Citation	1.4 State Medical Care Advisory Committee
42 CFR 43 1.12(b) AT-78-90	There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 43 1.12.
42 CFR 438.104	X The State enrolls recipients in MCO, PMP, PAHI', and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

DHCS is committed to providing information and seeking advice on a regular, ongoing basis from Tribes and designees of Indian health programs and Urban Indian Organizations concerning Medi-Cal matters having a direct effect on Indians, Indian health programs and Urban Indian Organizations. DHCS recognizes that the United States government has a unique legal relationship with American Indian Tribal Governments as set forth in the Constitution of the United States, treaties, statutes, and court decisions. DHCS also recognizes the State of California adopted Public Law 83-280 in 1954 at which time the State accepted responsibility for some Indian Affairs.

California Indian Health Care Delivery System

Indian health programs in California are operated by Tribes and urban Indian organizations. The Indian health care delivery system consists of a network of primary care clinics that are funded by the Federal Indian Health Services (IHS) to provide care to American Indians and other underserved populations as identified in the clinic charter /mission. These clinics participate in Medi-Cal as Tribal Health Providers funded under the authority of Public Law (PL) 93-638, 25 USC 450 et seq. or as Federally Qualified Health Centers. There are 7 urban Indian health programs operated by non-profit Boards of Directors (BOD) elected by the urban Indian community. There are also 31 tribally operated health programs. These programs are governed either by the Tribal council, BOD appointed by the Tribal Council, or BOD elected by Tribal membership separate from the Tribal Council, or as established under the bylaws of the organization.

(Tribal Consultation Requirements Continued)

Process to Seek Advice
DHCS will direct all communication to Tribal Chairpersons as officially listed on the Federal Bureau of Indian Affairs website and will update contact information on a semi-annual basis.

DHCS recognizes that only the Indian health program BODs have authority to designate representatives to speak on behalf of the respective Indian health program. Therefore, DHCS will request all Indian health program BODs identify a designee on an annual basis. DHCS will direct all communication to these designees.

DHCS will use a variety of methods to communicate information and solicit feedback on State Plan Amendments (SPA), Waivers, and Demonstration Project (SWDP) proposals, renewals, extensions or amendments, which directly effect Tribes and Indian health programs. 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.

The methods of communication include, but are not limited to the following:

- Written communication
  DHCS will send notifications of SWDPs at least 45 days prior to the submission of the SWDP to CMS. DHCS will allow for at least a 30 day time frame for response. However, circumstances beyond the control of DHCS, including State or Federal legislation authorization, promulgation of State or Federal regulations, etc, may require a notice shorter than 45 days. In the event that shorter notice is necessary, DHCS will immediately email/fax/mail information and convene a teleconference a minimum of 14 days prior to submission to CMS to allow for immediate feedback.
- Webinars
  DHCS will host webinars on a quarterly basis to review SWDPs and allow for discussion. Webinars will be scheduled at least 30 days prior to the end of the quarter. Tribes and Designees will be notified 30 days prior to the scheduled webinar. DHCS-Indian Health Program (IHP) will maintain invitee lists, monitor attendees, and record minutes regarding issue raised or discussed. An opportunity to provide written feedback will be available at all webinars.
- Face-to-face meetings
  DHCS will host one annual Tribal meeting. DHCS will ensure that Tribal leaders are provided at least 60 day notice of the meeting. Additionally, DHCS will convene other meetings if further discussion is warranted regarding SWDPs. DHCS-IHP will maintain invitee lists, monitor attendees, and record minutes regarding issue raised or discussed.
- Arrange stakeholder teleconference lines
  DHCS will notify Tribes and Indian health program designees when they can access meetings via teleconference

(Tribal Consultation Requirements Continued)

DHCS will also:

- Participate in federal agency consultation meetings and conferences

Expectations

➢ **DHCS Medi-Cal Program**

- Seek advice on a regular, ongoing basis from Tribes and designees of Indian health programs and Urban Indian Organizations
- Provide information through all the methods outlined above
- Consider input from Tribes and designees
- Provide responses to Tribal and designee feedback
- Organize meetings for follow up discussion
- Regularly evaluate advisory process and amend as necessary

➢ **Designees/Tribes**

- Participate in meetings and quarterly webinars
- Provide comments/input/advice

While the process described by this SPA provides increased ability to solve problems; it may not result in resolution of all issues. Therefore, it is understood that it is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, that party's executive office.

SPA 10-018 Development Process

Tribes and designees of Indian health programs and Urban Indian Organizations have been involved in the discussions during the development of this advisory process SPA. The discussions occurred during meetings held on September 29, 2009; December 15, 2009; January 7, 2010; January 29, 2010; March 10, 2010; April 23, 2010; July 21, 2010; November 22, 2010; and, November 30, 2010. These meetings included, but were not limited to; joint meetings of Indian Health Clinic Directors/Tribal Leaders, DHCS American Indian Health Policy Advisory Panel teleconferences, Annual California Area Office (CAO) IHS Tribal Leaders meeting, CAO IHS Tribal Advisory Council meetings, and IHS Program Directors meetings.

DHCS hosted two webinars on November 22, 2010 for Indian Health Program designees and Tribal Chairpersons to provide information and get feedback on the Medi-Cal Indian Health Program advisory process. Additionally, a notice of the proposed SPA was emailed and mailed to Indian health program

(Tribal Consultation Requirements Continued)

designees and Tribes for feedback. Invitations for feedback and attendance at meeting s were distributed to all Indian Health Clinic representatives and tribal chairs.

Finally, the draft SPA was also circulated to a representative sample of Tribal Chairpersons and designees followed by telephone contact for comments. The sample was selected by region and I/T/U type. It included representatives from Southern, Central, and Northern California. It included (7) Tribal/ Urban Indian health programs and (2) Indian health organizations representing (18) member Indian health programs and (33) Tribes throughout the State. This sample was not vetted with Tribal Chairpersons or designees, but yielded feedback that resulted in changes to the proposed SPA including the 60 day notice for Tribal meetings and the annual renewal of Indian health program designees rather than biannual renewal.

Feedback from the webinars, presentations, telephone calls, and the meetings described above was used to develop SPA 10-018.