Tribes and Indian Health Program Representatives Meeting

August 21, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Welcome, Introduction of Tribal Leaders, and Review of Agenda

René Mollow, Deputy Director
Health Care Benefits & Eligibility

DHCS

Welcome and Webinar Logistics

Dos & Don’ts of WebEx

- Participants who are joining by computer and phone
- Everyone will be automatically muted upon entry
- Use the Q&A or Chat box to submit comments or questions
- Please use the Chat box for any technical issues related to the webinar

Feedback Guidance for Hybrid Participants

- **Q&A or Chat Box.** Please feel free to utilize either option to submit feedback or questions during the meeting.
- **Spoken.**
  - Participants may "raise their hand" for Webex facilitator to unmute the participant to share feedback
  - Alternatively, participants who have raised their hand may unmute their own lines, but DHCS asks that you wait for a facilitator to recognize your request to speak
  - DHCS will take comments or questions first from tribal leaders and then all others in the room and on the webinar
- **If you logged on via phone-only.** Press "*6" on your phone to "raise your hand"

Director's Update

Michelle Baass, Director

Medi-Cal Managed Care Plan Contract: Managed Care Plan Transitions and 2024 Readiness

Bambi Cisneros, Assistant Deputy Director
Health Care Delivery Systems

DHCS

MCP Transition Principles

DHCS is applying the following principles to guide the planning, implementation and oversight of the 2024 transition:

- Plan for a smooth and effective transition.
- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from interruptions in care.
- Provide outreach, education and clear communications to members, providers, MCPs, and other stakeholders
- Proactively monitor MCPs' implementation of transition responsibilities.

Protections for American Indians and Alaskan Native Members

- The 2024 transition does not change existing protections for the American Indian and Alaska Native (AI/AN) population voluntarily enrolled in managed care.
- MCPs must allow an AI/AN member enrolled in managed care to receive services from an Indian Health Care Provider (IHCP) of their choice regardless of whether the IHCP is a Network Provider.
- MCPs are required to make payments to IHCPs for services provided to eligible AI/AN members at either the applicable All-Inclusive Rate (AIR) set by the Office of Management and Budget (OMB) for Tribal Health Programs or at the Prospective Payment System (PPS) Rate for Urban Indian Organizations participating in Medi-Cal as a Federally Qualified Health Center (FQHC).

Tribal Liaison Requirement

- Effective January 1, 2024, MCPs will be required to have an identified Tribal Liaison
- DHCS has been working with other states and managed care plans in other states to understand how tribal liaisons have functioned
- The liaison will be dedicated to working with Indian Health Care Providers (IHCPs) by coordinating referrals and payment for services provided to American Indian members

Tribal Liaison Stakeholder Discussion

- Open discussion regarding the role and potential requirements of the MCP Tribal Liaison on **Friday, September 8th, 2:00pm – 3:00pm**
- Link to register and attend meeting: https://dhcs.webex.com/weblink/register/r001ede338fa84d12f023c577afbe1e05

Or register using this QR Code

Contract Deliverables: Operational Readiness Review

All MCPs are subject to operational readiness for 2024 which entail a full review of readiness deliverables:

1. **MCPs in counties with no changes**
2. **MCPs in counties subject to county plan model changes**
3. **MCPs (Commercial) that are directly contracted with DHCS**

- Approximately 236 deliverables per MCP
- Of the 236 deliverables, 76 are considered key deliverables that are required to be approved prior to September 1, 2023, as part of the Go/No-Go decision of a MCP going live on January 1, 2024.
- Key deliverables pertain to specific domains including, network adequacy and access, delegation oversight, continuity of care, CalAIM (Enhanced Care Management/Community Supports)

Go-Live Assessment

Conducting deep dive of “high priority” MCPs

- Is the MCP entering a new market?
- Will the MCP take on a substantially new number of members?
- Consideration of other factors that may pose a potential risk to go-live
  - Networks in place to support adequacy and access to care in new markets/ membership
  - Capacity to support new markets/ membership (i.e., member relations)
  - Plans to ensure Continuity of Care policies, procedures, and processes are in place

Member Noticing for Transitioning Members

- Members of exiting MCPs will receive a:
  - 90-day notice from their exiting MCP
  - 60-day and 30-day notices from Medi-Cal Health Care Options (HCO), DHCS's enrollment broker
  - A choice packet will be sent with the 60-day notice when appropriate
  - Welcome packet from their new MCP in early January 2024
- These notices will include a QR code for an online Notice of Additional Information that will provide more details, which members can request to receive in print or alternative format
- Specific language regarding American Indian/Alaskan Native protections were added based on feedback from Office of Tribal Affairs
- The notices received stakeholder feedback and were reviewed by the Center for Health Literacy

Member Enrollment Process for Counties with an Exiting MCP

In "Choice" Counties (GMC, Two Plan and Regional Models):

- **Members enrolled in an MCP that will continue to operate in 2024** will remain in their MCP unless they opt to change MCPs, as they are allowed to do today
- **Mandatory managed care members enrolled in an exiting MCP will need to enroll in a new MCP:**
  - Dual-eligible members in Medi-Cal Matching Plan counties will be automatically enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan, where relevant
  - Other exiting MCP members will receive a choice packet with their 60-day notice.
  - ***Default Assignment:*** If a member does not make an active choice, they will be enrolled in a MCP based on the following assignment hierarchy: (1) provider linkage, (2) plan linkage, and (3) family linkage. Absent a member meeting any of the "linkage" criteria, their default MCP will be based on the Auto-Assignment Incentive Program algorithm, which includes quality and other adjustments to an annually defined ratio for auto-assignment among MCPs in each county

Member Enrollment Process for Counties with an Exiting MCP

In COHS Expansion and Single Plan Counties:

- **Members enrolled in a continuing MCP** (i.e., Alameda Alliance for Health, Contra Costa Health Plan, Kaiser) will remain in their MCP
- **Members enrolled in an exiting MCP** will be automatically enrolled into the COHS, Single Plan or – where relevant – Kaiser
  - Kaiser will receive default assignment for exiting MCP members in COHS and Single Plan counties where it participates on the basis of plan / family linkage and Medi-Cal Matching Plan policy (where relevant)

New Enrollment Freeze for Exiting MCPs

- DHCS will stop **new** enrollment into exiting MCPs (both for active choice and default assignment) three months prior to January 1, 2024
- Exiting MCPs will retain their existing membership though December 31, 2023
- New Medi-Cal members in late 2023 in counties with an exiting MCP will be offered or – in COHS, Single Plan or Medi-Cal Matching Plan counties – automatically enrolled into MCPs that will be operating in the county in 2024
  - If the new member chooses or is assigned to a 2024 MCP that is not yet operating in the county as a prime MCP, they will access care through the fee-for-service delivery system until the MCP is available in January 2024

Enrollment Impacts: American Indians and Alaskan Native Members

- COHS or Single Plan Model

  - Members with a currently approved Non-Medical Exemption request and newly eligible members in counties that are changing to a COHS or Single Plan Model, will be mandatorily enrolled into the new Managed Care Plan in that county. Just as occurs today, in a COHS county, members have the right to be seen at an IHCP regardless if that IHCP is contracted with the plan and the MCP must pay the All-Inclusive Rate.

- Two Plan, GMC, Regional Plan Model

  - Newly eligible members in counties that operate as a Two Plan, GMC or Regional Model, will be automatically enrolled into a Managed Care Plan if they do not make an active plan choice. Just like today, members can submit a non-medical exemption request and opt out of managed care.

  - Members with a currently approved Non-Medical Exemption request in a Two Plan, GMC or Regional Model, will not be noticed and will not be enrolled into a Plan. We have protections in place to ensure that members who have opted out of managed care previously in those counties, will not be impacted.

Policy Guide Outline

Final guidance published in Policy Guide in June

- **Table of Contents**
- **Updates from Prior Version**
- **Introduction**
  - Context
  - Purpose, Scope, Audience
- **Key Definitions**
- **Protections for American Indian and Alaska Native Members**
- **Member Enrollment**
  - Noticing
  - Enrollment policies for new Medi-Cal members during transition period
  - Enrollment policies for members transitioning from exiting plans
  - Other Kaiser-related enrollment policies
  - Other enrollment policies
- **Continuity of Care** – *Updated to reflect stakeholder feedback*
  - Special populations
  - Continuity of Care for Providers
  - Continuity of Care for Covered Services
  - Continuity of Care Coordination and Management Information
  - Additional Continuity of Care Protections for All Members of Exiting MCPs
  - Transplants
  - Transportation
- **Transition Policy for ECM**
- **Transition Policy for Community Supports**

Published in June with a follow up All Comer webinar on July 10

To be published in Q3 on a rolling basis

- **Data Transfer**
  - From exiting plan to DHCS
  - From DHCS to receiving plans
  - Plan-to-plan
- **Oversight and Monitoring**
- **Education and Communication**
- **Other Policies**, including participation in incentive programs (if needed)

The Policy Guide includes tentative dates for release

2024 Medi-Cal Managed Care Plans

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL MANAGED CARE PLANS BY COUNTY (AS OF 2023 AND 2024)

The following table lists Medi-Cal managed care plans[i] (MCPs) by county, as of January 1, 2023, and as they will be effective January 1, 2024. The changes are the result of an agreement among DHCS and MCPs in December 2022 to transform Medi-Cal into a more equitable health system that will result in better health outcomes for Californians. The table also reflects changes based on the County Plan Model changes that were approved in April 2022 and Assembly Bill 2724 enacted June 30, 2022 which added Section 14197.11 to the Welfare and Institutions Code. Starting in 2024, all MCPs will operate under the new restructured and rigorous contract that requires high-quality, equitable and comprehensive coverage.

County *County Plan Model Type*	2023 MCP(s)	2024 MCP(s)
Alameda *Two-Plan model (2023)* *Single Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Alameda Alliance for Health**
	Alameda Alliance for Health	**Kaiser Permanente**[ii]
Alpine *Regional model (2023)* *Two-Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Anthem Blue Cross Partnership Plan**[iii]
	California Health & Wellness	**Health Plan of San Joaquin**

- **The full list of Medi-Cal MCPs by county for 2023 and 2024 is available on the DHCS website** at: https://www.dhcs.ca.gov/Pages/MCP-Transition.aspx
- All MCPs are undergoing operational readiness reviews and participation by county is subject to readiness determinations.

Capacity and Infrastructure Transition, Expansion and Development (CITED) Funding

Dana Durham, Division Chief
Managed Care Quality and Monitoring

CITED Grant Funding

- CITED provides grant funding to enable the transition, expansion, and development of capacity and infrastructure to provide ECM and Community Supports.
- DHCS awarded over $200 million in Rounds 1A and 1B this spring. Applications for Round 2 closed on May 31, and information on additional rounds of CITED grants is forthcoming.
- Provider organizations including Tribes and Indian Health Facilities contracted to provide ECM or Community Supports are encouraged to apply, as well as those with an attestation from an MCP showing the intent to contact.
- DHCS has conducted webinars for tribal and Indian Health Facility interested in CITED.
- Additional tribal and Indian Health Facility Webinars will be continued for CITED Round 3.

DHCS' Policy Refinements for Enhanced Care Management and Community Supports

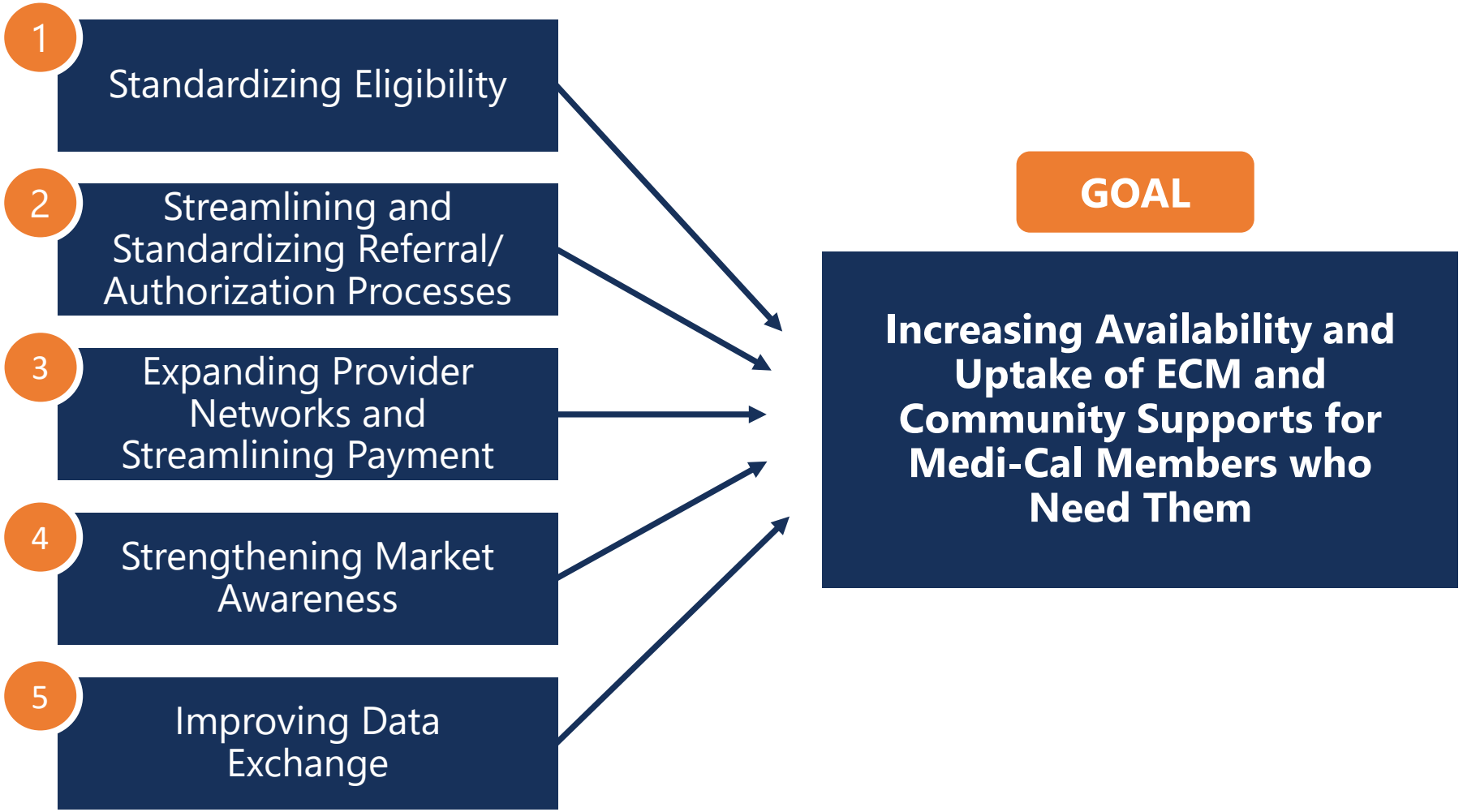
DHCS' Approach to Continuous Improvement

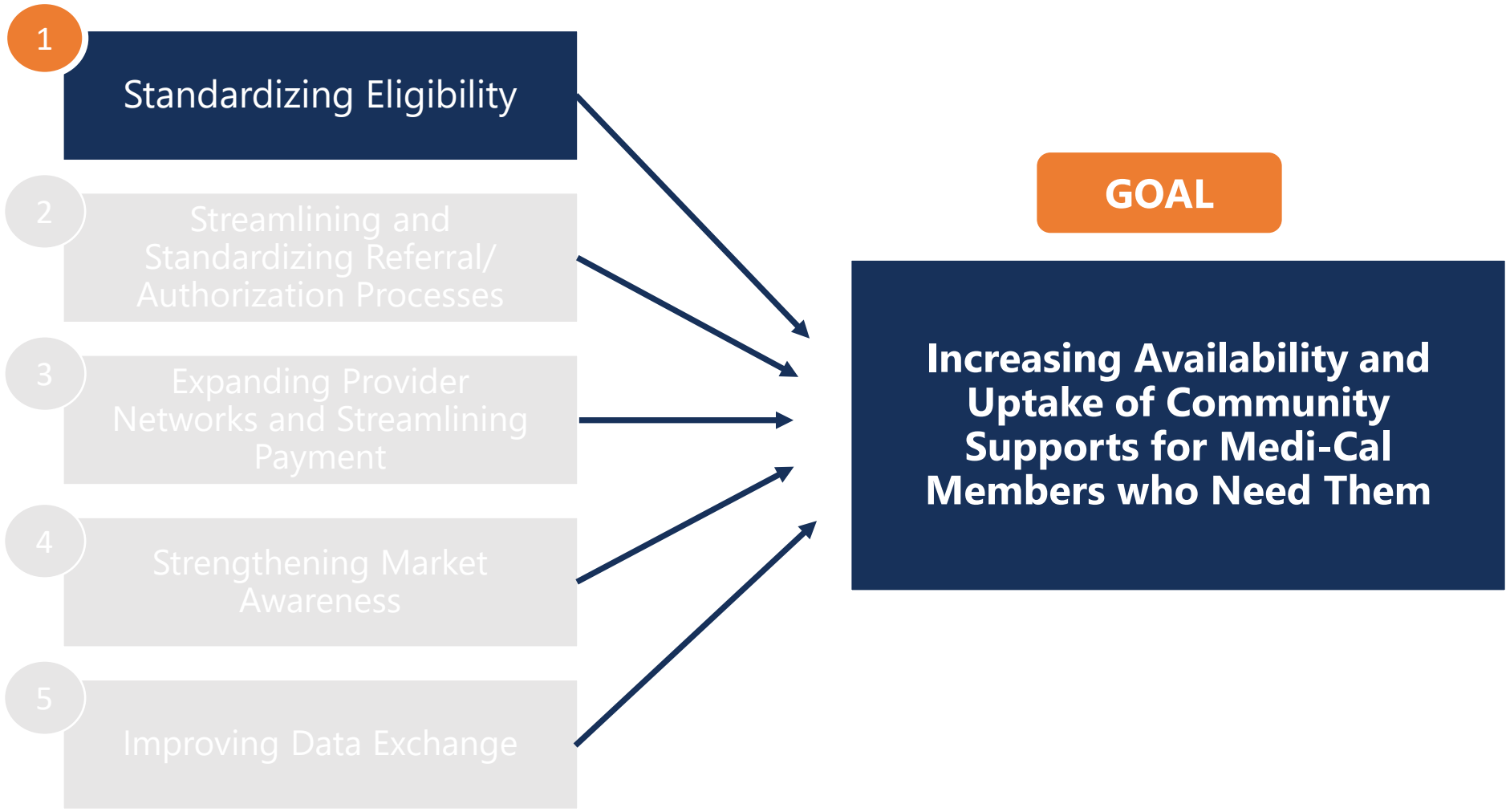
DHCS regularly engages with stakeholders and tribal partners to inform updates to Community Supports policies.

- **Stakeholder Advisory Groups including Tribes and Indian Health Program Meeting**
- **Surveys general and specific including Tribes and Indian Health Facilities**
- **Interviews including interviews with Tribes and Indian Health Facilities**
- **DHCS Leadership Listening Tours**
- **Data Submitted from MCPs**

Areas of DHCS Focus in Response to Data and Feedback

DHCS has identified the following priority areas and begun implementing program design refinements to increase the total number of Members served.

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Eligibility

Issue: Variation in how MCPs are applying ECM Population of Focus criteria is causing confusion and limiting uptake.

DHCS Actions: Reinforcement of Existing Expectations in ECM Policy Guide

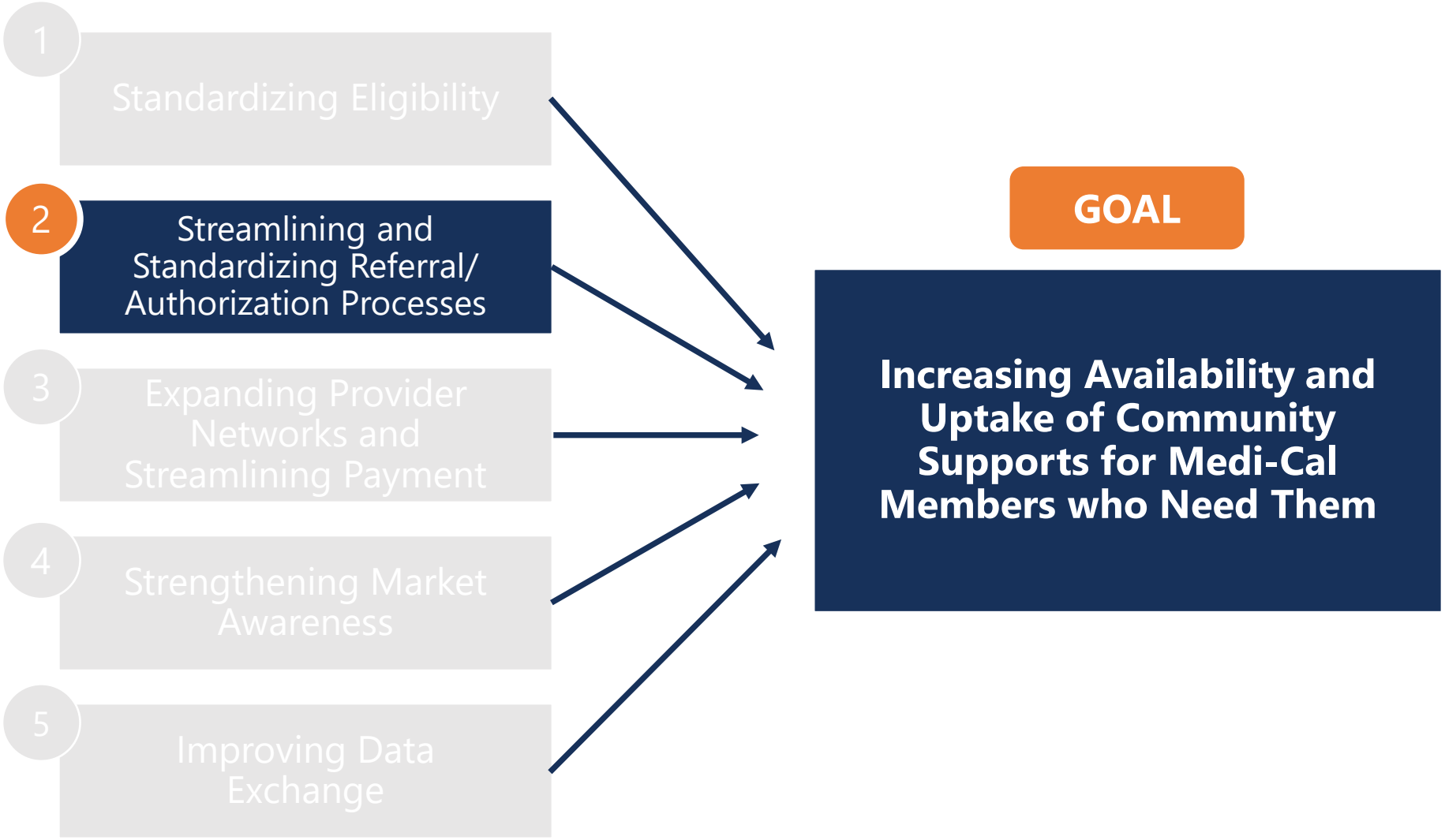
- ECM is a statewide benefit.
- MCPs **must** use the DHCS-established ECM Populations of Focus eligibility criteria to evaluate if Members qualify for ECM. DHCS does not intend to further modify the existing eligibility criteria at this time.
- **MCPs may not impose additional requirements to authorize ECM services** beyond the DHCS established eligibility criteria. For example:
  - An MCP may not add any clinical or social factors to the eligibility criteria.
  - An MCP may not require that the ECM provider have a certain number of contacts with the member as a condition of authorization.
- **MCPs may expand POF criteria to broaden eligibility for the "Individuals At Risk for Avoidable Hospital or ED Utilization ECM POF** (e.g. decrease the number of ED visits in 6 months that allows a Member to be eligible).

Eligibility

Issue: Some MCPs are narrowing Community Supports eligibility criteria relative to the DHCS Service Definitions, limiting the number of individuals who can access these services and are unclear about cost effectiveness.

DHCS Action: Increasing Standardization

- MCPs **must remove any previously approved restrictions or limitations and adhere with the full Community Supports service definitions by 1/1/2024**.
  - For example, if an MCP currently excludes Members from Recuperative Care who require the use of oxygen, they must remove that restriction by 1/1/2024.
- MCPs will **no longer have the option to narrow the eligibility criteria or impose additional limitations** on the service definitions (which include eligibility criteria), geographic or otherwise.
- **MCP offered Community Supports are available to all members including those receiving services through Tribes or Indian Health Facilities**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Referrals & Authorizations

Issue: MCPs have disparate timeframes for initial ECM authorization, reauthorization and reassessment decisions. This creates lack of parity for Medi-Cal Members around the state, as well as administrative burden for providers who are contracted with more than one MCP.

DHCS Actions:

#1. Standardizing authorization and reauthorization timeframes for ECM

- **Effective July 1, 2023**, for all Members authorized to receive ECM:
  - The initial authorization period will be **12 months**.
  - Reauthorization periods thereafter will be **6 months**.
  - **This means that providers including Tribal and Indian Health programs can better strategize and plan work with individuals**

#2. Modifying the approach for how Members can be reassessed

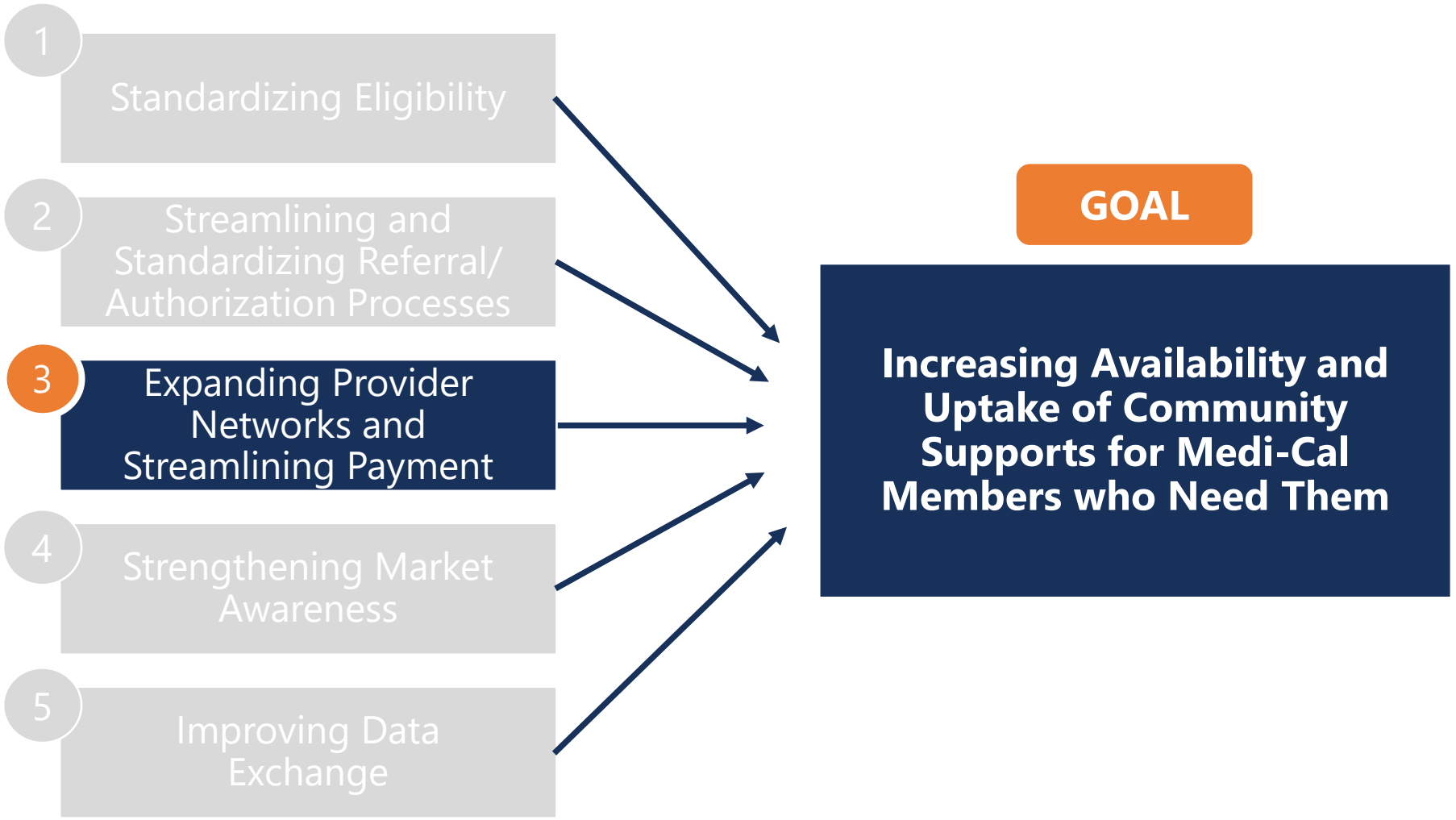
- MCPs must no longer apply blanket reassessment timeframes to determine if a Member should continue receiving ECM. Instead, progress toward reaching care plan goals may be reassessed at the discretion of the ECM Provider throughout the 12-month authorization period based on the Member's needs (e.g., hospitalization, change in member medical/social status). Plans may still perform periodic chart review.

Referrals & Authorizations

Issue: MCPs have disparate timeframes for initial Community Supports authorization and reauthorization decisions within and across services. This creates administrative burden for providers who are contracted with more than one plan and a lack of parity in the delivery of similar services for Members across the state.

DHCS Action:
Standardizing authorization and reauthorization timeframes for Community Supports

In the second half of 2023, DHCS will work to **standardize Community Supports authorization** and **reauthorization periods** for implementation in 2024.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Provider Network & Payments

Issue: MCPs are missing opportunities for partnering with a diverse group of additional providers that have specialized skills/expertise that may best serve Members with specialized needs.

DHCS Actions: **New policies requiring partnerships with specific provider types**.

- MCPs must prioritize contracting with ECM Providers specializing in each of the specific Populations of Focus, in addition to clinic-based providers who may serve a generalist role.
- MCPs should think creatively about how to engage providers in both ECM and the new CHW benefit **this includes Tribal and Indian Health Facility engagement**.
- MCPs' network directories must indicate which specific Population(s) of Focus each ECM Provider is equipped to serve.

Connection with the IPP:
IPP measures incentivize MCPs to increase uptake of the new CHW benefit in 2023-2024.

Provider Network & Payments

Issue: The DHCS ECM and Community Support HCPCS code set is being applied differently by different MCPs leading to increased administrative burden for providers.

DHCS Actions: DHCS intends to re-issue the HCPCS Coding with clarification that MCPs and ECM and Community Support Providers must use the HCPCS coding options for ECM and Community Supports, as defined by DHCS, without additional codes or modifiers.

Provider Network & Payments

Issue: Providers are not consistently reimbursed for ECM outreach.

DHCS Action:

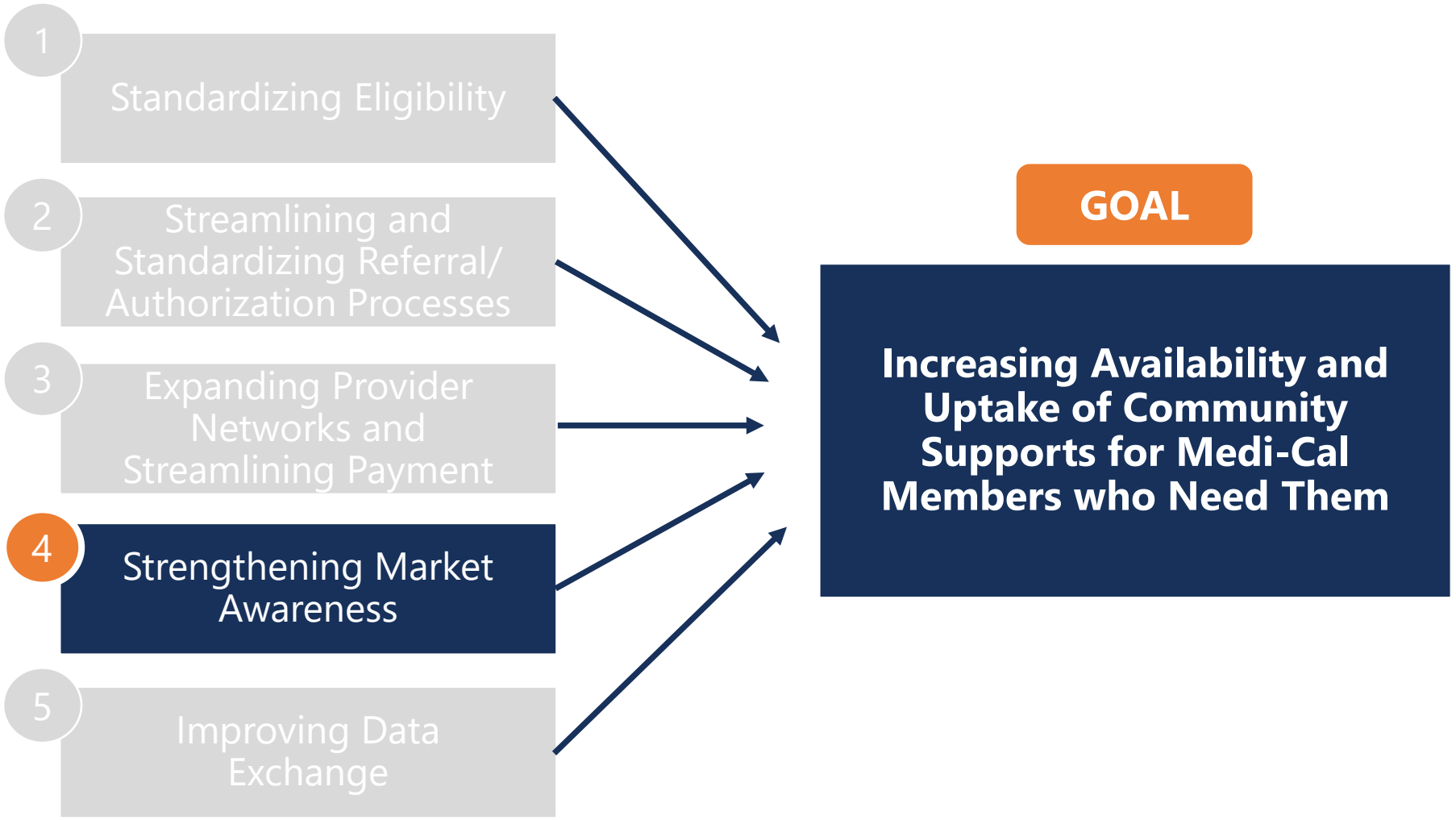
- **MCPs are expected to reimburse ECM Providers for outreach, including for unsuccessful outreach that did not result in a Member enrolling into ECM**.
- **Outreach conducted by Tribal and Indian Health Facilities is to be reimbursed.**
- **MCPs' ECM rates already include assumptions about the cost of outreach** that providers must undertake, which include multiple attempts and outreach to Members who do not ultimately enroll in ECM.
- DHCS is launching a Supplemental Data Request (SDR) to better understand the rates that ECM Providers are being paid, including for outreach.
- DHCS intends to **further standardize the thresholds that should trigger payment** to ECM Providers, including for initial outreach ***(future guidance priority)***.

Provider Payment & Networks

Issue: MCPs may be missing opportunities to contract with Community Supports Providers that have special skills or expertise, and who know Members best.

DHCS Actions: New policies requiring partnerships with specific provider types with experience serving individuals with specialized needs in the region.

- MCPs must contract with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities).
- This includes Tribes and Indian Health Facilities who serve populations that experience disparities.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Lack of Awareness

Issue: Low awareness among contracted providers and MCP internal staff about ECM and Community Supports as well as how to access the benefit.

DHCS Actions: Reinforcement of Existing Guidance

- MCPs must proactively **ensure their contracted networks of providers are aware** of the ECM benefit and Community Support offering, what the eligibility criteria are for each population of focus and encourage and make clear the pathway for submitting referrals to the MCP.
- MCPs must also train their **call centers** about how to take referrals for ECM and Community Supports.

Lack of Awareness

Issue: Low awareness among contracted providers and MCP internal staff about Community Supports and how to access them.

DHCS Actions: Reinforcement of Existing Guidance

- MCPs must proactively **ensure their contracted networks of providers including Tribes and Indian Health Facilities are aware** of Community Supports services, what the eligibility criteria are, and encourage and make clear the pathway for submitting referrals to the MCP.
- MCPs must also train their **call centers** about how to take referrals for Community Supports.

Connection with the IPP:
Incentive Payment Program measures incentivize MCPs to implement a strategy for comprehensive provider education
and training on ECM and Community Supports to their entire contracted provider networks.

Lack of Awareness

Issue: Low awareness in the community about Community Supports services, and how to access them.

DHCS Actions: Reinforcement of Existing Guidance

- As a reminder, MCPs must ensure public-facing **websites, Member Handbooks, and Provider Directories** include the most up-to-date information about the Community Supports offered and how to access them.
  - DHCS has begun monitoring websites and handbooks and will follow up with MCPs where gaps are seen.
- The DHCS Community Supports website contains fact sheets and other language that MCPs may use.
- DHCS welcomes and encourages additional and creative ways of getting the word out.

PATH as a Catalyst for Scaling Community Supports and ECM

CPIs Promote Regional Collaboration around CalAIM

Four Major PATH Initiatives
Collaborative Planning and Implementation (CPI) Initiative
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative
Technical Assistance Marketplace Initiative
Justice Involved Capacity Building

- CPI provides support for collaborative planning and implementation groups to promote readiness for ECM and Community Supports, including work to support standardization, public communications, and more.
- Launched in January 2023, there are 25 collaborative groups—one in each county and/or region—and over 600 participating organizations.
- **MCPs, Providers, Counties, and other stakeholders are encouraged to participate in their local CPIs to advance implementation and uptake of ECM and Community Supports**.

PATH as a Catalyst for Scaling Community Supports and ECM

CITED Provides Funding to Build Capacity and Infrastructure

Four Major PATH Initiatives
Collaborative Planning and Implementation (CPI) Initiative
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative
Technical Assistance Marketplace Initiative
Justice Involved Capacity Building

- CITED provides grant funding to enable the transition, expansion, and development of capacity and infrastructure to provide ECM and Community Supports.
- DHCS awarded over $200 million in Rounds 1A and 1B this spring. Applications for Round 2 closed on May 31, and information on additional rounds of CITED grants is forthcoming.
- **Provider organizations contracted to provide ECM or Community Supports are encouraged to apply, as well as those with an attestation from an MCP showing the intent to contact**.
- DHCS has conducted webinars for Tribal and Indian Health Facility interested in CITED. Webinars will be continued for CITED Round 3.

PATH as a Catalyst for Scaling Community Supports and ECM

TA Marketplace provides support direct to Community Support and ECM Providers

Four Major PATH Initiatives
Collaborative Planning and Implementation (CPI) Initiative
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative
Technical Assistance Marketplace Initiative
Justice Involved Capacity Building

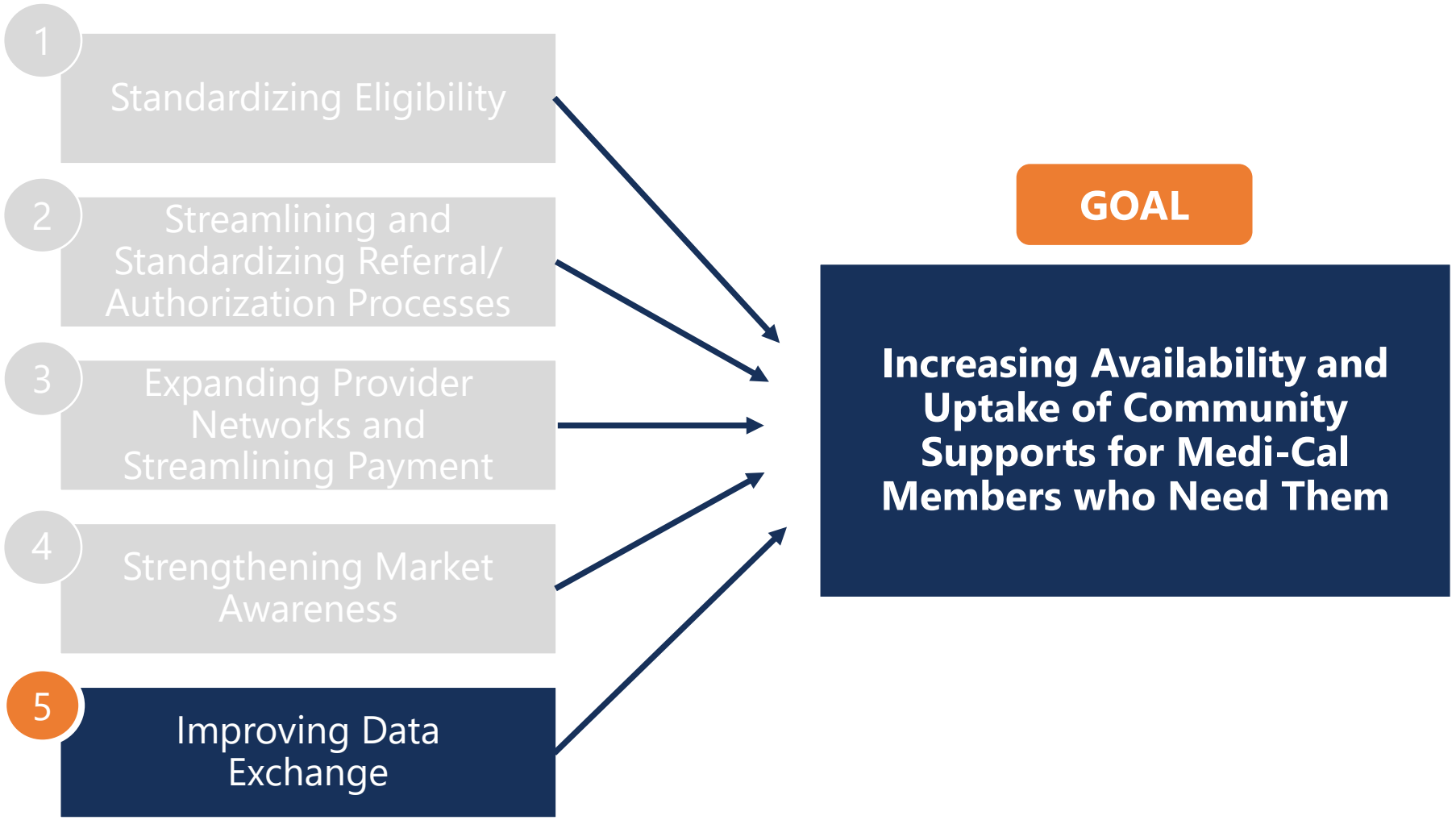
- The TA Marketplace Initiative provides off-the-shelf and hands-on TA to Providers, community-based organizations, county agencies, public hospitals, tribal partners, and others.
- TA is available across seven domains and include resources for Providers building data infrastructure and navigating contracting with MCPs.
- **Contracted and prospective ECM/Community Supports Providers are encouraged to shop for TA**.
- Tribal and Indian Health Facilities offering ECM and Community Supports can request training specifically tailored for identified needs.

PATH as a Catalyst for Scaling Community Supports and ECM

Justice Involved Capacity Building funding will support JI initiatives

Four Major PATH Initiatives
Collaborative Planning and Implementation (CPI) Initiative
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative
Technical Assistance Marketplace Initiative
Justice Involved Capacity Building

- PATH is providing funding to support the implementation of statewide CalAIM justice-involved (JI) initiatives, including pre-release Medi-Cal enrollment and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release.
- **Tribes and Indian Health Facilities who have experience working in the justice arena should work to be involved in this initiative.**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Improving Data Exchange

Issue: Many Providers and CBOs are being required to document the detail of their ECM and Community Supports delivery in plan-specific IT portals.

DHCS Actions: Clarifications of Current Policy:

- **MCPs must not require ECM (or Community Supports) Providers to use an MCP-specific portal for day-to-day documentation of services**.
- MCPs **may** use their own portals to exchange member engagement lists and authorization information.

ECM & Community Supports Data Sharing Guidance Documents

At the start of the programs, DHCS developed guidance to standardize information exchange between MCPs, and ECM and Community Supports Providers, as well as between MCPs and DHCS.

Standardization is designed to promote efficiency and reduce administrative burden.

- DHCS initially released standards for information sharing and reporting in 2021.
- In April 2023, DHCS released new and updated ECM and Community Supports data sharing guidance documents:
  - *(New April 2023)*
    - Community Supports Member Information Sharing Guidance
  - *(Updated April 2023)*
    - Member-Level Information Sharing Between MCPs and ECM Providers
    - Quarterly Implementation Monitoring Report Guidance
    - ECM and Community Supports Billing and Invoicing Guidance
  - *(Coming Q3 2023)*
    - Updated HCPCS Coding Guidance Document for ECM and Community Supports

Documents can be found at Enhanced Care Management and Community Supports (ILOS)

Incentive Payment Program

About IPP

The **CalAIM Incentive Payment Program (IPP)** is intended to support the implementation and expansion of ECM and Community Supports by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to:

- Drive **MCP delivery system investment** in provider capacity and delivery system infrastructure;
- **Bridge current silos** across physical and behavioral health care service delivery;
- **Reduce health disparities** and promote health equity;
- Achieve improvements in **quality performance**; and
- **Encourage take-up** of Community Supports.

IPP Priority Areas

MCPs that elect to participate in the IPP must meet requirements set forth in the reporting template, which includes measures in each of the following priority areas:

1. Delivery System Infrastructure

Fund core MCP, ECM and Community Supports Provider HIT, and data exchange infrastructure required for ECM and Community Supports

2. ECM Provider Capacity Building

Fund ECM workforce, training, TA, workflow development, operational requirements and oversight

3. Community Supports Provider Capacity Building & MCP Take-Up

Fund Community Supports training, TA, workflow development, operational requirements, take-up and oversight

MCPs are **required** to report on a minimum number of optional measures

4. Quality

Optional measures with a set number of points allocated to Priority Areas 2-3 (ECM/Community Supports Capacity Building)

Current Activities

Activities Currently in Progress

- **Upcoming Guidance**
  - 2024 Proposed Needs Assessment and Gap Filling Plan template
  - IPP data tracker/trend analysis for S1, S2A, S2B
  - Release of **Submission 3, Submission 4 and Submission 5 trackers**

Upcoming 2023 Deadlines

IPP Submission Deadlines		
Submission 3	***January 1- June 30, 2023 (PY 2)***	Due September 1, 2023
Submission 4	***July 1 – December 31, 2023 (PY2)***	Due March 1, 2024
2024 Proposed Needs Assessment and Gap Filling Plan template	***January 1, 2024 (PY3)***	Due May 1, 2024
Submission 5	***January 1 – June 30, 2024 (PY3)***	Due September 1, 2024

Tribal Collaborative

Collaborative Planning and Implementation Initiative

- Collaborative groups work together with the support of an assigned facilitator to identify, discuss, and resolve topical implementation issues and identify how PATH and other CalAIM funding initiatives – including IPP – may be used to address gaps identified in MCP Needs Assessments and Gap Filling Plans while avoiding duplication.
- DHCS and the Third Party Administrator for PATH are starting a Tribal and Indian Health Facility Collaborative.
- The Tribal and Indian Health Facility Collaborative will be the first Collaborative that isn't regional but focused a specific group.

Tribal Collaborative Goals

To build on the growth and successes of Regional Roundtables and transition and expand as a Collaborative, we will:

- Expand on the trusted relationships
- Lead with facilitators experienced in serving Native American and marginalized communities
- Implement success factors
- Align content to CalAIM and CPI objectives and participant feedback
- Expand our recruitment strategies and tactics
- Provide coaching to tribes and Indian Health Facilities requesting assistance

Coaching

This level of coaching would include:

- Listening sessions to understand their current state and processes to provide guidance
- Evaluation of needs for language interpretation
- Readiness assessment for submitting an application
- Review of required documents for appropriate language
- Question recommendations for MCP meetings and/or TA meetings
- Warm hand-off to Technical Assistance as needed

Medi-Cal Initiatives Update

Lindy Harrington, Assistant State Medicaid Director

DHCS

Update on Justice-Involved Waiver

National Context for California's 1115 Demonstration Request

Until now, due to a provision of federal Medicaid law known as the "inmate exclusion," inpatient hospital care was the only service that could be covered by Medicaid for individuals considered an "inmate of a public institution."

- In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) which requires HHS to provide guidance to states on how to seek 1115 demonstration authority to waive the inmate exclusion in order to improve care transitions to the community for incarcerated individuals.
- Prior to HHS' release of guidance, California, along with 14 other states, submitted 1115 demonstration requests to provide pre-release services to justice-involved populations.
- Through its CalAIM 1115 Demonstration, California received federal approval to provide a targeted set of Medi-Cal services to youth and adults in state prisons, county jails and youth correctional facilities for up to 90 days prior to release.

California was the first state in the nation to get federal approval to provide pre-release services.

Rationale for Providing Pre-Release Services

California has received approval to authorize federal Medicaid matching funds for select Medicaid services for eligible justice-involved individuals in the 90-day period prior to release from incarceration in prisons, county jails and youth correctional facilities.

- The intent of the demonstration is to **build a bridge to community-based care for justice-involved Medi-Cal members**, offering them services to stabilize their condition(s) and establishing a re-entry plan for their community-based care prior to release.
- **For example:** Connecting American Indians to Indian health providers, offering them services up to 90 days prior to their release to stabilize their health conditions and establish a plan for their community-based care (collectively referred to as "pre-release services").
- This demonstration is **part of California's comprehensive initiative to improve physical and behavioral health care for the justice-involved population** and builds on the State's substantial experience and investments on ensuring continuity of Medi-Cal coverage and access to care for JI populations.

Rationale for Providing Pre-Release Services Continued

California has received approval to authorize federal Medicaid matching funds for select Medicaid services for eligible justice-involved individuals in the 90-day period prior to release from incarceration in prisons, county jails and youth correctional facilities.

- With its 1115 demonstration, California will directly test and evaluate its expectation that **providing targeted pre-release services to Medi-Cal-eligible individuals will avert the unnecessary use** of inpatient hospitals, psychiatric hospitals, nursing homes, emergency departments and other forms of costly and inefficient care that otherwise would be paid for by Medi-Cal.

- Through a federal Medicaid 1115 demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) will partner with state agencies, counties, tribal health providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities.

- The initiative will help California address the unique and considerable health care needs of tribal justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

Justice-Involved Reentry Initiative Goals

The demonstration approval represents a first-of-its-kind section initiative, focused on improving care transitions for incarcerated individuals.

With the implementation of this demonstration, DHCS hopes to achieve the following:

Advance health equity: The issue of poor health, health outcomes, and death for incarcerated people is a health equity issue because Californians of color, including American Indians, are disproportionately incarcerated—including for mental health and SUD-related offenses. These individuals have considerable health care needs but are often without care and medications upon release.

Improve health outcomes: By implementing this initiative, California aims to provide a targeted set of services in the pre-release period to establish a supportive community reentry process, help individuals connect to physical and behavioral health services upon release, and ultimately improve physical and behavioral health outcomes. This includes establishing a supportive community reentry process that helps connect JI individuals to Indian health programs and services.

Serve as a model for the rest of the nation: California is the first state to receive approval for this initiative. We hope our model will serve as a blueprint for the dozen additional states with pending justice-involved 1115 waivers.

California Actively Works With Implementation Partners

Over the past 24 months, DHCS has actively met with its Justice-Involved Advisory Group and one-on-one with implementation partners, to inform the 1115 Demonstration and provide input into development of operational policies.

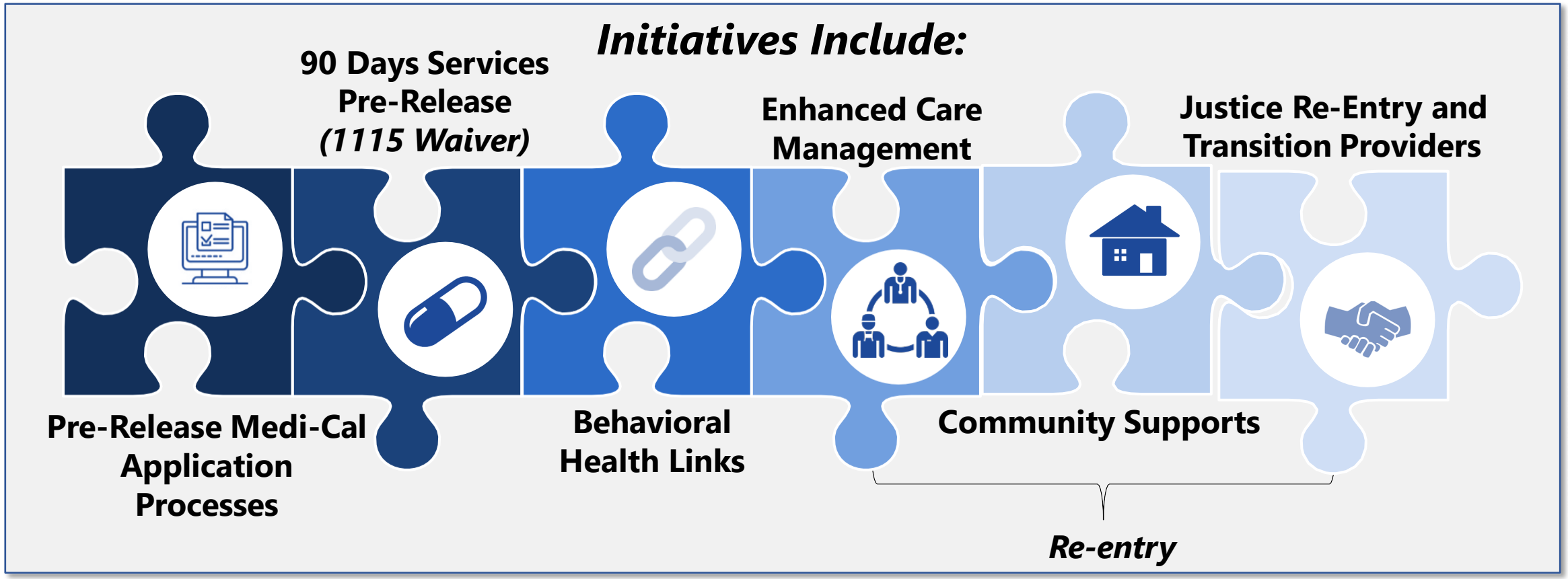
Justice-Involved Advisory Group members include:

- CDCR/California Correctional Health Care Services (CCHCS) which delivers health care services in State prisons
- County Jails, including correctional officers and correctional health staff
- Chief Probation Officers of California (CPOC)/County Youth Correctional Facilities
- Board of State and Community Corrections (BSCC)
- County Welfare Directors Association (CWDA)
- County Social Service Departments (SSDs)
- County Behavioral Health Department (including working group of county behavioral health directors)
- Council on Criminal Justice and Behavioral Health (CCJBH)
- Office of Youth and Community Restoration (OYCR)
- Reentry Providers (including TCN, STOP, Healthright360, WestCare, and Amity Foundation)
- Medicaid managed care plans
- Individuals with lived experience
- Community based organization
- **Consolidated Tribal Health Project**

Listen to this Medicaid Leadership Exchange podcast episode to hear more about the importance of collaboration with implementing partners

The Justice-Involved Reentry Initiative is One Component of the CalAIM Justice-Involved Initiative

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their re-entry.



Pre- and Post-Release Care Management to Support Re-Entry

Correctional facilities and community-based care managers will play a key role in re-entry planning and coordination, including notifying implementation partners* of release date, if known, supporting pre-release warm handoffs, facilitating behavioral health linkages, and dispensing medications and/or DME upon reentry.

Enhanced Care Management (ECM)

Individuals who meet the CalAIM pre-release service access criteria will qualify for ECM Justice Involved Population of Focus and **will be automatically eligible for ECM** until a reassessment is conducted by the managed care plan (MCP), which may occur up to six months after release.

*Implementation partners include social services departments, post-release care manager (if different from pre-release care manager, MCPs, and county behavioral health agencies

Behavioral Health Linkages

To achieve continuity of treatment for individuals who receive behavioral health services while incarcerated, DHCS will require correctional facilities to:

- **Facilitate referrals/linkages to post-release behavioral health providers** (e.g., Indian health providers, non-specialty mental health, specialty mental health, and SUD).
- **Share information with the individual's health plan** (e.g., MCPs, SMHS, DMC-ODS) or program (i.e., DMC).

Warm Handoff Requirement

Prior to release, the pre-release care manager must do the following:

- **Share transitional care plan** with the post-release care manager and MCP.
- **Schedule and conduct a pre-release care management meeting** (in-person or virtual) with the member and pre- and post-release care managers (if different) to:
  - Establish a trusted relationship.
  - Develop and review care plan with member.
  - Identify outstanding service needs.

Release of Draft Policy and Operational Guide for Stakeholder Comment

- In June 2023, DHCS released draft guidance that memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative. **Final guidance will be issued** no later than **September 2023**.
- The draft guidance is intended to lay out to implementing stakeholders—correctional facilities, County Behavioral Health Agencies, providers, community-based organizations, and Medi-Cal managed care plans, among others—the policy, design and operational processes that will serve as the foundation or implementing this important initiative.
- As implementing partners begin to advance the process of standing up the Reentry Initiative, and as CMS continues to refine its sub-regulatory guidance for states that receive 1115 demonstration approval, it is expected that this guide will be updated on an on-going basis.
- To be successful, this complex initiative requires a close working relationship across multiple stakeholders and tribal partners.

Providing Access and Transforming Health (PATH) Capacity Building Program

The approved CalAIM 1115 waiver authorizes $410 million for PATH Justice-Involved Capacity Building Program to support collaborative planning and IT investments intended to support implementation of pre-release and reentry planning services in the 90 days prior to release.

Funding from the PATH Justice-Involved Capacity Building Program will provide implementation grants to correctional facilities (or their delegates), county behavioral health agencies, community-based providers, probation officers, sheriff's offices, and other implementation stakeholders.

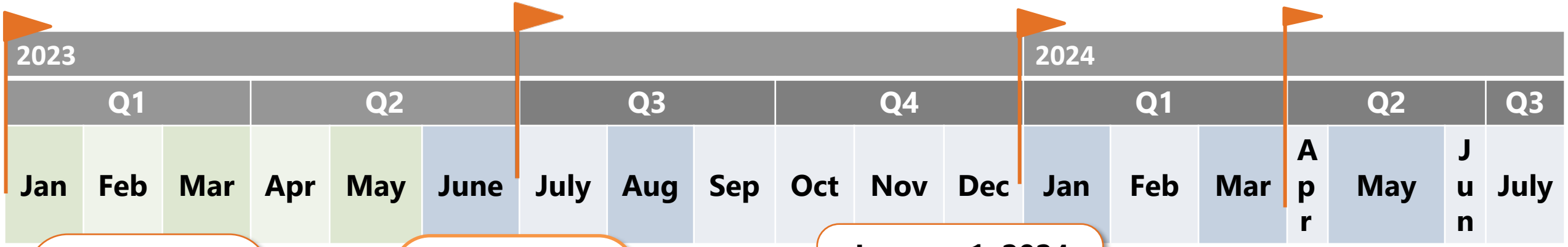
Funding is intended to support eligible entities as they stand-up processes, protocols, and IT system modifications that are necessary to implement or modify processes to support the provision of pre-release services.

This funding can be used for investments in personnel, capacity, or IT systems that are needed to effectuate pre-release service processes.

DHCS/ PATH website: PATH | TPA (ca-path.com)

CalAIM JI Initiatives Timeline

Over the last year, DHCS has worked closely with stakeholders to determine implementation dates and timelines for the CalAIM JI Initiatives, including Pre-Release Applications, ECM JI Population of Focus (POF), Pre-Release Services, and Behavioral Health Links.



January 1, 2023
Pre-Release Application Requirement Go Live

July 31, 2023
PATH Round 3 Applications Due

January 1, 2024
ECM JI Population of Focus Go Live

April 1, 2024 – March 31, 2026
Pre-Release Services Go Live
(two-year phase in)

April 1, 2024 – March 31, 2026
Behavioral Health Links Go Live
(in tandem with pre-release services)

Update on California's Reproductive Health Access Demonstration (CalRHAD)

Update on CalRHAD

California is seeking a new Medicaid Section 1115 demonstration to strengthen the State's reproductive health provider safety net, with an emphasis on ensuring access to sexual and reproductive health services, as well as the services and supports to access these services by addressing health-related social needs (HRSNs).

- On June 6, California submitted the CalRHAD Section 1115 request to the Centers for Medicare & Medicaid Services (CMS)
- The final application reflects feedback from stakeholders, including tribal partners, provided during the 30-day state public comment period from March 16, 2023 – April 17, 2023
  - Feedback from tribal partners centered on ensuring the eligibility criteria permitted broad participation from Tribal FQHCs and Tribal health clinics
  - Prior to submission, DHCS updated the eligibility criteria to incorporate this feedback and ensure it was not restrictive to Tribal providers
- CMS has initiated discussion of the CalRHAD demonstration with DHCS; implementation planned for no sooner than July 1, 2024 and subject to status of CMS negotiations

Recap: Goals of CalRHAD Request

Through CalRHAD, DHCS is requesting Section 1115 authority to provide $200 million in grants to sexual and reproductive health providers for enhancing capacity and access to sexual and reproductive health services.

Goals of CalRHAD

- **Support access to whole-person sexual and reproductive health services for individuals enrolled in Medi-Cal, as well as other individuals who may face barriers to access, including:**
  - Family planning services
  - Family-planning-related services (defined in CMS' State Health Official Letter #16-008)
  - Sexual health services, including STI testing, routine screenings, education, and access to Pre-Exposure Prophylaxis (PrEP)
  - Integrated primary and behavioral health services offered by sexual and reproductive health providers
- **Support the capacity and sustainability of California's sexual and reproductive health provider safety net,** including supporting partnerships with community-based organizations (CBOs) to build capacity and sustain access to services to address health-related social needs
- **Promote system transformation for California's sexual and reproductive health safety net,** including promoting integrated models for the delivery of reproductive, primary, and behavioral health services and mitigating access barriers arising out of the social drivers of health

Recap: Permissible Uses of CalRHAD Grants

CalRHAD grants would support provider and CBO capacity to provide sexual and reproductive health services and health related social need supports to reduce barriers to access. The grants would not be used to reimburse the direct provision of any services.

Permissible Uses

- **Investments in provider capacity to support costs associated with:**
  - Staff recruitment, retention, or training
  - Expanding available appointment times (e.g., evenings or weekends)
  - Expanding the range of services offered
  - Non-service expenditures (e.g., equipment, telehealth investments)
- **Patient access supports to:**
  - Establish or expand partnerships with CBOs who can assist with transportation, childcare, and similar needs
  - Assist patients in identifying an appropriate and available provider, arranging travel, and connecting patients to services to address social and health care needs

Providers that receive CalRHAD grants would not be permitted to use these funds to reimburse for services, including abortions.

Update: CalRHAD Grant Eligibility Criteria

To be eligible, providers must be one following provider types

- Providers enrolled in the Family Planning, Access, Care, and Treatment (PACT) program
- Community health centers (including Federally Qualified Health Centers (FQHCs), FQHC look-alikes, migrant health centers, rural and frontier health centers, and non-profit community or free clinics licensed by the state as primary care clinics, or clinics affiliated with Disproportionate Share Hospital (DSH) facilities)
- **Tribal FQHCs**
- **Indian Health Service/Memorandum of Agreement (IHS/MOA) clinics**
- Rural hospitals, small hospitals (fewer than 50 beds), or critical access hospitals that are not part of a large health systems or hospital systems
- Other Medi-Cal enrolled providers as designated by DHCS

Updated to use a more precise description of "IHS/MOA clinics" (criteria previously referred to "tribal health clinics")

AND must meet all of the following criteria:

- Enrolled in Medi-Cal
- Are located in California
- **If applicable and not exempted from licensure, licensed under California law**
- Provide a broad spectrum of sexual and reproductive health care services
- Serve a minimum volume of individuals enrolled in Medi-Cal
- Accept patients regardless of ability to pay

Updated criteria to ensure Tribal programs, who are exempt from licensure under H&S Code 1206(c), are eligible to participate

Recap: CalRHAD Funding and Grant Process

DHCS is requesting expenditure authority from CMS for $200 million over a three-year demonstration term.

- **The following table shows the with waiver expenditures across the three Demonstration Years (DYs)**

(in millions	DY 1	DY 2	DY 3
CalRHADs	**$200**	**$0**	**$0**

- California will provide **grant funds to providers in installments based on achievement of grant milestones**

- To the extent any of the funds associated with the CalRHAD grants are not fully expended or fully allocated in DY 1, CalRHAD **grant funds may be reallocated across other CalRHAD DYs**, subject to overall $200 million expenditure limit

Recap: Impact to American Indians, Indian Health Programs, & Urban Indian Organizations

Impact to Tribal Health Programs & FQHCs

- **Tribal FQHCs, Tribal health clinics, FQHCs, and FQHC look-alikes, among other providers, would be eligible to receive grant dollars** to support access, capacity, and sustainability for California's sexual and reproductive health safety net
- **DHCS is not proposing changes to:**
  - Tribal health program services, rates, benefits, eligibility, or any other related requirement
  - FQHC services, rates, eligibility, or any other related requirement
- The grants would not be used for provision of any services, including abortions

Impact to American Indian & Alaska Native Medi-Cal Enrollees

- **California seeks to support access to sexual and reproductive health services for individuals enrolled in Medi-Cal**, including American Indians and Alaskan Natives, as well as other individuals who may face barriers to access
- The grants would not be used for the direct provision of services, but would help increase access to services

Timeline & Next Steps

Milestones	Proposed Timeline
Release CalRHAD draft and conduct 30-day State public comment period	***Complete*** *(March 16 – April 17)*
Revise and submit CalRHAD application to CMS	***Complete*** *(June 6)*
CMS conducts federal 30-day public comment period	***Complete*** *(June 16 to July 16)*
Conduct negotiations with CMS	**In progress** (Summer – Winter 2023)
Implementation	**No sooner than July 1, 2024**

Population Health Management Update

Palav Babaria
Deputy Director & Chief Quality and Medical Officer
Quality and Population Health Management

DHCS

Birthing Care Pathway Project

Overview of Birthing Care Pathway

DHCS is developing a comprehensive **Birthing Care Pathway** that is envisioned as a **care model to cover conception through 12 months postpartum** with related benefit and payment strategies in Medi-Cal, to **reduce maternal morbidity and mortality** and **address significant racial and ethnic disparities** in maternal health outcomes among Black, **American Indian/Alaska Native (AI/AN),** and Pacific Islander individuals.

Overview of Birthing Care Pathway (BCP)

- DHCS will develop **Medi-Cal care delivery policy and program initiatives for pregnant and postpartum individuals** that translate and promote adoption of best practice clinical and whole person care management guidelines into standard care processes and workflows across settings.
- DHCS and the BCP project Participants and Partners will focus on best practices in the field from conception through 12 months postpartum.

Identified Pathways encompass physical health, behavioral health, and health-related social needs

- To inform the design of the Birthing Care Pathway, DHCS has created **Clinical Care** and **Social Drivers of Health Key Informant Workgroups.** Workgroups will meet with DHCS and other BCP Project partners meeting throughout the summer and fall 2023.
  - Clinical Care Workgroup: charged with **identifying what needs to happen in the hospital, birthing center, provider office, and other community settings from a Medi-Cal Member's perspective**
  - Social Drivers of Health Workgroup: charged with **identifying best practices and needs from programs and providers that currently work to address perinatal health-related social needs.**

BCP Workgroup Participant Representation

Clinical Care Workgroup Participants include OB-GYNs, Certified Nurse Midwives, Lactation Support Providers, **Tribal Health Providers**, Pediatricians, and other Providers representing birthing centers, behavioral health services, family medicine services, Federally Qualified Health Centers, the Comprehensive Perinatal Services Program (CPSP) and other Local Public Health programs, and Managed Care Plans.

- Tribal Partner participants representation:
  - CA Consortium for Urban Indian Health (CCUIH)
  - United Indian Health Services, Humboldt & Del Norte Counties (UIHS)
  - Tribal Health PRIME Community Health Scholars Program, UC Davis School of Medicine
  - Open Door Community Health Centers (FQHC supporting many AI/AN individuals)

BCP Workgroup Participant Representation

Social Drivers of Health Workgroup include community health workers, doulas, and other Providers representing organizations addressing the social needs of Birthing Persons including Violence Prevention organizations, local Public Health Maternal Child & Adolescent Health (MCAH) Programs including CPSP and Black Infant Health programs, Women, Infants and Children (WIC) and Food Banks, **Tribal Social Service Partners**, Organizations addressing housing and financial insecurity, Black-Centering Birthing Centers, and home visiting providers.

- Tribal Partner participants representation:
  - Native American Health Center (NAHC) Nutrition & WIC Program, City of Oakland

Birthing Care Pathway Member Engagement

A foundational priority for DHCS in the Birthing Care Pathway project is to ensure the design is shaped by Medi-Cal members with lived experience.

- DHCS will create a **Member Voice Workgroup** in fall 2023 **comprised of members that are currently or have recently been pregnant or postpartum while enrolled in Medi-Cal.** DHCS will focus particularly on engaging Black, AI/AN, and Pacific Islander members for the Member Voice Workgroup given the disparities in maternal health outcomes among these populations.
- DHCS will also conduct **1:1 interviews** in fall 2023 **with a subset of Medi-Cal members** who are currently or have recently been pregnant or postpartum and invite a small group of members to **journal about their individual pregnancy and postpartum experience in Medi-Cal.**
- The Birthing Care Pathway project will culminate with a **public-facing report** estimated for **summer 2024** outlining the policy recommendations for how DHCS can most effectively reduce maternal morbidity and mortality and address racial and ethnic disparities.

The Birthing Care Pathway project, which is led by DHCS, is generously supported by the California Health Care Foundation and the David & Lucile Packard Foundation.

Re-Imagined Population Needs Assessment Update

Context

- DHCS launched the Population Health Management (PHM) Program in January 2023 as a cornerstone of its Medi-Cal transformation efforts.

- To support the success of the PHM Program and broader transformation efforts, DHCS is re-designing MCP requirements for developing a **Population Needs Assessment (PNA).** The PNA has historically been the mechanism that MCPs use to identify the priority health and social needs of their members, including health disparities.

- On May 8th, DHCS released a concept paper to share its vision for the modified PNA for stakeholder feedback (public comment period ended on June 2nd).

- DHCS is in the process of scheduling a Tribal workgroup in September (date: TBD) to gather more input from Tribal partners to inform end of year guidance on the PNA.

DHCS' PNA Concept Paper: Vision for the Modified PNA

A central component of DHCS's approach is for MCPs to participate meaningfully on Local Health Departments' Community Health Assessments (CHAs)/ Community Health Improvement Plans (CHIPs) rather than to complete a separate PNA focused solely on their own members' data.

As outlined in its PNA concept paper, DHCS vision is for the modified PNA to:

Promote deeper understanding of member needs, particularly social drivers of health (SDOH)

Advance upstream interventions that look beyond the four walls of health care

Deepen relationships between MCPs, public health and other local entities, including **Tribal partners.**

Reduce community fatigue by aligning with other similar types of assessments.

Strengthen a focus on equity by integrating more diverse sources of data

Support public health's response to emerging trends, especially in areas where MCPs can intervene by providing coverage, education, and outreach

Historical Overview: Parallels and Intersections of Community-Level Needs Assessments

MCPs PNA and Action Plans (prior to 2023)

- MCPs completed an ***annual PNA***, focused on the Health Education, Cultural and Linguistic needs of their Member population.
- Findings informed future program development with an ***Action Plan deliverable***

LHD and Nonprofit Hospitals

- ***Community Health Assessments*** (CHAs) focus on multiple populations within the communities served, upstream interventions, and involves diverse data and community-wide input.
- Often accompanied by Community Health Improvement Plans (CHIPs), which are action plans that support communities improve their health and well- being based on the data collected by CHAs.

Tribal Health-led Community Level Needs Assessments?

DHCS-PROPOSED PNA REQUIREMENTS 2023-25 (1)

Starting in 2024, MCPs will be required to participate meaningfully in LHD CHA/ CHIP process.

» **Rather than completing an entirely separate process, MCPs will be required to participate in the LHD CHA process wherever MCPs serve Members.**

Meaningful MCP participation could entail:

- Providing MCP data on a de-identified basis
- Participating or leading the CHA/CHIP steering committee/decision-making body
- Participating in or leading one or more CHA/CHIP work groups
- **Exploring how MCPs and Tribal partners might collaborate on needs assessment in the communities where there is overlap in populations**
- Providing staff support to core activities
- Providing funding to support convenings, project management, and/or analytics
- Collaborating with LHDs and other local leadership to develop joint action plans to address public health issues

DHCS-PROPOSED PNA REQUIREMENTS 2023-25 (2)

The County LHD, in most cases, will serve as the anchor to align and integrate MCPs and other local partner assessments with County CHA/CHIP process within existing LHD CHA/CHIP timelines.

DHCS' Supporting Rationale

- LHD assessments are focused on the overall population and environment of a county or city, not limited to people enrolled in Medi-Cal.
- LHDs' CHAs/CHIPs often already have robust governance structures, gather community wide-input, and leverage diverse data sources.

Supporting the anchors is key. DHCS recognizes as anchors in this proposed requirement, LHDs are likely to need additional support to continue to grow their CHAs/CHIPs and to integrate MCPs.

Supporting Diversity in community participation: DHCS recognizes the responsibility we have to help MCPs additionally work with other community partners to realize this vision, which is why we value this time with you today to begin this dialogue with you.

DHCS-PROPOSED PNA REQUIREMENTS 2023-25 (3)

Future-state MCP deliverables will emphasize LHD collaboration.

PNA:
MCPs will meet requirement t*hrough the publication of the LHD CHA/CHIP* itself in each county it serves.

» MCPs expected to *publish all LHD CHAs/CHIPs in their service areas on their website,* with a brief description of how they participated in the LHD CHA/CHIP process.

PHM Strategy:
Annual MCP submission of PHM Strategy brief to DHCS informed by insights gained from the LHD CHA/CHIP process collaboration in addition to findings from other MCP data analysis

» 2023 Submission Deliverables must include:
- One SMART goal aligned with CQS Clinical Focus Areas & Bold Goals that includes collaboration with LHDs in counties where MCP operates
- Description of how a MCP has started/will start to participate in LHD CHA/CHIP process

Next Steps & Upcoming Guidance for 2023

May

» Concept paper detailing proposed approach for the modified PNA and new PHM Strategy deliverable for stakeholder review and feedback.

> Multi-sector stakeholders who contributed to these comments acknowledge the importance of including Tribal Partners in re-imagined PNA efforts.

July/August

» Near term guidance for MCPs on PNA and PHM strategy published in PHM Policy Guide.

» 2023 PHM Strategy Deliverable template shared with MCPs.

» A new, high-level APL (APL 23-021) on the PNA/PHM Strategy issued to supersede APL 19-011.

September

» **Tribal workgroup on PNA to inform end of year guidance**

*If interested in participating, please email PHMSection@dhcs.ca.gov with **subject line that includes** "Tribal workgroup on PNA"*

October

» 2023 PHM Strategy Deliverable is due for MCPs.

By end of year, more detailed guidance will be issued in the PHM Policy Guide.

May Quarterly Tribal Meeting Responses

What may make you excited to work with DHCS, MCPs or LHDs on these types of assessments?
What may make you hesitant?

Hesitation

Excitement

Questions/Comments?

Email

General PNA Concepts:
PHMSection@dhcs.ca.gov with **subject line that includes** "PNA" and/or "PHM Strategy"

Workgroup Volunteer:
PHMSection@dhcs.ca.gov with **subject line that includes** "Tribal workgroup on PNA"

Equity & Practice Transformation Payment Program

Overview of EPT Payments Program

- **Funding**: One-time $700M initiative
- **Goal** is to improve primary care for Medi-Cal recipients:
  - Advance equity
  - Reduce COVID-19-driven care disparities
  - Invest in up-stream care models/partnerships to address health/wellness
  - Fund practice transformation aligned with value-based payment models

EPT Payments Program

Program Component	Intended Recipients	Application	Purpose/Deliverable
Initial Planning Incentive Payments $25M first year of program Managed Care Plan (MCP)-directed incentive program	**Small/medium-sized independent practices (1-50 providers)** that might not otherwise be able to participate in Provider Directed Payment Program; **MCP choose practices**	Practices **work with contracted MCPs** (no formal application to DHCS)	**Practices complete practice assessment tool phmCAT as PDF** and get practice transformation support from MCPs/contractors Goal is to **increase # of practices that apply for Provider Directed Payment Program**
Provider Directed Payment Program $650M ($200M for preparing practices for value-based payment) over multiple years Directed payment program	**Primary Care** (Primary Care Pediatrics, Family Medicine or Internal Medicine), Primary Care OB/GYN, or Behavioral Health providers providing integrated behavioral health services in a primary care setting; any size practice can apply	**Formal web-based application** (released with this presentation)	**First cohort January 2024** Payments for **delivery system transformation activities**

EPT Payments Program

Program Component	Intended Recipients	Application	Purpose/Deliverable
Statewide Learning Collaborative $25M for program duration Structure still being determined	**All practices in Provider Directed Payment Program**	None	Provide **support to practices with practice transformation**; will be largely modeled on PHMI materials

Initial Planning Incentive Payments: Eligible Practices

- **Small- or medium-sized independent practices** not associated with a health care system or FQHC (with exception of tribal health programs or Rural Health Clinics)
  - Small includes up to 25 providers
  - Medium includes 26 to 50 providers
- **Must be**:
  - **In-network for MCP** to work with practice
  - **Primary care** practice:
    - Pediatrics, Family Medicine or Internal Medicine, OR
    - Primary Care OB/GYN, OR
    - Behavioral Health providers providing integrated behavioral health services in a primary care setting
  - **Serving at least 1,000* Medi-Cal members**

*500 member limit acceptable for Rural Health Clinics or other rural practice

Recommended for Inclusion

- Serve disproportionate numbers of Black/African American, Alaska Native/Native American, or LGBTQ+ populations compared to county demographics
- Tribal health programs, Rural Health Clinics, and other rural practices
- Practices whose current performance on key measures is <50th percentile, especially those <25th percentile
- Practices located in Healthy Places Index quartile 1 areas
- Practices not otherwise receiving funding for the same activities in the Cal-AIM Incentive Payment Program (IPP) or the PATH TA Marketplace program or the Data Exchange Framework (DxF) Grant Program

Next Steps

- Managed care plans should be reaching out to tribal partners about Initial Planning Incentive Payments
- Application and public webinar for larger program (Provider Directed Payment Program) to be released later this month
- Applications due late September
- Cohort 1 begins 2024

Behavioral Health Update

Erika Cristo, Assistant Deputy Director
Medi-Cal Behavioral Health

DHCS

Behavioral Health Updates

- BH-CONNECT Update
- Traditional Healers and Natural Helpers
- 988 Update
- Tribal Fentanyl Crisis

BH-CONNECT Update

The CalBH-CBC Demonstration is Now the BH-CONNECT Waiver

DHCS is renaming the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration. The name is new, but the vision, objectives, and approach remain the same.

CalBH-CBC Demonstration → **BH-CONNECT Waiver**

The new name, the **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment** (BH-CONNECT) waiver, emphasizes DHCS' commitment to providing a robust continuum of community-based behavioral health care and improving access, equity, and quality for Medi-Cal members with mental health needs, particularly populations experiencing disparities in behavioral health care and outcomes including American Indians/Alaskan Natives.

Section 1115 Demonstration Opportunity

The BH-CONNECT demonstration will strengthen the continuum of community-based behavioral health services, while also taking advantage of CMS' opportunity to receive federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Diseases (IMDs).

- **CMS' 2018 guidance** permits states to use 1115 demonstrations to receive FFP for short-term care* provided to Medicaid members living with SMI/SED in qualifying IMDs, provided states establish a robust continuum of community-based care and enhance oversight of inpatient and residential settings.
- **California was the first state to obtain a similar waiver allowing IMD expenditure authority for substance use disorder (SUD) care provided in IMDs** in exchange for strengthening SUD services under the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- In October 2021, **CMS created new flexibility to secure FFP for longer stays in Short-Term Residential Therapeutic Programs (STRTPs) classified as IMDs** for youth in the child welfare system for up to two years. States must submit a detailed plan with key milestones and timeframes for transitioning children out of STRTPs that are IMDs.
- In November 2022, DHCS **released an external concept paper outlining the proposed** approach to the BH-CONNECT demonstration (formerly the CalBH-CBC demonstration).
- On August 1, 2023, **DHCS released the proposed BH-CONNECT Section 1115 application.**

**The opportunity is limited to stays that are no longer than 60 days, with a requirement for a statewide average length of stay of 30 days.*

BH-CONNECT Waiver: Vision and Objectives

DHCS' vision for the BH-CONNECT waiver is to ensure a robust continuum of community-based behavioral health care services is available to all Medi-Cal beneficiaries living with SMI and SED across the state.

As part of CalAIM, California committed to pursuing a Section 1115 Demonstration to enhance the continuum of community-based services to support adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). The objectives of the BH-CONNECT waiver include:

1. **Amplify the state's ongoing investments** in behavioral health and further strengthen the continuum of community-based care.
2. **Meet the specific mental health needs** of children, individuals who are justice-involved, and individuals experiencing or at risk of homelessness.
3. **Ensure care provided in facility-based settings** is high-quality and time-limited.

Proposed Approach

BH-CONNECT aims to:

- **Expand the continuum of community-based services and evidence-based practices (EBPs)** available through Medi-Cal.
- **Strengthen family-based and supports** for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Connect members living with significant behavioral health needs to **employment, housing, and social services and supports**.
- **Invest in statewide practice transformations** to better enable county behavioral health plans and providers to support Medi-Cal members living with behavioral health conditions.
- **Strengthen the workforce** needed to delivery community-based behavioral health services and EBPs to members living with significant behavioral health needs.
- Reduce the risk of individuals **entering or re-entering the criminal justice system** due to untreated or under-treated mental illness.
- **Incentivize outcome and performance improvements** for children and youth involved in child welfare that receive care from multiple service systems.
- **Reduce use of institutional care** by those individuals most significantly affected by significant behavioral health needs.

Next Steps

- **Public Comment Period.** The BH-CONNECT application is available for public comment through August 31, 2023. Please submit all written comments to BH-CONNECT@dhcs.ca.gov.
- **Response to Public Comment.** DHCS will revise the draft BH-CONNECT application, integrating stakeholder feedback, in fall 2023.
- **Submission to CMS.** DHCS intends to submit the final BH-CONNECT application for CMS review in late 2023.
- **Demonstration Go-Live.** The BH-CONNECT demonstration will be implemented on a phased timeline to ensure ample time for successful implementation (*see slide 27*).
- **Ongoing Stakeholder and Tribal Partner Engagement.** DHCS is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of the proposed BH-CONNECT demonstration.

Find the draft BH-CONNECT demonstration application posted on https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

Traditional Healers and Natural Helpers Update

Traditional Healers and Natural Helpers: Background

- In 2017, DHCS requested authority from CMS to cover Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery System (DMC-ODS)
- In 2020, DHCS submitted a second request to CMS
  - CMS neither approved nor disapproved
- In 2021, DHCS submitted a third request to CMS
  - CMS neither approved nor disapproved
  - Request is still pending
- DHCS remains committed to securing CMS approval

Traditional Healers and Natural Helpers: Draft Provider Qualifications

- A **Traditional Healer** would be a person currently recognized as a spiritual leader and in good standing with his/her Native American Tribe, Nation, Band or Rancheria, and recognized Native American spiritual leader practicing in a setting recognized by his/her Native American Tribe, Nation, Band or Rancheria who is contracted or employed by the IHCP. A Traditional Healer would be a person with knowledge, skills and practices based on the theories, beliefs, and experiences which are accepted by that Indian community as handed down through the generations and which can be established through the collective knowledge of the elders of that Indian community
- **Natural Helpers** would be health advisors contracted or employed by the IHCP who seek to deliver health, recovery, and social supports in the context of Tribal cultures. Natural Helpers could spiritual leaders, elected officials, paraprofessional and others who are trusted members of his/her Native American are trusted members of his/her Native American Tribe, Nation, Band or Rancheria.
- IHCPs seeking reimbursement for Natural Helpers and/or Traditional Healers would develop and document credentialing (e.g., recognition and endorsement) policies consistent with the minimum requirements above.

Traditional Healers and Natural Helpers: Draft Service Descriptions

- Traditional Healers may use an array of interventions including, music therapy (such as traditional music and songs, dancing, drumming), spirituality (such as ceremonies, rituals, herbal remedies) and other integrative approaches.
- Natural Helpers may assist with navigational support, psychosocial skill building, self-management, and trauma support to individuals that restore the health of those DMC-ODS beneficiaries receiving care at IHCP.

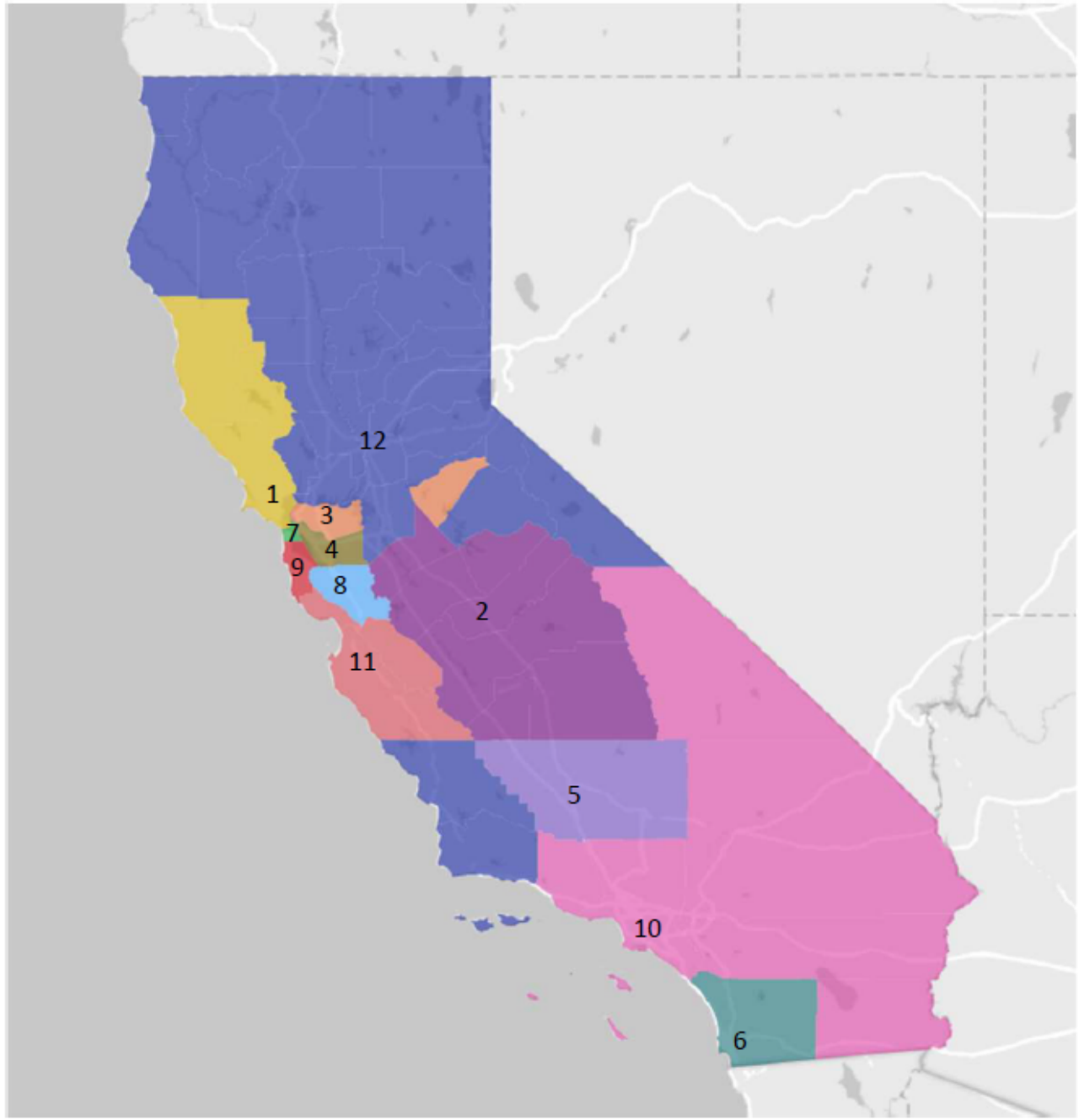
988 Update

CA 988 Suicide & Crisis Lifeline

- The National Suicide Hotline Designation Act of 2020 designated 988 as the new, easy to remember three-digit number for the National Suicide Prevention Lifeline, now known as the 988 Suicide and Crisis Lifeline
- In 2022, about 1 out of 8 calls to the national 988 network originated in California
- California 988 crisis centers received over 332,000 calls between July 2022 and June 2023
- 12 call centers provide 988 Suicide & Crisis Lifeline services to all 58 counties in California

California Lifeline Network Crisis Centers

1	Buckelew Suicide Prevention Program
2	Central Valley Suicide Prevention Hotline – Kings View
3	Contra Costa Crisis Center
4	Crisis Support Services of Alameda County
5	Kern Behavioral Health & Recovery Services Hotline
6	Optum
7	San Francisco Suicide Prevention Felton Institute
8	Santa Clara County Suicide and Crisis Services
9	StarVista
10	Suicide Prevention Center - Didi Hirsch Mental Health Services
11	Suicide Prevention Service of the Central Coast
12	WellSpace Health



988 Tribal Summits

- Purpose: To gather tribes, legislators, and mental health services providers to expand implementation efforts to ensure statewide suicide prevention resources for American Indian communities.
- Goal: To create a safe space for tribal members and their local community partners to share their experiences and needs in relation to suicide prevention.
- Included panels, speaker presentations, and small group listening sessions centered on community and trust building to increase awareness of 988 and address barriers to care.

Who Attended

- Hosted by Department of Health Care Services (DHCS), Didi Hirsch Mental Health Services, and CA Assemblymember James C. Ramos
- 219 attendees – 70% noted tribal affiliation (representing 15 nations)
- All twelve CA 988 Suicide and Crisis Lifeline Centers
- Service providers from Indian Health clinics and staff from the Substance Abuse and Mental Health Services Administration, California Health and Human Services, and DHCS

Key Takeaways

- Identified barriers:
  - Stigma
  - Safety concerns
  - Lack of trust
  - Cultural competencies
- CA 988 centers wish to learn more about how they can specifically address the unique needs of tribal members.
- Identified resource recommendations for 988 counselors to build their competency to better serve tribal communities.

Tribal Fentanyl Crisis

Naloxone Distribution Project (NDP)

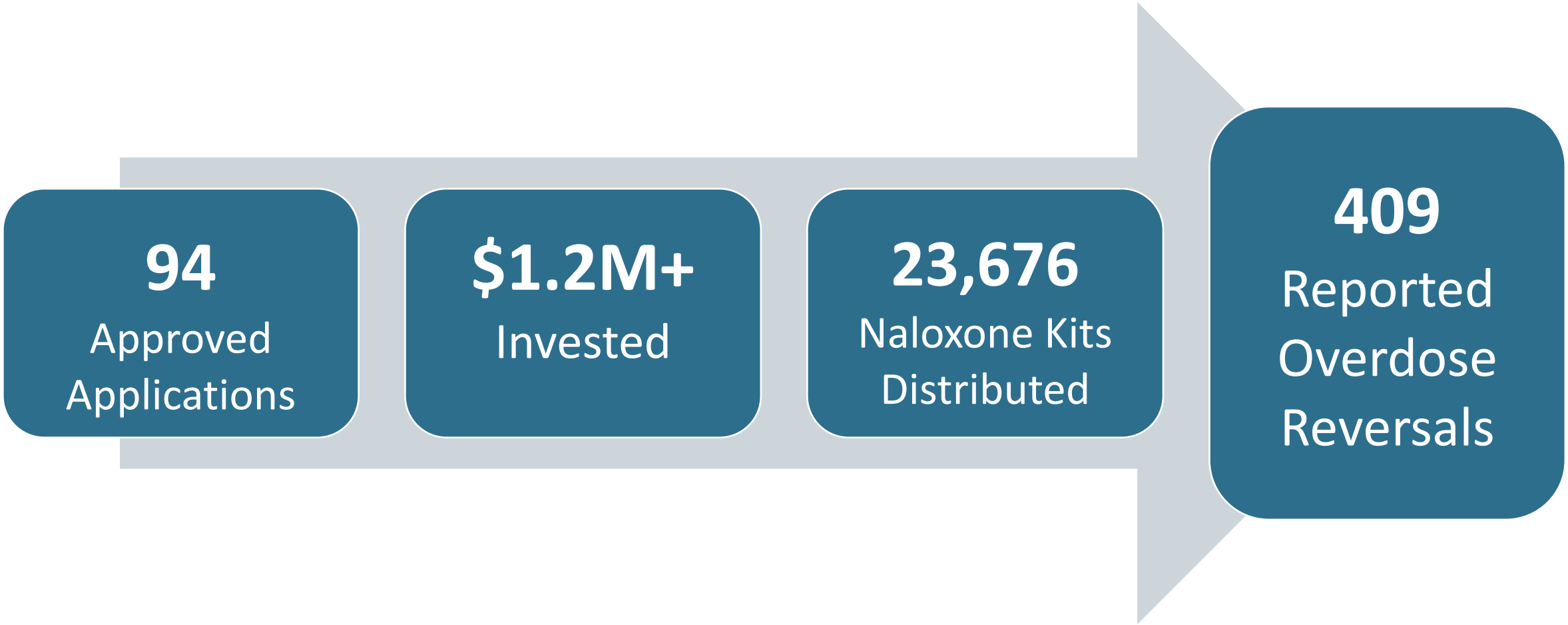
- The NDP was created in 2018 to **combat fatal opioid overdoses** through the provision of **free naloxone** to eligible California entities, including **tribes** and **tribal organizations**
- Tribes and Tribal organizations can apply to the NDP to have naloxone **shipped directly to their address**
- DHCS is available to provide **technical assistance** on the NDP application process by emailing:

naloxone@dhcs.ca.gov

NDP Updates

- As of July 2023, the **NDP application** is now an easy-to-use **online form which can be found on the DHCS NDP webpage.**
- DHCS received over **$110M** in FY 2023/24 to **support the NDP**
- DHCS will soon be offering **free fentanyl test strips through the NDP.**

NDP and Tribal Organizations



**Tribal Organization NDP Data as of August 8, 2023*

Tribal MAT Project

- The Tribal Medication Assisted Treatment (TMAT) Project is designed by California's Rural and Urban Indian communities to promote opioid safety, improve the availability and provision of MAT, and facilitate wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments.

- TMAT shares knowledge among Tribal and Urban Indian communities, Tribal and Urban Indian health programs, and community-based partners on best practices for prevention, treatment and recovery from opioid use disorder (OUD), stimulant use disorders, and other co-occurring substance use disorders (SUDs) across California's 109 federally recognized Tribes.

CA Rural Indian Health Board (CRIHB)

- **CRIHB TMAT Project Goals**
  - TMAT Champions share information about training and TA services including:
    - Educational materials
    - NDP training
- **CRIHB Tribal Local Opioid Coalitions (TLOC) Grants**
  - DHCS awarded $1,241,048 to TLOCs to create partnerships of community members, stakeholders, and service providers.
  - 11 Tribal Communities and Tribal Health Programs were selected.

CRIHB Website

CA Consortium for Urban Indian Health (CCUIH)

- **CCUIH TMAT Project Goals**
  - Emphasis on development and dissemination of culturally-relevant overdose prevention and education for our urban communities.
  - Training for accessing Naloxone via the Naloxone Distribution Project (NDP).
- **CCUIH Subcontract Program for Opioid Coalition and Community Engagement (SPOC) Grant**
  - DHCS awarded $230,000 Urban Indian health organizations to engage and collaborate with opioid safety coalitions and community partners through SPOC.
  - 6 Urban Indian health organizations were selected.

CCUIH Website

Kauffman and Associates, Inc. (KAI)

- **KAI TMAT Project Goals**
  - Provide training and TA support to tribal and urban Indian health programs.
  - Expand Native access to services through new partnerships with mainstream, statewide SUD systems.
- **Tribal Urban Indian Community Defined Best Practices (TUICDBP)**
  - DHCS awarded $3,483,354 to twenty-three entities providing MAT services through TUICDBP.
- **California Native MAT Network for Healing and Recovery (NMAT Learning Network)**
  - DHCS awarded $1,048,032 to seven tribal and urban Indian health entities for the NMAT Learning Network.

KAI Website

Behavioral Health Continuum Infrastructure Project (BHCIP)

- The BHCIP was signed into law in July 2021 under Assembly Bill 133 (Chapter 143, Statutes of 2021), and will provide $2.2 billion in funding through DHCS to construct, acquire, and expand properties and invest in mobile crisis infrastructure through June 30, 2027.
- DHCS is releasing these funds through six BHCIP grant funding rounds.
- BHCIP provides competitive grants to counties, cities, tribal entities, non-profit and/or for-profit entities.
- Funding is only for new or expanding infrastructure (brick, mortar and mobile crisis) projects and not BH services nor preservation of existing BH infrastructure.

BHCIP Updates

To date, DHCS has awarded a **total of $1.7 billion** through the five rounds of BHCIP grant funding.

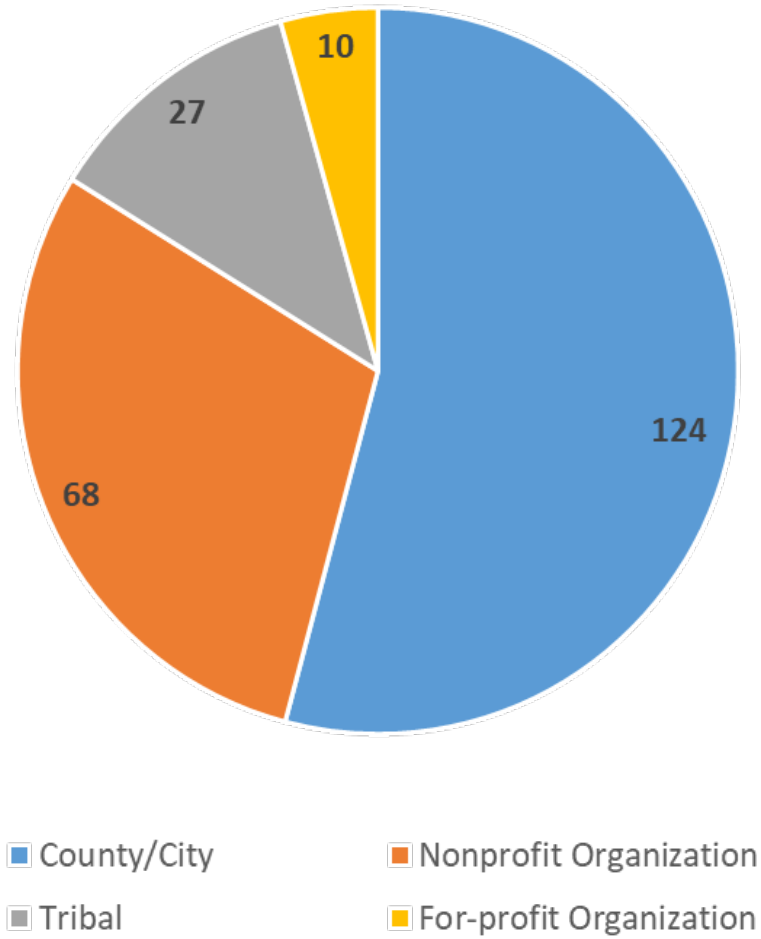
- **Round 1 - Crisis Care Mobile Units:** More than $163 million awarded to 49 (county, city, tribal) BH authorities to create or enhance 245 Crisis Care Mobile Units (CCMU) response teams throughout California to expand mobile crisis infrastructure. Awards announced: 1A in November 2021 and 1B in February 2022.
- **Round 2 - Planning Grants:** More than $7 million awarded to 48 county and tribal entities to support activities associated with planning for the construction, acquisition, or rehabilitation of BH facilities. Awards announced: 2A in January 2022 and 2B in April 2022.
- **Round 3 - Launch Ready:** $518.5 million awarded 45 launch ready projects (includes 2 tribal entities) to build/expand 37 new inpatient and residential facility sites that offer 1,176 new BH treatment beds, and 44 outpatient facilities to offer more than 130,000 new annual BH treatment slots. Awards announced in June 2022.

BHCIP Updates cont.

- **Round 4 - Children and Youth:** $480.5 million awarded 54 children and youth focused projects (includes 4 tribal entities) to support 29 new inpatient and residential facility sites to offer 498 new treatment beds, and 46 outpatient facilities to offer close to 74,000 new annual treatment slots. Awards announced in December 2022.
- **Round 5 - Crisis and BH Continuum:** $430 million awarded to 33 crisis and/or BH focused projects (includes 2 tribal entities) to support the addition of 29 new inpatient/residential facility sites to offer 774 new treatments beds, and 41 outpatient facilities to offer more than 84,000 new annual treatment slots. Awards announced in June 2023.
- **Round 6 - Unmet Needs** (In development)**:** This round of funding will be divided into two parts and totals $480 million for eligible tribal, county, city, and non-profit or for-profit organizations. Release of Request for Application for Round 6 Part I is anticipated in January 2024 and award announcements will follow in July 2024. Round 6 Part II is anticipated to follow the same timeframe in 2025.

BHCIP Rounds 1 to 5: Awarded Projects by Entity Type

- 124 County/City
- 10 For-profit Organization
- 68 Nonprofit Corporation
- 27 Tribal
- **Total Projects = 229**



Point in time data

Behavioral Health Bridge Housing (BHBH) Program

- Enacted in September 2022 under Assembly Bill 179 (Ting, Chapter 249, Statutes of 2022), providing a total of $1.5B in funding through June 30, 2027.
- Primary focus is to help people experiencing homelessness who have serious behavioral health conditions that prevent them from accessing help and moving out of homelessness.
- The following priorities drive the implementation of the BHBH Program:
  - This is a critical need, and the focus is on immediate solutions.
  - Collaboration will complement ongoing state, county, and tribal efforts to address homelessness.
  - BHBH Program settings will provide supportive services and housing navigation to assist people who have serious behavioral health conditions and are experiencing homelessness.

Four Funding Rounds

Round	Eligibility	Timeline
1	County behavioral health agencies	See awards
2	Tribal entities (planning track and implementation track)	RFA now open Deadline September 15, 2023
3	Competitive RFA for county behavioral health agencies and Tribal entities	Winter 2023-24 (information forthcoming fall 2023)
4	Competitive RFA for county behavioral health agencies and Tribal entities	Fall 2024 (information forthcoming fall 2023)

BHBH Program Tribal Entities Request for Applications

- **Opportunity and Focus:** This round of BHBH Program funding is making available $50,000,000 to tribal entities through two tracks:
- **Track 1:** Planning Grant:
  - Planning grant awards will be given for $150,000 for related planning activities.
- **Track 2:** Implementation Grant:
  - Implementation grant awards will be given for any amount up to $5 million. This option is intended for grantees to launch and operate a BHBH Program that addresses the immediate housing needs of the individuals in their communities' experiencing a serious behavioral health condition and homelessness.
- **Application Timeline:** Applications accepted through **September 15, 2023**

Benefits Division Update

Michael Freeman, Assistant Deputy Director
Health Care Benefits & Eligibility

DHCS

Telehealth

Telehealth Background

- **Telehealth**: The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.
- Telehealth is a cost-effective alternative to health care provided in-person, particularly to underserved areas.
- Telehealth is not a distinct service, but a way that providers deliver health care to their patients that approximates in-person care.
- The standard of care is the same whether the patient is seen in-person or through telehealth.

Key Telehealth Activities To Date

- Hosted Telehealth Advisory Workgroup
- Published final Telehealth Policy Paper
- Published final Research and Evaluation Plan on Telehealth
- Published Model Telehealth Patient Consent Language for Providers
- Updated Telehealth FAQs on DHCS Telehealth Web page
- Revised the Telehealth Provider Manual
- Submission of SPAs to seek federal approval to continue PHE provisions
- Trailer Bill Language and Legislative Language:
  - SB 184 (Chapter 47, Statutes of 2022)
  - AB 32 (Chapter 515, Statutes of 2022)

DHCS Guiding Principles

DHCS's permanent telehealth policy was informed by the following Guiding Principles:

- Equity
- Access
- Confidentiality
- Patient Choice
- Standard of Care
- Stewardship
- Payment Appropriateness

Medi-Cal & Telehealth: 2023 and Beyond

- Continue coverage of **synchronous video and audio-only telehealth** coverage across multiple services and delivery systems, including Tribal health providers as covered during the PHE.
- Continue coverage of **asynchronous telehealth** across many services and delivery systems including Tribal health providers.
- Continue **parity in reimbursement levels** between in-person services and select telehealth modalities.
- Continue to reimburse **Tribal FQHCs** at the Alternative Payment Methodology (set at the AIR) and **FQHCs/RHCs** at PPS rate for otherwise billable visits delivered via telehealth. Continue exemption from site limitations for patient or provider.
- **Modifiers 93, 95, and GQ** will be required for FQHC, RHC, IHS-MOA, and Tribal FQHC providers.
- **Enhance existing consent requirements** to require additional information be shared with beneficiaries.

Establishing new patients

- Providers may establish a relationship with new patients in-person or via synchronous video telehealth visits.
- Generally speaking, providers including Tribal FQHCs and IHS/MOAs may not establish a relationship with new patients via audio-only synchronous telehealth (i.e., over the phone), except for in the following instances:
  - The visit is related to sensitive services as defined in subsection (n) of Section 56.06 of the Civil Code.
  - The patient requests an audio-only modality.
  - The patient attests they do not have access to video.

New Telehealth Coverage Policies Effective No Sooner Than January 1, 2024

Policy Area	Description
Patient Choice of Telehealth Modality	The Department will phase in an approach that **requires a provider offer both video and audio-only telehealth to ensure patients have their choice of telehealth modality**. The Department will issue future guidance on exceptions to this requirement.
Patient Right to In-Person Services	The Department will phase in an approach where **providers who offer services via telehealth will be required to either offer those same services in-person and/or appropriately link the enrollee to in-person care.**

Telehealth Research and Evaluation Approach

Bi-Annual Report	DHCS plans to release a bi-annual report on telehealth that will help public stakeholders understand telehealth trends, visit volume, and how telehealth utilization compares to in-person visits.
Data Dashboard	DHCS will publish a Data Dashboard that allows users to stratify data by race, ethnicity, geography and other variables.
Open Data Portal	DHCS will publish a raw dataset that allows users to analyze telehealth claims and data.

Note - DHCS Telehealth Research and Evaluation Plan - [DHCS RE Plan (ca.gov)]

Dyadic Services Benefit

Dyadic Services

- Will allow FQHC, RHC and THP providers the option to be reimbursed for dyadic services provided to the parent(s) or caregiver(s) at fee-for-service or managed care Network Provider contracted rate.
- On March 30, 2023, State Plan Amendment was submitted to Centers for Medicare and Medicaid Services (CMS) and is currently being reviewed.
- Upon CMS approval, retroactive effective Date of March 15, 2023.

Dyadic Services

- Dyadic services are preventive behavioral health services for recipients under age 21 and/or their parent/caregivers
- Dyadic services refers to serving both the infant/child and the parent/caregiver(s) together as a dyad
- Billed to the Managed Care Plan with the child's Medi-Cal ID.

Dyadic Services

Dyadic services for recipients under age 21 include:

- Dyadic Behavioral Health (DBH) Well-Child Visits
- Other Support Services
  - Dyadic Comprehensive Community Support Services, per 15 minutes
  - Dyadic Psychoeducational Services, per 15 minutes
  - Dyadic Family Training and Counseling for Child Development Services, per 15 minutes

Dyadic Services

Dyadic parent/caregiver services include the following assessment, screening, counseling, and brief interventions services provided to the caregiver for the benefit of the child:

- ACE screening
- Alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT)
- Brief emotional/behavioral assessment
- Depression screening
- Health behavioral assessments and interventions
- Psychiatric diagnostic evaluation
- Tobacco cessation counseling

Doula Services Benefit

Doula Enrollment

- Doulas enroll as providers through the Provider Application and Validation for Enrollment (PAVE) portal.
- Doulas need to contract with a member's managed care plan to receive reimbursement for services to them.
- Information about enrolling and billing:
  - https://files.medi-cal.ca.gov/pubsdoco/doulas.aspx

Doulas and Tribal Clinics

- A Tribal clinic may use doulas to provide services, but doulas are not considered Indian Health Services-Memorandum of Agreement 638 clinic providers.
- Therefore, doula services will not be considered billable encounters and will not be eligible for reimbursement at the federal AIR.
- However, reimbursement for doula services will be available at FFS rates outside of the federal AIR or Tribal FQHC Alternative Payment Methodology (which is set at the AIR).

Doulas and FQHCs

- Doulas are not considered Federally Qualified Health Centers (FQHC) providers so their services will not be considered billable encounters and will not be eligible for Prospective Payment System rate reimbursement.
- However, FQHCs may offer services provided by doulas. Some FQHCs may have some costs for doula services built into their PPS rate.
- FQHCs that choose to add doula services for clinic patients, may qualify for a Change in Scope of Services Request if they meet specific criteria as required in the statute.

Doula Services – Stakeholders and Implementation

- DHCS convened a new doula stakeholder workgroup March 30, 2023, to review the Department's implementation of the doula benefit.
- The Doula Implementation Workgroup is required by Senate Bill 65, which added section 14132.24 to the Welfare and Institutions Code.
- Workgroup will meet through June 2025 and inform a report of recommendations to be issued by DHCS.

Input from Tribal Members

- RACE For Equity conducted focus groups with tribal members to hear about their birthing experiences.
- We will continue work with RACE for Equity to examine disparities.
- We want to include voices of tribal members in the recommendations from Doula Implementation Workgroup for the report due in 2025.

Community Health Representatives (CHR) Services Benefit

CHR Services

- Became a benefit on July 1, 2022.
- Available in fee-for-service and managed care delivery systems.
- CHRs are included under the umbrella term of community health workers (CHW) in Medi-Cal
  - CHWs include Promotores, Navigators, and other non-licensed public health workers, including Violence Prevention Professionals.
- CHRs are trusted members of their community who help address chronic conditions, preventive health care needs, and health-related social needs.

CHR Qualifications:

- CHRs need to meet the qualifications listed in the State Plan, as determined by supervisor:
  - Training Pathway: Certificate demonstrating skills and/or practical training in core skills
  - Experience Pathway: 2,000 hours in volunteer or paid capacity within previous three years, and must earn certificate of completion demonstrating skills and/or practical training in core skills
  - Six hours of additional training annually

CHR/CHW Supervision

- Services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.
- CHRs must supervised by a provider who bills on their behalf – licensed provider, clinic, hospital community-based organization (CBO), or local health jurisdiction (LHJ).
- DHCS is working to create CBOs and LHJs as new provider types in 2024.
- Managed care plans can contract with CBOs before there is a pathway for them to enroll with DHCS.

CHRs and Tribal Clinics

- A tribal clinic may use CHRs/CHWs to provide services, but CHRs/CHWs are not considered Memorandum of Agreement 638 clinic providers.
- Therefore, CHR/CHW services will not be considered billable encounters and will not be eligible for reimbursement at the federal All-Inclusive Rate (AIR).
- The federal AIR includes costs for services delivered by the clinic, which may include services provided by CHRs/CHWs at the clinic's discretion.

CHRs and FQHCs

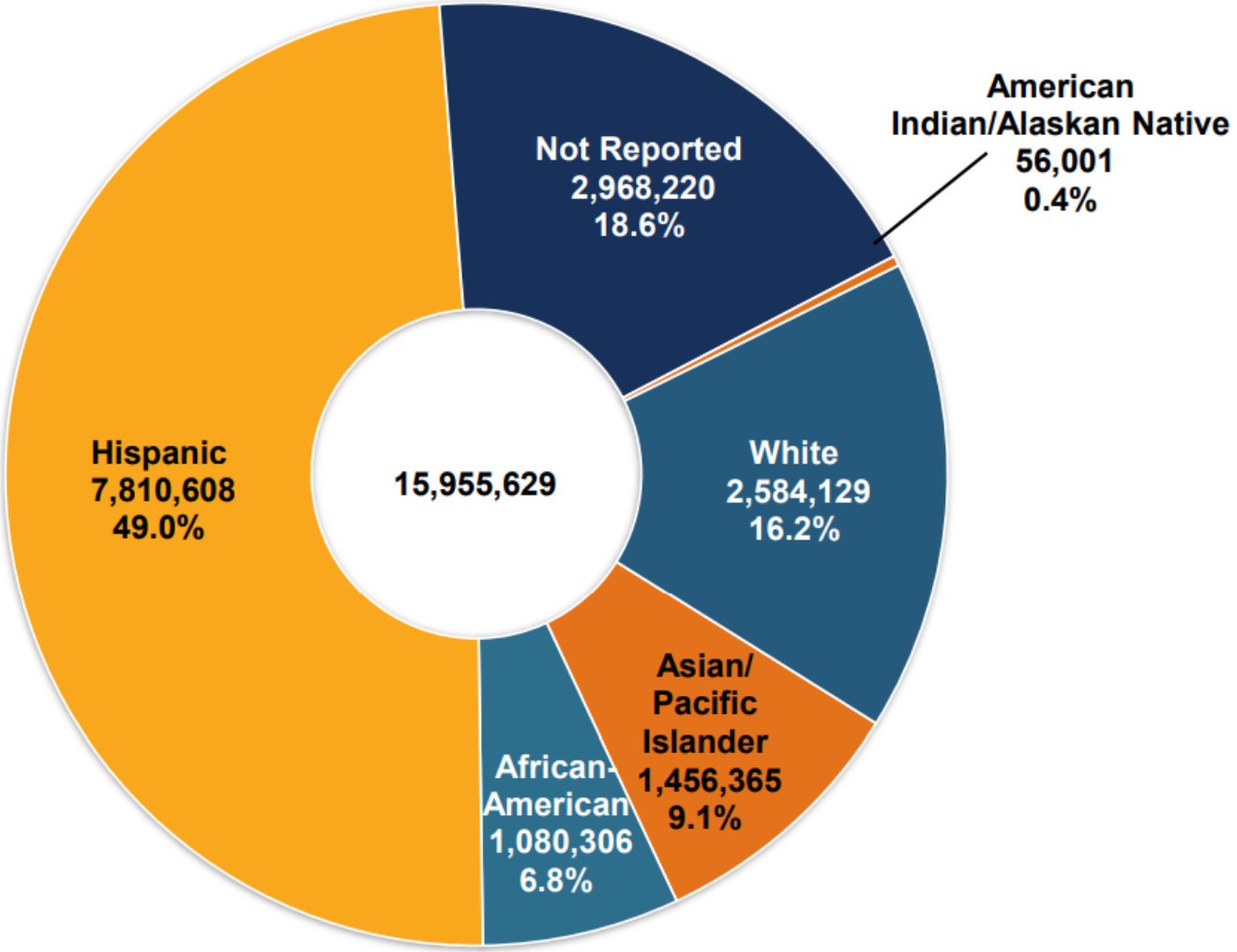
- CHRs/CHWs are not considered FQHC providers so their services will not be considered billable encounters and will not be eligible for Prospective Payment System (PPS) rate reimbursement.
- Some FQHCs may have some costs for CHR/CHW services built into their PPS rate.
- FQHCs that choose to add CHR/CHW services for clinic patients may qualify for a Change in Scope of Services Request (CSOSR) under Welfare Institutions Code Section 14132.100 (e)(3)(B) if they meet specific criteria as required in the statute.

Office of Tribal Affairs Update

Andrea Zubiate, Chief
Office of Tribal Affairs

DHCS

American Indians/Alaskan Native Medi-Cal Members as of April 2023



Source: [Medi-Cal Monthly Eligibles Fast Facts]

American Indian Medi-Cal Redetermination Campaign Release for Tribal Partner Feedback

- Draft materials sent for tribal partner review and feedback on 8/8.
- Feedback is due back to DHCS by COB on 8/22 (tomorrow)
- DHCS would like to acknowledge the California Rural Indian Health Board, Inc. who provided the California tribal artwork utilized in these outreach materials

Medi-Cal Enrollment Navigators

- The DHCS Navigators Project released Bulletin 2023-008: Assisting Tribal Health Programs and Urban Indian Organizations with Medi-Cal Unwinding to its partners on Friday, August 17, 2023.

- Tribal partners wishing to contacting Navigators Project partners directly should refer to SB 154 Project Partner Contact Information; or can reach out to Navigators subcontracts and local CBOs identified in the SB 154 Subcontractors and Local CBO Assistance document

Indian Health Grant Program Update

- Total of 27 grantees for Round 1 and 2 of the IHP RFA
- Total funds awarded for both rounds is $10,376,000
- To date, OTA has processed payment requests of $3,207,604
- Grantees are encouraged to send payment request letters as soon as possible. If you need additional information or a copy of the payment letter instructions and template, please email TribalAffairs@dhcs.ca.gov
- OTA has also awarded 4 Traditional Indian Health (TIH) Educational Grants to grantees in Southern, Central, and Northern California and 1 statewide Urban program
- Total funds awarded for TIH is $400,000

Future Funding Release

- Available funds for year 2 total $23,376,000
- Year 2 award amounts to be released in December/January
- OTA will work with existing grantees to amend grants as necessary for new award amounts and will consider an additional RFA release for unfunded programs
- Initial IHP funding is multi-year and available until June 30,, 2025
- IHP was awarded $22.6 million ongoing beginning in FY 2024-2025
- OTA will work with the American Indian Health Policy Panel (AIHPP) for funding recommendations and use of ongoing funds once the panel is appointed.

American Indian Health Policy Panel (AIHPP) Update

- 8 nomination packets will go to DHCS Director for appointment by 8/31. There are still 2 urban Indian vacancies.
- Nominees that are employees of nominating bodies will need to complete an Attestation of Personal Representation. This attestation affirms that the individual is serving on the AIHPP as a representative of their tribe and not as representative of either nominating entity.
- OTA is planning the first convening of the AIHPP prior to the next Tribal and Indian health representatives meeting in November.

Thank you for attending.

DHCS