



## Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program August 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
<b>Welcome/Overview</b>	Andrea Zubiata, Indian Health Program (IHP) Coordinator
<b>Medi-Cal Incentives to Quit Smoking (MIQS)</b>	<p>Gordon Sloss, MPA, MIQS Project Manager, DHCS</p> <p>Christopher M. Anderson, Program Director California Smokers' Helpline-Center for Tobacco Cessation Moore's UCSD Cancer Center</p> <p>Tami MacAller, MPH, CHES, Senior Health Promotion Specialist, California Diabetes Program- California Department of Public Health</p>
<b>Update on DHCS Proposal To Limit Physician Office Visits to 7 Per Year State Plan Amendment (SPA) 11-013</b>	Linh Le, Medi-Cal Benefits Division
<b>State Plan and SPA Overview</b>	Andrea Zubiata, IHP Coordinator
<b>SPA's Scheduled for Submission by September 30, 2012</b>	
<b>Review of Proposed SPA 12-025</b>	Teresa Castillo, Mental Health Services Division
<b>Review of Proposed SPA 12-003</b>	Michelle Wilkerson, Medi-Cal Benefits Division
<b>Review of Proposed SPA 12-018/1115 Bridge to Reform Waiver Amendment</b>	Sherilyn Walden, Medi-Cal Eligibility Division
<b>Medicaid Waiver Overview</b>	Andrea Zubiata, IHP Coordinator
<b>Waivers Scheduled for Submission by September 30, 2012</b>	
<b>California Managed Care Copayment Demonstration Waiver</b>	Cynthia L. Smiley, Medi-Cal Benefits Division
<b>Health Plan Changes in San Joaquin and Stanislaus Counties</b>	Carrie Allison, Medi-Cal Managed Care Division
<b>Coordinated Care Initiative: Mandatory Enrollment in Managed Care for Medi-Cal and Long-term Supports and Services Benefits and Services 1115 Waiver</b>	Margaret Tatar, Chief, Medi-Cal Managed Care Division
<b>Feedback/Closing</b>	All

# Medi-Cal Incentives to Quit Smoking (MIQS)

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# Update on DHCS Proposal to Limit Physician Office to 7 Per Year SPA 11-013



# SPA 11-013 Update

- **Recap:** SPA 11-013 will amend the State Plan to implement Welfare and Institutions (W&I) Code Section 14131.07.
- Section 14131.07 limits physician office and clinic visits to seven per fiscal year (July 1-June 30).
- Visits limited are for services provided by a physician, or a medical professional under the direction of a physician, that are covered benefits under the Medi-Cal program.
- Visits that **WILL NOT** count towards the limit: **EXEMPTIONS** and **EXCEPTIONS**.

*Information on this slide is a summary of the actual statute. Please refer to Welfare and Institutions Code Section 14131.07 for detailed statutory requirements.*

# Exemptions

Visits for the following services and beneficiaries **WILL NOT** count towards the seven visit limit:

- Specialty mental health services;
- Any pregnancy related visit or any visit relating to conditions that may complicate a pregnancy;
- Beneficiaries in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, who are under 21 years old with full scope Medi-Cal;
- Beneficiaries in a nursing facility for long-term care services;
- Beneficiaries enrolled in Senior Care Action Network and AIDS Healthcare Foundation.

# Exceptions

Visits for the following services **WILL NOT** count. Providers must document these exceptions in the beneficiary's medical records.

- The visit keeps beneficiary from going to the emergency room;
- The visit keeps beneficiary from being admitted to a hospital;
- The visit continues ongoing medical or surgical care;
- The visit is for diagnostic workup to keep beneficiary from staying in the hospital or going to an emergency room; and,
- The visit is for evaluation for In-Home Support Services.

# Impact

## Impact on Indian Health Programs

- This SPA affects all Indian health care facilities that provide physician services to Medi-Cal beneficiaries.
- For visits that meet an applicable **EXCEPTION**, providers must certify in writing that the visit meets one of the exceptions and include a description of the services provided. The certification must be maintained at the place of service in the beneficiary's medical records.
- Providers will be encouraged to track the number of visits through review of the medical record, billing records, and information that the beneficiary self-reports.

*Information on this slide is a summary of the actual statute. Please refer to Welfare and Institutions Code Section 14131.07 for detailed statutory requirements.*

# Impact

## Impact on Indian Medi-Cal Beneficiaries

- This seven visit limit affects beneficiaries who receive physician services at Indian health care facilities. This will impact Indian Medi-Cal beneficiaries, if the visit does not meet one or more of exemptions or exceptions and the beneficiary has received seven physician visits in a fiscal year.
- ***Visits that do not have an applicable exemption or exception and exceeds the seven visit limit, will not be covered by Medi-Cal.***

*Information on this slide is a summary of the actual statute. Please refer to Welfare and Institutions Code Section 14131.07 for detailed statutory requirements.*

# Status

- SPA 11-013 was initially submitted on July 28, 2011.
- CMS recently issued standard questions for limiting federally mandated Medicaid services such as physician services.
- DHCS continues to work closely with CMS on SPA 11-013.
- DHCS is also working on the beneficiary notice, provider bulletins, systems changes, etc. in anticipation of an approval by CMS.
- Additional information will be forthcoming for beneficiaries and providers, after CMS makes a decision on SPA 11-013.

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# 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.

**Licensed Professional Clinical Counselors  
(LPCCs) Providers for Specialty Mental Health  
Services  
SPA 12-025**



# Background

- In 2009, the Legislature passed Senate Bill (SB) 788 which allows the Board of Behavioral Sciences, in the Department of Consumer Affairs, to license, register and regulate Licensed Professional Clinical Counselors (LPCCs) and interns. The purpose of professional clinical counseling is to use counseling interventions and psychotherapy techniques to improve mental health.
- DHCS is planning to submit a SPA to include LPCCs as providers for Medi-Cal specialty mental health services. Specialty mental health services are provided through a Section 1915(b) Freedom of Choice waiver. Pursuant to this waiver, DHCS contracts with county Mental Health Plans (MHPs) and each MHP provides services directly and/or contracts with providers to provide services at the local level.

## Description

- DHCS is required to submit a SPA seeking federal approval from CMS to include LPCCs as Medi-Cal providers for Medi-Cal specialty mental health services consistent with the scope of practice for LPCCs.
- This SPA will provide the authority for MHPs to hire or contract with LPCCs to provide Medi-Cal specialty mental health services, at the MHPs' discretion and in accordance with MHP personnel, employment, and contracting practices.
- SPA 12-025 will be submitted to CMS by September 30, 2012 for an effective date of July 1, 2012.



# Impact

## Impact on Indian Health Programs

- DHCS does not anticipate any direct effect on Indian Health Programs from this proposal. However, to the extent that Indian health program participants participate as specialty mental health services providers this proposal may impact them because it will add an additional eligible provider type.

## Impact on Indian Health Beneficiaries

- DHCS does not anticipate any direct effect on Indian Medi-Cal beneficiaries. The inclusion of LPCCs as Medi-Cal providers will add an additional provider type for Medi-Cal specialty mental health services providers. Consequently, Indian Medi-Cal beneficiaries receiving services through the specialty mental health services program may have increased access to services under this proposal.

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# Two-Visit Limit per Month SPA 12-003

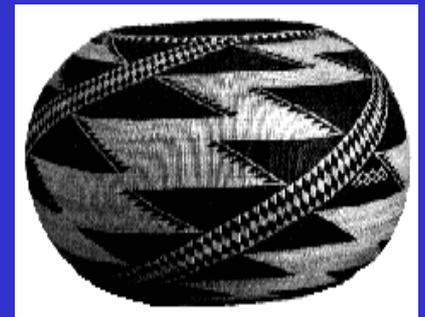


# Background

- SPA 12-003 will amend the State Plan to clarify existing limits for Medi-Cal beneficiaries at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).
- Per California Code of Regulations, Title 22, Section 51304 Medi-Cal limits coverage for a beneficiary to:
  - Two optional benefit services, or any combination of two optional benefit services from among the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatric services, prayer or spiritual healing, psychology, and speech therapy each calendar month

## Background Cont'd.

- Pursuant to Welfare and Institutions Code section 14131.10, Medi-Cal will only reimburse FQHCs and RHCs for acupuncture services, audiology services, chiropractic services, podiatric services, and speech therapy if the beneficiary is:
  - under 21;
  - a pregnant woman for pregnancy-related services or treatment of other conditions that might complicate her pregnancy;
  - a resident of a skilled nursing facility (A or B);
  - a resident of an Intermediate Care Facility-Developmentally Disabled (ICF-DD); or
  - enrolled in the Program for All-Inclusive Care for the Elderly (PACE)



# Impact

## Impact on Indian Health Programs

- SPA 12-003 will not directly impact Indian Health Programs and Urban Indian Organizations because it only clarifies existing regulatory limits.

## Impact on Indian Medi-Cal Beneficiaries

- This SPA will not directly impact American Indian Medi-Cal beneficiaries because it only clarifies existing regulatory limits.
- Accordingly, if an Indian Health Program or Urban Indian Organization operating an FQHC or RHC provides more than two optional benefit services, or any combination of two optional benefit services (noted previously) per calendar month for a beneficiary, DHCS will deny Medi-Cal reimbursement for those services over the limit.

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# Optional Targeted Low-Income Children SPA 12-012 and the California “Bridge to Reform” (BTR) Section 1115 Waiver Amendment Request



# Background

- The Healthy Families Program (HFP) is California's Children's Health Insurance Program (CHIP).

The HFP provides health care to children up to age 19 whose family income is up to 250 percent of the Federal Poverty Level (FPL). The Managed Risk Medical Insurance Board (MRMIB) administers the HFP by providing complete health, dental, and vision benefits through participating health plans

- Assembly Bill (AB) 1494

The California State Legislature passed AB 1494 (Chapter 28, Statutes of 2012) on June 27, 2012. Among the many requirements of this bill is that the HFP stop enrolling new children and move their existing HFP children into the Medi-Cal Program no sooner than January 1, 2013.

# Description

DHCS proposes to move the HFP children to Medi-Cal in four phases.

- Phase 1 begins no earlier than January 1, 2013
- Phase 2 begins no earlier than April 1, 2013
- Phase 3 begins no earlier than August 1, 2013
- Phase 4 begins no earlier than September 1, 2013



# Description

- DHCS plans to submit SPA 12-018 to
  - Increase the Federal Poverty Limit (FPL) for the Medi-Cal Program to include Targeted Low-Income Children
  - Operate the Optional Medically Needy Program for Targeted Low-Income Children
  - Operate Accelerated Eligibility
  - Allow for Premiums
  - Amend Section 1115 Waiver



# Impact

## Impact on Indian Health Programs

### Eligibility

No anticipated changes to the eligibility of existing children enrolled with Indian Health Providers for Medi-Cal Eligibility or in the Medi-Cal Managed Care delivery or enrollment systems.



### Expansion of Medi-Cal Program To Include Targeted Low-Income Children

Expansion of the Medi-Cal program to include Targeted Low-Income children gives Indian Health providers and programs a wider range of children to provide services to within the Medi-Cal program.

# Impact

## Impact on Indian Health Programs

### Health Plan Enrollment

There is a potential impact to Indian Health Program providers once the beneficiaries move from HFP Plan to a Medi-Cal Managed Care Plan.

Members in **Two-Plan and Geographic Managed Care (GMC)** counties receive a choice of the available Medi-Cal managed care plans. In these two models Indian Health Programs will have no change to their enrollment rights.

### For **County Organized Health Systems (COHS)**

counties, the members in a Healthy Families plan that is not the same as the COHS plan will be enrolled in the COHS plan and the same protections for Indian Health programs in Medi-Cal managed care, for access to services, will not change.

# Impact

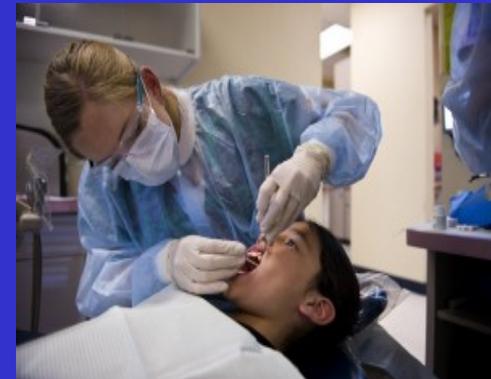
## Impact on Indian Health Programs

### Dental Enrollment

DHCS anticipates changes in dental plan enrollment for the Healthy Families members will have an impact on Indian Health Program Dental Providers.

#### **Sacramento County -**

In Sacramento County, dental plan enrollment is mandatory. Children transitioning from HFP to Medi-Cal in Sacramento County will move over with their existing dental plan as long as that plan is contracted with Medi-Cal. If the plan is not contracted with Medi-Cal they will choose from a choice of dental plans.



# Impact

## Impact on Indian Health Programs

### Dental Enrollment Cont'd.

#### **Los Angeles County -**

HFP children moving to Medi-Cal that live in Los Angeles County, where dental plan enrollment is voluntary, will move over with their existing dental plan to the extent the plan is contracted with Medi-Cal. If the plan is not contracted with a Medi-Cal dental plan, they will move into

Denti-Cal, the Medi-Cal Fee-for-Service dental program and given the option to enroll into a Medi-Cal dental plan.

#### **All Other Counties -**

Children moving from HFP to Medi-Cal in all other counties move to Denti-Cal.

# Impact

## Impact on Indian Medi-Cal Beneficiaries

### Eligibility of Beneficiaries -

DHCS does not anticipate a change to the eligibility for existing children in the Medi-Cal or in the Medi-Cal Managed Care delivery or enrollment systems.



### Expansion of Program To Include Targeted Low-Income Children -

Expanding the Medi-Cal program to include Targeted Low-Income Children allows Medi-Cal to reach more children and also provides healthcare coverage for children previously enrolled in the HFP.

# Impact

## Impact on Indian Medi-Cal Beneficiaries

### Premiums/Cost Sharing –

As a result of the implementation of the Deficit Reduction Act of 2005, individuals that seek services within the Indian Health Provider Network or are referred to an outside provider by an Indian Health Provider will not have any cost sharing assessments.

Individuals that seek provider services outside the Indian Health Provider network without a referral from the Indian Health Provider network can be subject to cost sharing assessments.

DHCS does not anticipate any change to the current Medi-Cal managed care delivery or enrollment systems.

# Impact

## Impact on Indian Medi-Cal Beneficiaries



### Health Plans -

DHCS anticipates a change in enrollment for Indian Health Beneficiaries who are Healthy Families members if they are enrolled in a HFP plan that is not the same plan in Medi-Cal.

#### Two-Plan and Geographic Managed Care (GMC)

Members in Two-Plan and Geographic Managed Care (GMC) counties will get a choice of the available Medi-Cal managed care plans. In these two models, Indian Health Programs will have no change to their enrollment rights.

#### County Organized Health Systems (COHS)

For members in a HFP plan in a COHS county where the plan is not the same as the COHS plan will be enrolled in the COHS plan and the same protections for Indian Health programs in Medi-Cal managed care, for access to services will not change.

# Impact

## Impact on Indian Medi-cal Beneficiaries

### Dental Enrollment

DHCS anticipates changes to dental plan enrollment for the Healthy Families members enrolled in a Healthy Families dental plan that is not the same as a Medi-Cal dental plan.

### Sacramento and Los Angeles Counties

Children moving from HFP to Medi-Cal in Los Angeles County, where dental plan enrollment is voluntary, move over with their existing dental plan as long as the plan is contracted with Medi-Cal. If the dental plan does not contract with Medi-Cal, they move to Denti-Cal where they have the option to enroll into a Medi-Cal dental plan. Denti-Cal is the Medi-Cal Fee-for-Service dental program.

Children moving from HFP to Medi-Cal in Sacramento County, where dental plan enrollment is mandatory, move over with their existing dental plan as long as the plan is contracted with Medi-Cal. If the dental plan does not contract with Medi-Cal, they move to Denti-Cal where they have the option to enroll into a Medi-Cal dental plan.

Children transitioning in all other counties from Healthy Families will move into Denti-Cal.

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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.

# California Managed Care Copayment Demonstration Waiver



# Background

**Pursuant to Welfare and Institutions Code Section 14134(c)(1)**, the Department of Health Care Services (DHCS) will submit a waiver request to the Centers for Medicare and Medicaid Services (CMS) to implement a two-year demonstration project to impose a \$15 copayment on Medi-Cal Managed Care beneficiaries who present at an emergency room and request treatment for a nonemergency medical condition.



# Description

DHCS will implement the \$15 copayment in select California counties with Medi-Cal Managed Care delivery systems. Emergency room providers will be required to complete all federally required medical screening and examination and make a medical determination if the beneficiary's medical condition is an emergency or nonemergency.



# Medical Examination

- Hospitals must comply with the Emergency Medical Treatment and Labor Act (EMTALA)
  - Provide a medical screening exam of all patients who present in the emergency room without regard to patient's ability to pay;
  - Stabilize patient with emergency medical conditions or provide appropriate transfer; and
  - Ensure that alternative sources of nonemergency, outpatient services are available.

## After the Medical Examination

- Emergency medical services required.
  - The provider will provide the emergency medical care and/or inpatient admission, and the beneficiary will not be charged the \$15 copayment.

## After the Medical Examination

- Non-emergency medical services are needed.
  - The provider will give the Medi-Cal beneficiary two options:
    - Receive nonemergency medical care in the emergency room and be charged the \$15 copayment; or
    - Receive referral information back to their primary care provider or managed care plan for follow-up care and not be charged the \$15 copayment



# Impact

- **Impact on Indian Health Programs**

- The \$15 copayment will not impact Indian Health Beneficiaries because federal laws prohibit states from imposing cost sharing to American Indian/Alaskan Native Medi-Cal beneficiaries.

- **Impact on Indian Medi-Cal Beneficiaries**

- The \$15 copayment will not impact Indian Health Programs because federal laws prohibit states from imposing cost sharing for furnished items or services provided to American Indians/Alaskan Natives directly by Indian Health programs.

- **Other Exempted Populations**

- Any child in Aid to Families with Dependent Children-Foster Care.
- Any person defined as dually eligible for both Medicare and Medi-Cal.

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**California "Bridge to Reform" Section 1115  
Waiver Amendment Request – Medi-Cal  
Managed Care Health Plan Changes in San  
Joaquin and Stanislaus Counties**



# Background

- The Medi-Cal Managed Care Division (MMCD) contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Approximately 4.9 million Medi-Cal beneficiaries in 30 counties receive their health care through three models of managed care: Two-Plan Model (TPM), County Organized Health Systems, and Geographic Managed Care.
- MMCD operates its Medi-Cal Managed Care Program under the authority of the 1115 Bridge to Reform Demonstration Waiver.



# Description

- MMCD will be submitting an 1115 Waiver Amendment and TPM contract amendments to the Centers for Medicare and Medicaid Services (CMS) to change the managed care health plans operating in San Joaquin and Stanislaus Counties. Both counties operate under the TPM of Medi-Cal managed care. The TPM consists of a Commercial Plan (CP) and a Local Initiative (LI) health plan.
- Anthem Blue Cross (Anthem) currently operates as the designated LI health plan in Stanislaus County. Anthem also serves as the contracted CP in San Joaquin County.
- Beginning January 1, 2013, Anthem will no longer be a Medi-Cal managed care health plan (MCP) choice in either county. Health Plan of San Joaquin (HPSJ) will replace Anthem in Stanislaus County as the new designated LI, and Health Net Community Solutions (Health Net) will replace Anthem in San Joaquin County. The proposed effective date is beginning January 1, 2013.

# Impact

## Impact on Indian Health Programs:

- DHCS does not anticipate that this proposal will impact Indian Health Programs. If an Indian Health Program is currently providing, or will be providing medical services to an individual who is receiving Medi-Cal benefits, and that individual is required to enroll in a MCP, the Indian Health Program may complete an exemption request and submit it to the Health Care Options Program. The Indian Health Program Exemption Form enables the individual to receive services through the Indian Health Program facility as an alternative to MCP enrollment. The Indian Health Exemption is valid until the individual chooses to enroll in a MCP.

This form and instructions can be accessed at:

[http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/content/en/forms/MU\\_0003382.pdf](http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/content/en/forms/MU_0003382.pdf)

# Impact

## Impact on Indian Medi-Cal Beneficiaries

- **Mandatory Medi-Cal Managed Care Beneficiaries:**  
Mandatory members are required to enroll in a MCP. However, Indian Medi-Cal members may request to be exempt from MCP enrollment to receive health care services through an Indian health Program. To be exempted from MCP enrollment the member must have their Indian Health Program submit an Indian Health Program Exemption Form.
- **Voluntary Medi-Cal Managed Care Beneficiaries:**  
If an Indian Medi-Cal member is assigned a voluntary aid code and is currently enrolled in Anthem they will be given the option of selecting either an alternate MCP or Medi-Cal fee-for-service (FFS). If they do not make a choice they will be automatically enrolled in FFS. Since these aid codes are voluntary, and the member is not required to enroll in a MCP, an Indian Health Program Exemption is not necessary to be exempt from MCP enrollment.

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# Coordinated Care Initiative: Mandatory Enrollment in Managed Care for Medi-Cal and Long-term Supports and Services Benefits and Services 1115 Waiver Amendment



# Background

In January 2012, Governor Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities by shifting service delivery away from institutional care, and into the home and community. Governor Brown enacted the CCI by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).



# Description

- Enacted in June 2012 through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).
- An important step to transform California's Medi-Cal delivery system in 8 counties to better serve low-income seniors and persons with disabilities.
- Builds on many years of stakeholder discussions to integrate delivery of medical, behavioral, and long-term care services and Medicare and Medi-Cal for people in both programs – “dual eligible beneficiaries.”



# Major Components

- **Duals Demonstration:** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries to coordinate medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system.
- - Dual eligible's are individuals who are both Medi-Cal and Medicare eligible.
- **Managed Medi-Cal Long-Term Supports and Services:** All Medi-Cal beneficiaries, including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including Long-Term Services and Supports (LTSS) and Medicare wrap-around benefits.

# Goals of the CCI

- Improve the quality of care for beneficiaries.
- Maximize the ability of beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
- Coordinate Medi-Cal and Medicare benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services settings using a person-centered approach.
- Optimize the use of Medicare, Medi-Cal and other State/County resources.

# 1115 Waiver Changes Needed

To enable the state to comply with state law establishing the CCI, DHCS will be proposing changes to the federal 1115 Waiver. These waivers will do the following:

- Allow the state to implement a Medi-Cal and Medicare combined, capitated reimbursement rate, and passively enroll (if beneficiaries do not make a choice) dual eligible beneficiaries in the dual eligible demonstration for their Medicare and Medi-Cal benefits;
- Allow the state to expand mandatory Medi-Cal managed care enrollment to dual eligible beneficiaries; and
- Allow the state to require dual eligible and Medi-Cal only beneficiaries receiving LTSS (nursing facility care, In-Home Supportive Services, Multi-purpose Senior Services Program, and Community-Based Adult Services) to receive those benefits via managed care health plans.

# 1115 Waiver Changes Needed

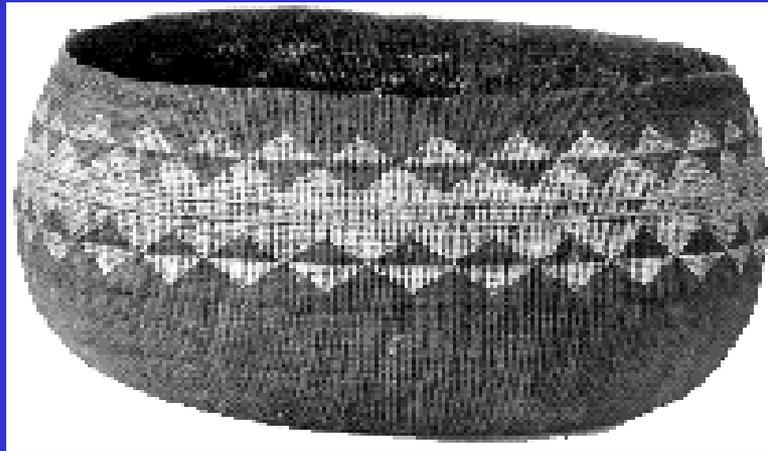
- These waiver changes would be in effect in the 8 participating counties in 2013. These counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- SB1008 expresses the intent to expand additional counties in subsequent years.
- Specified categories of beneficiaries would be exempt from these requirements.



# Impact

## Impact on Indian Health Programs

- The waiver changes will not alter current law regarding Indian Health Programs. Dual eligible and Medi-Cal-only American Indian beneficiaries will not see any disruption to accessing primary care services through any providers as specified by state law.



# Impact

## Impact on Indian Medi-Cal Beneficiaries

- All Medi-Cal beneficiaries residing in a participating county, including dual eligible and Medi-Cal only American Indian beneficiaries, will be passively enrolled in managed care for their Medi-Cal and LTSS benefits and services.

## Exemption for Indian Medi-Cal Beneficiaries

- However, American Indian Medi-Cal beneficiaries may request to be exempt from managed care enrollment in order to receive their health care services through an Indian health program. To be exempted from managed care enrollment the member must have their Indian health program provider submit an Indian Health Program Exemption Form to the Health Care Options (HCO) Program

This form and instructions can be accessed at:

[http://www.healthcareoptions.dhcs.ca.gov/HCOCSPE/Enrollment/content/en/forms/MU\\_0003382.pdf](http://www.healthcareoptions.dhcs.ca.gov/HCOCSPE/Enrollment/content/en/forms/MU_0003382.pdf)

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# Thank You!

