



## Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program February 27, 2013

# 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 Zubiate, Indian Health Program (IHP) Coordinator
<b>State Plan and SPA Overview</b>	Andrea Zubiate, IHP Coordinator
<b>Department of Health Care Services (DHCS) Medi-Cal Eligibility Division Cost Sharing Exemption Update</b>	Clarissa Poole-Sims, DHCS, Medi-Cal Eligibility Division
<b>SPA's Scheduled for Submission by March 30, 2013</b>	
<b>SPA 13-001 Outpatient Drug Coverage for Persons with Medicare and Medi-Cal</b>	Mack Sajjan, DHCS, Pharmacy Benefits Division
<b>SPA 13-003 Payments to Primary Care Physicians</b>	Guadalupe Martinez, DHCS, Fee- For- Service Rates Development Division
<b>Waivers Scheduled for Submission by March 30, 2013</b>	
<b>Waiver Overview</b>	Andrea Zubiate, IHP Coordinator
<b>1115 California Bridge to Reform Demonstration Waiver (BTR) for Tribal Health Program Reimbursement for Uncompensated Care</b>	Wendy Soe, DHCS, Health Care Financing Division
<b>Medi-Cal Specialty Mental Health Services (SMHS) Waiver Renewal Request</b>	Teresa Castillo, DHCS, Mental Health Services Division
<b>Medi-Cal Managed Care Rural County Expansion Waiver Amendment</b>	Keith Parsley, DHCS, Medi-Cal Managed Care Division
<b>1115 California Bridge to Reform Demonstration Waiver (BTR) Amendment for the Coordinated Care Initiative-Dual-Eligible Demonstration</b>	Javier Portela, Chief, DHCS, Medi-Cal Managed Care Division
<b>Feedback/Closing</b>	All

# Department of Health Care Services (DHCS) Medi-Cal Eligibility Division Cost Sharing Exemption Update



# Background

- Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012), provides for a Medicaid expansion to include targeted low-income children up to 250% of the FPL and for the transition of children from the Healthy Families Program (HFP) to the Medi-Cal Program no sooner than January 1, 2013. The expected completion date of this transition is September 2013.
- The Medicaid expansion operates under an amendment to California's 1115 Bridge to Reform waiver.
- When the transition of HFP children completes, all children in this coverage group will fall under the state plan through a new state plan amendment.

# Cost Sharing Exemption

- American Indians/Alaska Natives are exempt from cost sharing in the Medi-Cal program, including premiums, if they are eligible to use or receive a service from an IHS/Tribal 638/Urban Indian organization (I/T/U).
- Premium payments are a new requirement for Medi-Cal as a result of the transition of children from the Healthy Families Program to the Medi-Cal Program.
- In order to exempt eligible individuals, DHCS plans to provide the Indian health care providers a template letter which will serve as confirmation that the AI/AN has received services or is eligible to receive services from an I/T/U. Please provide feedback on this process to: [hfptransition@dhcs.ca.gov](mailto:hfptransition@dhcs.ca.gov)

# Timeline

- The process for exempting American Indians must be finalized by April 1, 2013. This process must be approved by the Centers for Medicare and Medicaid Services (CMS) and requires the submission of a State Plan Amendment
- The tribal/designee notice will be sent by April 26, 2013
- DHCS must submit the SPA to CMS by June 1, 2013
- The SPA will take affect September 1, 2013

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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](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.

# Outpatient Drug Coverage for Persons with Medicare and Medi-Cal SPA 13-001



# Background

- Since January 1, 2006, Medicare Part D, rather than Medi-Cal, has covered most drugs provided to people who are eligible for both Medicare and Medi-Cal
  - Some categories of drugs are excluded from coverage by Medicare Part D; however, Medi-Cal has continued to cover some of the excluded categories (including, for example, benzodiazepines and barbiturates)
- As a result of changes in federal law, effective January 1, 2013, the following drugs are no longer excluded from coverage by Medicare Part D, and Part D plans must cover them:
  - barbiturates when used for the treatment of epilepsy, cancer, or a chronic mental health disorder and
  - benzodiazepines
- As a result, Medi-Cal must modify its state plan to be consistent with federal law.

# Description of SPA and Effective Date

- SPA 13-001 will remove, effective January 1, 2013
  - (1) barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and
  - (2) benzodiazepinesas categories of drugs that Medi-Cal will cover for people who have Medicare and Medi-Cal.
- This change will bring California's state plan into conformity with federal law.
- DHCS will be submitting this SPA no later than March 31, 2013.

# Description of SPA and Effective Date (cont.)

- Dual eligibles will still be able to get drugs from Medi-Cal that are in the following categories:
  - Medications used for anorexia, weight loss, or weight gain;
  - Prescription medications when used for the symptomatic relief of cough and colds (Medi-Cal does not cover over-the-counter (OTC) cough and cold products);
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
  - Select non-prescription (OTC) drugs



# Impact

## Impact on Indian Health Programs

- Indian Health Programs will be minimally impacted, since these drugs will still be covered, but will be covered by Medicare instead of Medi-Cal.

## Impact on Indian Health Beneficiaries

- The only Indian Medi-Cal beneficiaries, who will be impacted are those who are covered by both Medi-Cal and Medicare and are currently taking barbiturates for the treatment of epilepsy, cancer, or a chronic mental health disorder or are taking benzodiazepines.



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# Payments to Primary Care Physicians SPA 13-003



# Background

- The Patient Protection and Affordable Care Act (PPACA) as amended by H.R. 4872-24, section 1202, requires DHCS to increase payments for primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. This requirement is as specified in the Federal Register, Volume 77, Number 215, 42 CFR Part 438, 441, and 447
- The H.R. 4872.24, section 1202 payment increase is effective for dates of service on or after January 1, 2013, through December 31, 2014.

# Description of SPA and Effective Date

- DHCS will submit a SPA to the Centers for Medicare & Medicaid Services on or before March 31, 2013, to obtain federal approval for the increased payments to eligible providers for certain primary care services and vaccine administration codes. The payment increase will be effective for dates of service beginning January 1, 2013, through December 31, 2014



# Impact

## Impact on Indian Health Programs

- DHCS does not anticipate that this SPA will have an effect on Indian Health Programs because this SPA does not increase payments for physician services provided by Indian health programs or Federally Qualified Health Centers (FQHC). Indian health programs and FQHCs receive payment for Medi-Cal services provided at a pre-determined per visit rate.

## Impact on Indian Medi-Cal Beneficiaries

- This SPA may impact Indian Medi-Cal beneficiaries to the extent that the payment increase would expand the level of certain physician services to Indian Medi-Cal beneficiaries for services rendered outside an Indian health program.

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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.

**Department of Health Care Services (DHCS)  
1115 Bridge to Reform (BTR) Waiver  
Amendment  
Tribal Health Program Reimbursement for  
Uncompensated Care**



# Tribal Health Programs Uncompensated Care Amendment

## Overview:

- Amendment to the State's existing Section 1115 Bridge to Reform Waiver
- Allows DHCS to make uncompensated care payments for services to tribal health programs operating under the Indian Self-Determination and Education Assistance Act (ISDEAA)
- Demonstration period: March 2013 to December 31, 2013
- DHCS would partner with the California Rural Indian Health Board (CRIHB) to implement this waiver
- The purpose of the demonstration is to determine whether Medicaid funding under this Demonstration results in an increased
  - volume of primary care services delivered
  - capacity to deliver such services for participating providers

# Tribal Health Programs Uncompensated Care Amendment (cont.)

- Provision of services at tribal health program facilities operating under section 813 of the Indian Health Care Improvement Act
- Payment would be made for services provided to uninsured individuals
  - With incomes up to 133 percent of the Federal Poverty Level and
  - Not eligible for county LIHP due to income level, cap on LIHP income limit, or no LIHP existing in the county
- Payment for services to Medi-Cal beneficiaries would be limited to optional services eliminated from the state plan
- DHCS would provide uncompensated care payments to tribal health programs using the Indian Health Service (IHS) encounter rate for
  - Medi-Cal state plan primary care services
  - Optional services eliminated from the state plan for Medi-Cal enrollees (adult dental, psychology, behavioral health, optometry, and podiatry)

# Tribal Health Programs Uncompensated Care Amendment (cont.)

- DHCS would partner with CRIHB to implement the waiver demonstration
- CRIHB is the central administrator for the Tribal Medicaid Administrative Activities program through contracts with 17 tribal Health Programs in California
- All tribal health programs are eligible to contract with CRIHB to participate in the waiver (“provider network”)



# Tribal Health Programs Uncompensated Care Amendment (cont.)

- CRIHB would establish a third party administrator arrangement with a network of tribal health providers
- Network providers would submit to CRIHB certified claims through an encounter-based claiming protocol administered by CRIHB
- The facilities will conduct a high-level income determination to certify income level, Medi-Cal eligibility status and LIHP eligibility status to determine eligibility under this demonstration. The determination can include, but is not limited to, self-attestation or the use of a recent pay stub.
- CRIHB would submit claims to DHCS on a quarterly basis
- DHCS would make payments to CRIHB based on claims submitted and CRIHB would then pay network providers
- CRIHB would be able to bill network providers an administrative fee for the net administrative costs incurred

# Benefits and Eligibility for Uncompensated Care Payment

## Current Medi-Cal Enrollees Over Age 21

- Medical optional benefits eliminated on July 1, 2009:
  - Adult Dental
  - Psychology
  - Behavioral Health
  - Optometry
  - Podiatry
  - Speech Therapy, chiropractic, Acupuncture, Audiology services, and Incontinence washes and creams

## Uninsured Over Age 19

- Who are not eligible for Medi-Cal
- Who are not eligible for county LIHP due to income level, cap on LIHP income limit, or no LIHP existing in the county
- Who have incomes below 133% Federal Poverty Level

- Primary Care Services in Medi-Cal state plan
- Medi-Cal optional benefits eliminated in **July 1, 2009**

# Claiming Methodology for Uncompensated Payment

- Claiming for Federal Financial Participation (FFP) under this demonstration will be based on certified public expenditures with CRIHB providing the non-federal share of the expenditures.
  - IHS eligible individuals
    - Claims for allowable services will be paid at the IHS encounter rate. Claims for services provided to IHS eligible individuals will be reimbursed with 100% FFP.
  - Non-IHS eligible individuals
    - CRIHB would provide the non-federal share to the state through Certified Public Expenditures (CPE) as do county LIHPs and will be reimbursed at California's FMAP rate (50%)

# Next Steps

- DHCS is currently developing the encounter-based claiming protocols
- The amendment is expected to be submitted to the Federal Centers for Medicare and Medicaid Services (CMS) this week.
- Administrative claiming protocols will be developed through ongoing discussions with CRIHB.
- We will continue to engage stakeholders as this process moves forward.



# Impact

## Impact on Indian Health Programs

- This waiver amendment may impact participating Tribal Indian Health Programs because it will enable them to be reimbursed for uncompensated care provided to IHS eligible individuals.

## Impact on Indian Health Beneficiaries

- Indian Medi-Cal beneficiaries may experience an increase in the volume of primary care services offered at participating Tribal Health Programs.



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# Department of Health Care Services (DHCS) Medi-Cal Specialty Mental Health Services (SMHS) Waiver Renewal Request



# 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 SMHS waiver program has been in effect since 1995 and the proposed waiver term (July 1, 2013 - June 30, 2018) represents the eighth waiver renewal period.
- DHCS operates and oversees this waiver.



# Description of Waiver and Effective Date

- The SMHS waiver program is administered locally by each county's Mental Health Plan (MHP).
- Each MHP provides, or arranges for, Specialty Mental Health Services for Medi-Cal beneficiaries. MHPs may provide services directly or contract with outside providers.
- The SMHS waiver population is defined as all full-scope Medi-Cal beneficiaries. Therefore, all Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to waiver services if they meet medical necessity conditions.

# Description of Waiver and Effective Date (cont.)

- Medical necessity conditions include specific: (1) Diagnoses, (2) Impairment and (3) Intervention criteria.
- For a complete description of the medical necessity conditions please refer to the following California Code of Regulations (CCR), Title 9, Sections:
  - 1830.205. Medical Necessity Criteria for Specialty Mental Health Services
  - 1830.210. Medical Necessity Criteria for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age
  - 1820.205. Medical Necessity Criteria for Psychiatric Inpatient Hospital Services

# Description of Waiver and Effective Date (cont.)

Specialty Mental Health Services provided through the waiver are the following:

- Rehabilitative mental health services, including:
  - 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 services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services (i.e. Therapeutic Behavioral Services)

# Description of Waiver and Effective Date (cont.)

- The SMHS waiver renewal request will be submitted to the Centers for Medicare and Medicaid Services (CMS) for their review and approval by March 30, 2013.
- The effective date for this waiver renewal will be July 1, 2013.



# Impact

## Indian Health Programs

- Indian Health Programs and Urban Indian Organizations may contact their county MHP to obtain information on contracting with the program to provide Specialty Mental Health Services at the clinic for eligible Medi-Cal beneficiaries.

## Indian Health Beneficiaries

- Indian Health Beneficiaries who are Medi-Cal eligible and not otherwise covered for Medi-Cal Specialty Mental Health Services through another health care program or provider, including another Medi-Cal Managed Care Program, Federally Qualified Health Center (FQHC), Indian Health Clinic (IHC), or Rural Health Clinic (RHC), may be eligible for services under the SMHS waiver.

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# Department of Health Care Services (DHCS) Medi-Cal Care Rural County Expansion Waiver Amendment



# Background

The Department of Health Care Services (DHCS) administers the Medi-Cal managed care program in accordance with federal and state law and regulations which includes special protections for American Indians in managed care that are located in the American Recovery and Reinvestment Act of 2009 and state regulations in the California Code of Regulations.

Approximately 4.9 million Medi-Cal beneficiaries in 30 counties receive their health care services through three models of Medi-Cal managed care as described below.

- County Organized Health Systems (COHS): In COHS model counties, DHCS contracts with a health plan created by the County Board of Supervisors.
- Geographic Managed Care (GMC): In GMC counties, DHCS contracts with several commercial health plans.
- Two-Plan Model (TPM): In most TPM counties, there is a "Local Initiative" and a "Commercial Plan."

# Description of Waiver Amendment and Effective Date

- In accordance with Assembly Bill 1467 (Chapter 23, Statutes 2012), the 2012-13 State Budget Act authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 rural California counties who currently receive Medi-Cal services on a Fee-For-Service (FFS) basis. Approximately 386,000 Medi-Cal beneficiaries will make the transition from FFS to Medi-Cal managed care in these rural counties on June 1, 2013. DHCS will be submitting a waiver amendment request by March 31, 2013 to implement this expansion.
- The 28 Medi-Cal managed care rural expansion counties are Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

# Description of Waiver Amendment and Effective Date (cont.)

- DHCS intends to implement the expansion through contract(s) with managed care health plans. A Request for Application was issued inviting interested health plans to submit formal applications in November 2012.
- Applications were due to DHCS on January 22, 2013. Health plans that submitted applications were required to have previous experience serving Medicaid beneficiaries, including diverse populations, experience partnering with public and traditional safety net health care providers, and experience working with local stakeholders, including consumers, providers, advocates, and county officials on health plan oversight and in the delivery of care. Health plans were required to show recent successful experience administering managed care in a rural area.
- Health plans that pass the application and interview process will be issued an "Intent to Award" in March 2013.

# Description of Waiver Amendment and Effective Date (cont.)

- DHCS is currently conducting a stakeholder process to ensure that beneficiaries, health care providers, and Medi-Cal managed care health plans have an opportunity to provide input into the managed care delivery model and to help ensure a smooth transition for beneficiaries. Stakeholder meetings will continue throughout the implementation of this expansion effort.
- The effective date of this waiver amendment will be June 1, 2013



# Impact

## Impact to Indian Health Programs

- Indian health program operations may be impacted by this proposal depending on the model of managed care selected in each county and the program's participation in managed care. Further information about the TPM, COHS, and GMC managed care models and sample health plan contracts can be viewed at <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>



# Impact

## Impact on Indian Medi-Cal Beneficiaries If Residing in COHS Model Counties

- All Medi-Cal beneficiaries, including American Indians, residing in COHS model counties are required to enroll in the COHS plan. However, COHS plans may not restrict access to Indian health programs for these members. American Indian beneficiaries may receive services from an Indian health program either within the COHS provider network, or out-of-network.



# Impact

## Impact on Indian Medi-Cal Beneficiaries If Residing in Non-COHS Counties

- Indian Medi-Cal beneficiaries may be exempt or disenrolled from managed care health plan enrollment at any time to receive health care services through an Indian health program.

## Impact to All Indian Medi-Cal Beneficiaries

- American Indians receiving Medi-Cal services directly from an Indian health program are not charged enrollment fees, premiums, and are not subject to cost sharing arrangements (e.g. deductibles, copayments).

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**Department of Health Care Services (DHCS)  
1115 California Bridge to Reform  
Demonstration Waiver (BTR) Amendment for  
the Coordinated Care Initiative-Dual-Eligible  
Demonstration**



# Background

## 1115 Waiver

Under the terms of the Waiver, California created more accountable coordinated systems of care, strengthen the health care safety net, reward health care quality and improve outcomes, slow the long-term expenditure growth rate of Medi-Cal, and expand coverage to uninsured Californians.

- 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. The counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- 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 of the CCI

- 1) Duals Demonstration:** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries in the 8 CCI counties to coordinate medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system.
- 2) Mandatory Enrollment of Dual Eligible Beneficiaries into a Medi-Cal Managed Care Plan:** As part of the CCI, all dual eligible beneficiaries in the 8 CCI counties, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care plan to receive their Medi-Cal benefits.
- 3) Managed Medi-Cal Long-Term Supports and Services:** All Medi-Cal beneficiaries in the 8 CCI counties, 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.

# 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:

- 1) Allow the state to expand mandatory Medi-Cal managed care enrollment to dual eligible beneficiaries in the 8 CCI counties; and
- 2) Allow the state to require dual eligible and Medi-Cal only beneficiaries in the 8 CCI counties 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.

These waiver changes would be in effect in the 8 participating counties in 2013, and additional counties in subsequent years, and 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 experience a 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

- 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.

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# FEEDBACK



# Thank You!

