for Current
Recipients and Future Applicants
SPA 12-010**



Background

- Senate Bill 73 (Chapter 34, Statutes of 2011) added section 12301.07 to the California Welfare and Institutions Code that requires the California Department of Social Services (CDSS) and DHCS to implement a 20 percent reduction in authorized service hours for the PCSP, IHSS Plus Option, and CFCO.
- SPA 12-010 will amend the State Plan, in accordance with the mandates of W&I Code section 12301.07, to permit CDSS and DHCS to implement a 20 percent reduction in PCSP, IHSS Plus Option, and CFCO. This change will impact current recipients' and future applicants' total authorized monthly service hours, effective April 1, 2012.
- Recipients with a documented unmet need, excluding protective supervision, will have the reduction first applied to the unmet need before being applied to authorized service hours.

Exemptions

- Counties will pre-approve exemptions from the reduction based upon an assessment whether the individual is at serious risk of out-of-home placement as a result of the reduction. Counties will use a screening tool with pre-determined criteria that will address cognitive and physical impairments in order to identify and assess individuals at serious risk of out-of-home placement as a result of the reduction.
- The reduction will not be applied to individuals receiving services under any of the State's Section 1915(c) Home and Community-Based Services waivers, which include the following:
 - Acquired Immune Deficiency Syndrome Waiver
 - Home and Community-Based Services Waiver for the Developmentally Disabled
 - In-Home Operations Waiver
 - Multipurpose Senior Services Program Waiver
 - Nursing Facility/Acute Hospital Waiver
 - Other Section 1915(c) waivers approved by the Centers for Medicare & Medicaid Services

Exemptions Con't.

- Individuals who believe that they will be at serious risk of out-of-home placement because of the reduction will be able to file an application for supplemental care to replace part or all of the reduced hours. The individual may submit an application to the county to determine if he or she is at serious risk of out-of-home placement. The county will determine whether the individual is at serious risk of out-of-home placement and whether the individual's hours need to be partially or fully restored in order to alleviate that risk.
- An individual who disagrees with his or her supplemental care determination may request a state hearing to appeal that determination. If the individual files for a state hearing in a timely manner, he or she will be eligible to receive the hours of service authorized prior to the reduction, pending the outcome of the hearing. If the individual demonstrates that he or she is at serious risk of out-of-home placement if service hours are not restored, the individual will be authorized the services.

Impact

Impact on Indian Health Programs

- It is not anticipated that this SPA will impact members of Indian health programs or urban Indian organizations. However, SPA 12-010 could affect the amount of Medi-Cal in-home services that Indian health program members receive.

Impact on Indian Medi-Cal Beneficiaries

- This SPA would reduce by 20 percent, recipients' service hours based on a determination of need under the Statewide Uniform Assessment, unless they have a documented unmet need or are subject to an exemption.



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AB 97 Exemption for Certain Distinct Part Nursing Facilities - SPA 12-012



Background

- As enacted on March 24, 2011, by Assembly Bill (AB) 97 (Statutes of 2011), the Department of Health Care Services (DHCS) is required to reduce payments to Medi-Cal Long-Term Care providers. AB 97 added section 14105.192 of the Welfare and Institutions Code, which provides for provider payment reduction and rate freeze at the 2008-09 levels up to 10 percent for various services, effective June 1, 2011.
- Section 14105.192, subdivision (m), authorizes the Director of DHCS not to implement a particular payment reduction as necessary to comply with federal Medicaid requirements. DHCS is submitting SPA 12-012 to the federal CMS under this authority.

Description of SPA

- The proposed SPA will provide an exemption from the 10 percent payment reduction and freezing of per-diem rates (at the 2008-09 levels) required by AB 97 to any Distinct Part Nursing Facility - Level B (DP/NF-B) that provides at least 90 percent of its services to children under 21 years of age.



Impact

Impact on Indian Health Programs

- This SPA proposes an exemption from the payment reduction to any Medi-Cal DP/NF-B that provides at least 90 percent of its services to children under the age of 21. DHCS does not anticipate that this SPA will have any direct impact on Indian Health Programs.

Impact on Indian Medi-Cal Beneficiaries

- This SPA exempts the 10 percent payment reduction to any DP/NF-B that provides at least 90 percent of its services to children under 21; therefore, it will not negatively impact the Indian Medi-Cal beneficiaries.

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Pharmacy Provider Rate Reduction Implementation SPA 12-014



Background

- SPA 11-009, approved by CMS 10/27/11, provides for a 10% provider payment reduction, effective June 1, 2011.
 - Based on its analysis of information and input from pharmacy providers received subsequent to CMS's approval of the 10 percent payment reduction, DHCS believes that for selected specific drug products, or for specific types of providers, or in specific geographic areas, a 10% reduction may impede access to selected Medi-Cal drug benefits and possibly result in a violation of federal Medicaid requirements.
- DHCS submitted SPA 11-038 on Dec. 30th, requesting the flexibility to adjust provider payment reductions as needed (to other than 10%) in cases where DHCS determined that a 10% reduction would result in a negative impact on beneficiary access to the pharmacy benefit.
 - CMS subsequently informed DHCS that the language of SPA 11-038 was not specific enough, and asked that it be revised.

Description of SPA

- SPA 12-014 provides the clarification that CMS has requested by
 - Outlining the factors the Department intends to consider to determine whether to adjust drug product or pharmacy provider payment reductions in amounts other than 10 percent.
 - Describing the process by which DHCS will notify providers of such changes.
- Allows DHCS to reduce by less than 10 percent payments for specific drugs within specific identified categories of drugs if pharmacy providers submit verifiable pricing information sufficient to demonstrate that the 10 percent reduction will result in reimbursement below actual acquisition cost for a particular product and as a result, will negatively impact beneficiary access.

Categories of Drugs

- Reductions of less than 10% will be considered for the following categories of drugs:
 - Drugs purchased through the 340B program
 - Physician Administered Drugs
 - Blood factors
 - Drugs to treat pulmonary hypertension
 - Drugs to treat immunodeficiency (HIV/AIDS)
 - Nucleoside-Nucleotide Analog
 - Protease Inhibitors
 - Drugs to treat errors of metabolism
 - Growth hormones
 - Anti-inflammatory tumor necrosis factor inhibitors
 - Hepatitis C drugs
 - Antineoplastic
 - Anti-rejection drugs
 - Drugs to treat multiple sclerosis
 - Antiviral Monoclonal antibodies
 - Mental health drugs
 - Vaccines

Description of SPA

DHCS may reduce payments to specific providers by less than 10 percent

- if providers submit verifiable pricing information sufficient to demonstrate that the 10 percent reduction will reduce beneficiary access to pharmacy services in a specific area as determined by the following threshold metrics:
 - In urban areas, at least 90 percent of Medi-Cal beneficiaries, on average, live within 2 miles of a participating retail pharmacy.
 - In suburban areas, at least 90 percent of Medi-Cal beneficiaries, on average, live within 5 miles of a participating retail pharmacy.
 - In rural areas, at least 70 percent of Medi-Cal beneficiaries, on average, live within 15 miles of a participating retail pharmacy.

Description of SPA Con't.

DHCS will:

- establish a list of specific drug products and/or providers subject to the modified payment reductions
- update the list of drug products based on actual acquisition cost data received by the Department in the prior quarter and
- publish the list on at least a quarterly basis
- notify providers at least 30 days in advance of any change in drug product payment reduction



Impact

Impact on Indian Health Programs

- This SPA does not affect Indian Health pharmacy providers that are otherwise exempt from the 10 percent payment reductions authorized by the 2011 Health Budget Trailer bill. It will lessen the negative economic impact of the 10 percent payment reductions on Indian Health pharmacy providers that are subject to the reductions.

Impact on Indian Medi-Cal Beneficiaries

- This SPA will not affect beneficiaries who receive pharmacy services from providers who are otherwise exempt from the 10 percent provider payment reductions. It will help provide continued access to pharmacy benefits for those that receive services from providers affected by the 10 percent provider payment reductions.

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Amendments to Department Health Care Services Tribes and Designees of Indian Health Program Advisory Process-SPA 12-002



Background

- CMS has advised DHCS to clarify certain parts of SPA 10-018 dealing with the process for seeking advice on matters having a direct effect on Indian health programs and situations that would trigger an expedited notification process. Additionally, DHCS is proposing changes in the timeframes for notification. Thus, DHCS is submitting SPA 12-002 to revise and clarify these parts of SPA 10-018.
- SPA 12-002 will clarify situations where DHCS is required to notify Tribes, designees of Indian health programs and Urban Indian Organizations concerning proposed changes to Medi-Cal program. Additionally, SPA 12-002 proposes to modify the schedule for sending notice about pertinent DHCS submissions to CMS, webinars concerning those submissions, and DHCS' annual advisory meeting. Further, SPA 12-002 will clarify what situations allow for an expedited notification process.
- The effective date of SPA 12-002 will be January 1, 2012.

Proposed Changes to SPA 10-018

SPA 10-018	SPA 12-002
<p>DHCS defines direct effect as a change to the Medi-Cal Program that decreases/increases services, restricts eligibility, changes provider qualifications/requirements, or changes a reimbursement rate or methodology, or otherwise negatively impacts Tribes, Indian health programs, and/or Urban Indian organizations .</p>	<p>Revise definition of direct effect as follows: DHCS defines direct effect as a change to the Medi-Cal Program that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to Indian health providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact Indians or Indian health providers.</p>
<p>DHCS will send notifications of SWDPs at least 45 days prior to the submission of the SWDP to CMS.</p>	<p>Change to 35 days</p>
<p>However, circumstances beyond the control of DHCS, including to State or Federal legislation authorization, promulgation of State or Federal regulations, etc.</p>	<p>Add the following wording (in bold): However, circumstances beyond the control of DHCS, including but not exclusive to State or Federal legislation authorization, promulgation of State or Federal regulations, direction from CMS, court orders, settlement agreements, technical changes, etc.</p>
<p>Tribes and Designees will be notified 30 days prior to the scheduled webinar.</p>	<p>Change to 20 days</p>
<p>DHCS will ensure that Tribal leaders are provided at least 60 day notice of the meeting.</p>	<p>Change to 45 days</p>

Impact

Impact on Indian Health Programs

- SPA 12-002 may impact Indian health programs and urban Indian Organizations because SPA 12-002 proposes to clarify and change some notice requirements to Tribes, designees of the Indian health programs, and Urban Indian Organizations. SPA 12-002 does not propose to alter the time allotted for feedback or comments. Rather it seeks to clarify in what situations DHCS will request input from Tribes, designees of the Indian health programs, and Urban Indian Organizations.

Impact on Indian Medi-Cal Beneficiaries

- DHCS does not anticipate that this proposal will directly impact American Indian beneficiaries.

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Waiver Overview



What Are Medicaid Waivers?

- “Waive” specified provisions of Medicaid Law (Title XIX of the Social Security Act).
- Allow flexibility and encourage innovation in administering the Medicaid program to meet the health care needs of each State’s populations.
- Provide medical coverage to individuals and/or services that may not otherwise be eligible or allowed under regular Medicaid rules.
- Approved for specified periods of time and often may be renewed upon expiration.

Amendment of the Section 1915(b) Freedom of Choice Waiver –Medi-Cal Specialty Mental Health Services (SMHS) Waiver



Background

- California administers a Section 1915(b) Freedom of Choice waiver to provide specialty mental health services (SMHS) using a managed care model of service delivery.
- The Department of Mental Health (DMH) currently operates this waiver through an interagency agreement with the DHCS.
- DMH contracts with County Mental Health Plans (MHPs) and each MHP provides services directly and/or contracts with outside providers to provide services at the local level.
- All full-scope Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to the waiver services if they meet the medical necessity criteria conditions.
- These conditions include specific: (1) Diagnosis, (2) Impairment and (3) Intervention components.

Background Con't.

Specialty Mental Health Services:

- Rehabilitative mental health services
 - Mental health services ; Medication support services ; Day treatment intensive; Day rehabilitation; Crisis intervention; Crisis stabilization; Adult residential treatment services; Crisis residential treatment services; Psychiatric health facility services.
- Psychiatric inpatient hospital services
- Targeted case management
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services (i.e. Therapeutic Behavioral Services).

Description of Waiver Amendment

- Pursuant to Assembly Bill (AB) 102, effective July 1, 2012, the waiver program will be transferred from DMH to DHCS.
- Transfer is intended to:
 - Allow DHCS to have direct oversight of the SMHS waiver program and the MHPs
 - Reduce duplicative processes at the State level and work directly with MHPs and stakeholders to improve the coordination and delivery of services.
- Funding will be realigned to the MHPs
 - Funding will come from dedicated revenue sources and not from the State's General Fund which is subject to annual budget allocation
 - Designed to provide MHPs with a known, reliable and stable funding source.
- The waiver amendment effective date is July 1, 2012.

Impact

Impact on Indian Health Programs

- The transfer of the waiver program from DMH to DHCS is a change that will occur at the state level and should not have an impact on Indian Medi-Cal beneficiaries or Indian Health Programs.

Impact on Indian Medi-Cal Beneficiaries

- The change in the MHPs funding sources should not have an impact on Indian Medi-Cal beneficiaries or Indian Health Programs .
- The intent is to implement these changes with no impact to beneficiaries or service interruptions .

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Thank You