Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services

August 29, 2025

(virtual)

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Welcome, Introduction of Tribal Leaders, and Review of Agenda

Yingjia Huang, Deputy Director
Health Care Benefits & Eligibility

DHCS

Welcome and Webinar Logistics

Microsoft Teams Tips

- 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 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 Microsoft Teams 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"

CalAIM Section 1115 Waiver Renewal Update

Tyler Sadwith
State Medicaid Director

DHCS

Continuing the Transformation of Medi-Cal: Concept Paper Overview

DHCS released the concept paper on July 23. Initial comment period closed on August 26

- The Concept Paper:
  - Summarizes California's efforts to date to transform Medi-Cal.
  - Outlines the Department's principles and goals for Medi-Cal for 2027 and beyond.
  - Includes preliminary plans for advancing the renewal of CalAIM Section 1115 and 1915(b) waivers, which are set to expire on December 31, 2026.
- The paper was informed by a series of in-person listening sessions, virtual Medi-Cal Member Advisory Committee meetings, and standing forums (e.g., CalAIM Implementation Advisory Group, CalAIM Behavioral Health Workgroup, stakeholder meetings, etc).
- Stakeholders included Medi-Cal members, community-based organizations (CBOs), Tribal partners and Urban Indian providers, managed care plans (MCPs), county behavioral health plans (BHPs), public health agencies, sheriff's departments, probation agencies, housing service providers, health care providers, and advocates.

DHCS' principles and goals for Medi-Cal may evolve based on policy developments at the federal and state level.

Medi-Cal's Transformation To Date

Over the next five years, starting in 2027, DHCS seeks to build upon California's existing efforts to transform Medi-Cal.

California Advancing and Innovating Medi-Cal(CalAIM)

DHCS implemented a range of initiatives to **advance whole person care and address social drivers of health**. As part of the Section 1115 and 1915(b) waiver renewals, DHCS proposes to continue key CalAIM components such as **Enhanced Care Management, Community Supports, the Justice-Involved Initiative, Drug Medi-Cal Organized Delivery System, Traditional Healers and Natural Helpers, and the Global Payment Program**, among others.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

DHCS expands the continuum of behavioral health care through BH-CONNECT. Key initiatives include **Workforce Investments, Transitional Rental Assistance, Activity Funds, Access, Reform, and Outcomes Incentive Program, Community Transition In-Reach Services**, and **federal funding for short-term mental health care provided in institutions for mental diseases**. California also expanded Medi-Cal coverage of evidence-based practices.

Behavioral Health Transformation

DHCS continues to invest in SUD and mental health delivery systems through Behavioral Health Transformation, which includes **funding supports for people with significant behavioral health needs, expanded behavioral health services, and enhanced focus on outcomes, accountability and equity**.

Behavioral Health Transformation also includes investments in treatment sites and permanent supportive housing.

Overview of Principles and Goals

This Concept Paper outlines key guiding principles and proposes new goals that are central to DHCS' efforts to continue the core commitments of CalAIM, and to enhance the Medi-Cal member experience.

Principles for Medi-Cal Transformation (1 of 2)

Centering Medi-Cal Members across programs and initiatives: Placing Medi-Cal members at the heart of DHCS' programs ensures members' needs and experiences drive DHCS policies, initiatives, and implementation approach. This member-centered approach fosters a more responsive and inclusive health care system, with the goal of improving access, health outcomes, and member experience.

Strengthening and building on DHCS' current initiatives and accomplishments to date: DHCS and its partners have collectively established a strong foundation for the future of Medi-Cal transformation, and DHCS recognizes that its partners are undergoing massive change management processes to implement significant new initiatives. By re-committing to the initiatives DHCS has undertaken under CalAIM, the Department will be able to continue momentum and ensure continuity and stability in programs that are making a difference to Medi-Cal members today.

Doubling down on initiatives backed by data and evidence: Utilizing data and evidence to inform DHCS' initiatives ensures that the Department's decisions are grounded in proven strategies and best practices. This evidence-based approach enhances the effectiveness of DHCS' programs, leading to more efficient resource allocation.

Principles for Medi-Cal Transformation (2 of 2)

Improving program efficiency: Streamlining processes and reducing administrative burdens allows DHCS, providers, plans, and other partners to deliver services more effectively and efficiently. This focus on efficiency helps to maximize the use of available resources, reduce costs, and improve the overall performance of DHCS' programs.

Investing in initiatives that are scalable: By investing in scalable initiatives, DHCS ensures that successful programs can be expanded and replicated across different regions and populations. This scalability allows DHCS to extend the benefits of the Department's initiatives to a larger number of Medi-Cal members and for stakeholders to learn from each other's experiences and progress, promoting equity and access to high-quality care.

Goals for Medi-Cal Transformation

Centering Members Within the Delivery System: Ground Medi-Cal policies and programs in member-centered design principles, and create networks of community-embedded providers to deliver high-quality, culturally responsive, whole-person care that optimizes the member experience.

Improving Eligibility and Enrollment: Help eligible Californians get and keep Medi-Cal coverage through application and eligibility processes that are efficient, accurate, and respectful.

Comprehensive Purchasing Strategy: Establish a comprehensive Medi-Cal purchasing strategy that incentivizes plans and providers to deliver: the right care, at the right time, in the right place, at the right cost.

Increasing Data Sharing: Improve data sharing among plans, providers, and partners within the Medi-Cal ecosystem to support stronger data-informed care, care coordination, and member experiences.

Strengthening Accountability: Strengthen and enforce accountability across the Medi-Cal delivery system (fee-for-service, managed care, and BHPs) to improve member access, experience, quality, and outcomes.

Preparing for the Future: Prepare Medi-Cal to meet the needs of the aging population in 2030 and beyond.

American Indian Proposals Included In CalAIM Section 1115 Waiver Renewal

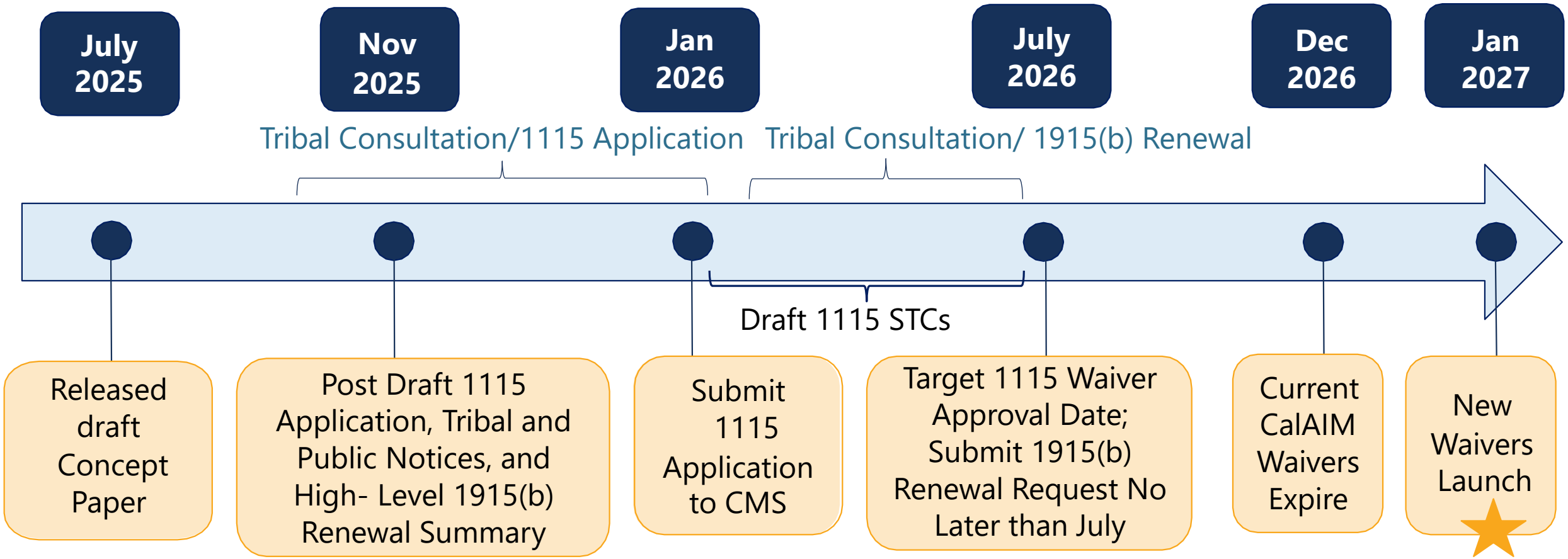
- **Traditional Healers and Natural Helpers:** Culturally appropriate care for members with substance use disorder receiving care at Indian Health Service, Tribal, or Urban Indian Organization facilities.
- **Chiropractic Services from IHS and Tribal Facilities:** Chiropractic services furnished by Indian Health Service and tribal providers to Medi-Cal members.

CalAIM Section 1115 Waiver Renewal and Tribal Consultation

- Comment period on concept paper closed on 8/23/25.
  - DHCS acknowledges receipt of feedback from the California Consortium for Urban Indian Health and Bakersfield American Indian Health Project
- DHCS will follow the DHCS Tribal Advisory Process for seeking input from Tribes and Tribal Partners which includes opportunity for written and verbal feedback on the CalAIM Section 1115 Waiver renewal prior to submission to CMS.
- Tribes can also request consultation on DHCS proposals at any time.

Waiver Renewal Timeline

DHCS will embark on a planning process over the coming months, including drafting a concept paper and drafting/submitting California's next 1115 and 1915(b) waivers.



Questions?

DHCS Director's Update

Michelle Baass
DHCS Director

DHCS

2025-26 Budget Updates

2025-26 Budget Act Update

- DHCS' enacted budget is $202.7 billion in total funds.

- The Medi-Cal budget includes $179.1 billion ($37.4 billion General Fund) in 2024-25 and $196.7 billion ($44.9 billion General Fund) in 2025-26. Medi-Cal is projected to cover approximately 15 million Californians in 2024-25 and 14.9 million in 2025-26—more than one-third of the state's population.

2025-26 Budget Act Update

» To address a statewide budget shortfall, solutions included:

- **Freeze on enrollment** for full scope, state-only Medi-Cal expansion undocumented adults, ages 19 and older.
- State-only **Medi-Cal premiums of $30** for adults 19-59 with unsatisfactory immigration status (UIS).
- Elimination of state-only **Prospective Payment System** rates for Federally Qualified Health Centers and Rural Health Clinics for members with UIS.

2025-26 Budget Act Update

- **Elimination of dental benefits** for UIS adults, ages 19 and older.
- Reinstatement of the **Medi-Cal Asset Test Limit**, effective January 1, 2026.
- Elimination of $362 million in 2026-27 and ongoing in **dental supplemental payments**.

2025-26 Budget Act Update

- Pharmacy changes include:
  - Implementation of a **rebate aggregator** to secure rebates for members with UIS.
  - **Elimination of coverage for Glucagon-Like Peptide-1 (GLP-1)** for weight loss and certain over-the-counter drugs.
  - Implementation of **prescription drug utilization management**, step therapy protocols, and prior authorization for certain prescription drugs.

2025-26 Budget Act Update

- **Proposition 36** implementation funding of $50 million to provide non-competitive grants to county behavioral health departments.
- **Title X funding restoration** of $15 million to replace lost funding for family planning providers.
- **988 Suicide and Crisis Lifeline Centers** one-time funding totaling $17.5 million.
- **Next Generation Digital Therapeutics** funding as part of the Children and Youth Behavioral Health Initiative (CYBHI), totaling $2 million.
- $2 million in funding to support **Adverse Childhood Experiences (ACEs)** provider trainings.

Major Impacts to Medi-Cal of Enacted H.R.1 Reconciliation Legislation

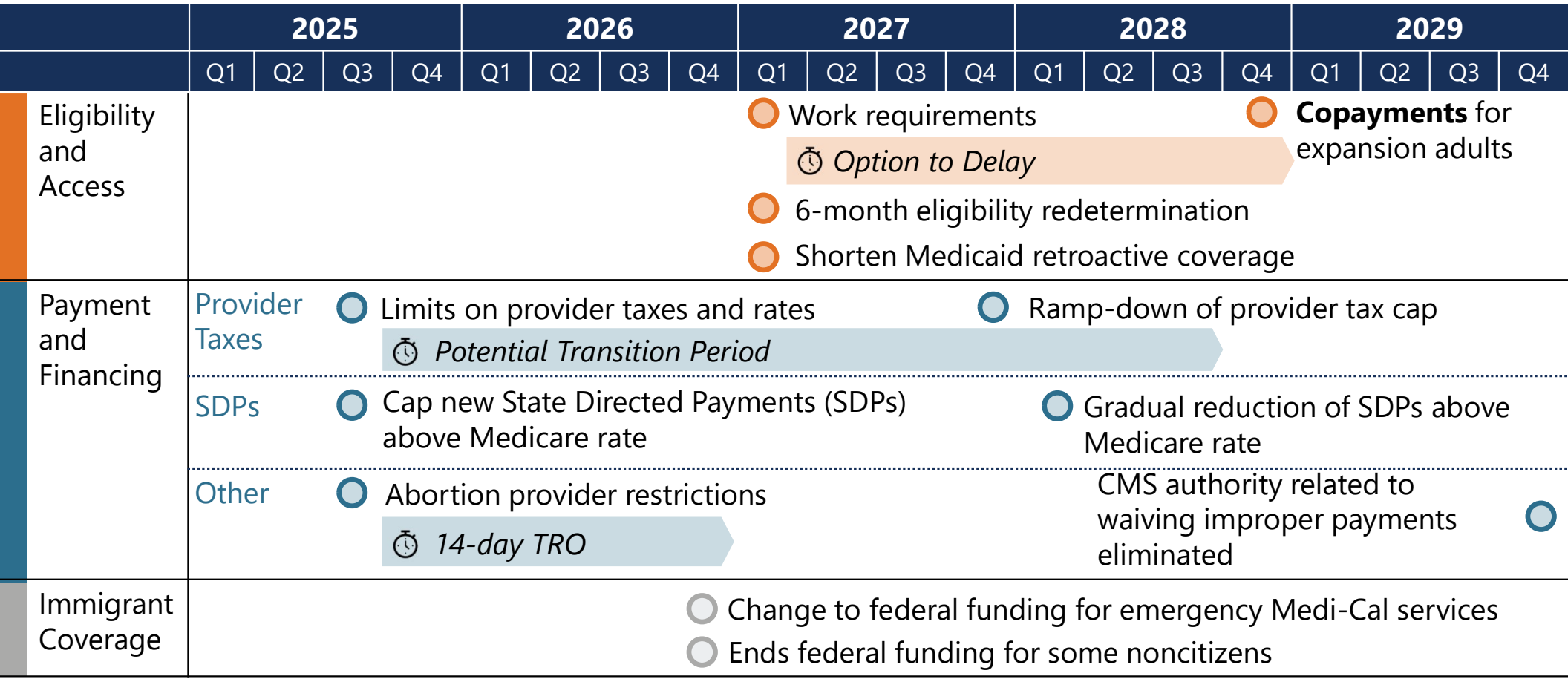
Major Medicaid Provisions of H.R.1

**Bottom Line: Up to 3.4 million Medi-Cal members may lose coverage;
$30+ billion in federal funding is at risk annually;
major disruption in Medi-Cal financing structure for safety nets.**

Eligibility/Access Requirements	State Financing Restrictions	Immigrant Coverage Limitations	Abortion Providers Ban
» Work requirements » 6-month eligibility checks » Retroactive coverage restrictions » Cost sharing	» Managed Care Organization (MCO) and Provider Tax limitations » State Directed Payment (SDP) restrictions » Federal funding repayment penalties for eligibility-related improper payments	» Reduction in FMAP* for emergency UIS** » Restrictions on lawful immigrant eligibility (increases UIS) ** Federal Medical Assistance Percentage* ***Unsatisfactory immigration status*	» One-year ban on federal Medicaid funding for "prohibited entities" that provide abortion services

All numbers are estimates and subject to change.

Effective Dates for Key Provisions



Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Eligibility and Access

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JANUARY 1, 2027:** Implement **mandatory work requirements** for Medicaid expansion adults ages 19 to 64.

  *State option to delay implementation until **December 31, 2028,** with Secretary approval.*

- **JANUARY 1, 2027:** **Redetermine eligibility** for expansion adults once every 6 months.
- **JANUARY 1, 2027:** Shorten Medicaid **retroactive coverage**; provide Children's Health Insurance Program (CHIP) retroactive coverage at state option.
- **OCTOBER 1, 2028:** Impose **copayments** on most services for expansion adults with incomes above 100% of the federal poverty level (FPL).

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Payment and Financing (*Provider Taxes)*

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JULY 4, 2025:**
  1. Prohibits implementation of any new Medicaid provider taxes and increasing existing tax rates.
  2. Prohibits any tax that imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to providers with higher Medicaid volumes, or taxes Medicaid units of service at a higher rate than non-Medicaid units of service (as well as taxes that have the same effect) – impacts Managed Care Organization (MCO) tax and Hospital Quality Assurance Fee (HQAF).

- **OCTOBER 1, 2027:** Ramp-down of **provider tax** cap begins, with the 6% tax threshold reduced by half a percentage point per year until the threshold hits 3.5% in 2032.

⏱ *CMS may allow for a transition period of up to **3 years***

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Payment and Financing (*SDPs and Other)*

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JULY 4, 2025:** Caps any future State-Directed Payments **(SDPs)** at 100% of Medicare payment levels.

- **January 1, 2028:** Requires states with existing **SDPs** above Medicare rates to reduce payments by 10 percentage points per year until they are no greater than 100% of Medicare.

- **JULY 4, 2025– July 4, 2026:** Bars Medicaid participation by certain **providers of abortion services.**

  14-day Temporary Restraining Order (TRO)

- **OCTOBER 1, 2029: Eliminates CMS authority to waive states' disallowance of federal funds** associated with "excess" improper payments.

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Immigrant Coverage

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **OCTOBER 1, 2026:**
  Provides regular **Federal Medical Assistance Percentage (FMAP) for emergency Medi-Cal.**

- **OCTOBER 1, 2026:**
  Ends the availability of federal Medicaid and CHIP funding for **refugees, asylees, and certain other noncitizens.**

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Eligibility/Access Requirements

Eligibility: Work Requirements

Section 71119: Requires states to condition Medicaid eligibility on compliance with work requirements (called "community engagement requirements") for adults ages 19 through 64. The provision applies to individuals enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage.

Exemptions must be verified every 6 months

Effective *Parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 and under or a disabled individual; medically frail individuals; pregnant/receiving Medicaid postpartum coverage; foster/former foster youth under age 26; American Indian and Alaska Native individuals; veterans with a disability rated as total; incarcerated or recently released within 90 days, Medicare Part A/Part B; meet Temporary Assistance for Needy Family or Supplemental Nutrition Assistance Program work requirements; drug addition/alcohol treatment program*

Date: January 1, 2027

Impact:

An estimated **up to 3 million Medi-Cal members may lose coverage**, which will significantly drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: 6-Month Eligibility Checks

Section 71107: Requires states to redetermine eligibility for adults enrolled through Medicaid expansion or an expansion-like section 1115 waiver once every six months.

Effective Date: January 1, 2027

Impact:

An estimated **400,000 Medi-Cal members may lose coverage**, which will drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: Retroactive Coverage

Section 71112: Shortens Medicaid retroactive coverage from three months to one month for expansion adults and two months for all other Medicaid applicants. This provision also allows states to provide two months of CHIP retroactive coverage. (Currently, CHIP does not have retroactive coverage, and services may only be paid in the month of the application.)

Effective Date: January 1, 2027

Impact:

An estimated **86,000 Medi-Cal members/ year would be affected** by this policy and receive 1 month of retroactive coverage, rather than 3 months.

All numbers are estimates and subject to change.

Eligibility: Cost Sharing

Section 71120: Requires states to impose cost sharing for services provided to Medicaid expansion adults with incomes above 100% of the FPL ($15,560 per year). States would decide the amount, not exceed $35 per service and subject to an aggregate limit of 5% of family income.* Cost sharing must not apply to exemptions under current law or to primary care services, behavioral health services, federally qualified health center services, rural health clinic services, and certified community behavioral health clinic services.

Effective Date: October 1, 2028

*Note: For drugs, cost sharing must be $4 (preferred) and $8 (non-preferred); for non-emergent services received in the hospital emergency department, cost sharing must be no more than $8. (This is as of 2015 and adjusted for inflation over time.)

Impact:

- The cost sharing requirement will limit access (e.g., due to members delaying or forgoing care, confusion about new requirements) among the Medicaid expansion population.
- Providers will likely see an increase in uncompensated care.

All numbers are estimates and subject to change.

State Financing Restrictions

Provider Tax Limitations

Section 71115 and 71117:

- Prohibits any new Medicaid provider tax or increases to existing tax rates (for both local- and state-imposed taxes).
- Prohibits any tax that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes, or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. Also prohibits taxes that have the "same effect" as in (1) or (2) above.
- Modifies the provider tax cap whereby the 6% tax threshold must be reduced by half a percentage point per year until the threshold hits 3.5%.

Effective Date: Moratorium effective immediately; phase-down beginning October 1, 2027.

Impact:

- CA's current MCO tax structure is non-compliant under these new parameters and will need to be modified to align with the new federal standards (though it may be challenging to do so without decreasing the revenue from the tax).
- The new constraints jeopardize other major provider taxes, including the Hospital Quality Assurance Fee, threatening revenue streams.
- Going forward, these limitations may undermine CA longstanding strategy to finance the non-federal share of Medi-Cal.

All numbers are estimates and subject to change.

State Directed Payment Restrictions

Section 71116: Caps any future SDPs at 100% of Medicare payment levels. Requires payments with existing SDPs above Medicare rates to be reduced by 10 percentage points per year until the SDPs are no greater than 100% of Medicare payment levels.

Effective Date: Immediately for new SDPs; reduction in existing SDPs starting January 1, 2028

Impact:

- Limits CA's ability to use SDPs to increase provider payment rates above Medicare levels, which may reduce provider participation and access in Medicaid.
- Constrains CA's ability to raise the non-federal share of Medicaid funding, potentially pressuring other areas of the budget.
- Limits future SDP increases, including for public hospitals and private hospitals, all of which have inpatient and/or outpatient rates exceeding Medicare.

All numbers are estimates and subject to change.

Mitigation: Rural Health Transformation Fund

Section 71401: Establishes $50 billion funding program to mitigate federal funding cuts on rural health providers.

Funding Disbursement: CMS will allocate $10 billion each FY for FY 2026-2030.

Funding Distribution:

- 50% distributed equally across states with approved applications
- 50% distributed to states per CMS discretion, pursuant to specific rural impact factors (e.g. state's % of rural residents; share of rural health facilities in the state compared to nationwide), with at least 25% of states with an approved application included.

Allowable Uses: CMS and states have flexibility to decide (1) allowable uses, and (2) eligible recipients (recipients and benefitting providers are not limited to rural health care facilities used in the funding distribution criteria). States must implement at least three activities specified (e.g., prevention and disease management; training and technical assistance; recruitment; etc.).

Limitations: Cannot be used as non-federal share of Medicaid payments. Admin cap 10%.

Next Steps:

- State to submit application (including a detailed rural health transformation plan) by TBD deadline, no later than December 31, 2025.
- CMS required to approve by December 31, 2025.

All numbers are estimates and subject to change.

Federal Funding Repayment Penalties

Section 71106: Except in limited cases involving the Medicaid "spend down" group and when there is insufficient documentation to confirm eligibility, the law eliminates CMS' ability to waive federal penalties associated with improper payments related to eligibility even when states are making a good faith effort to address them. CMS is also required to issue disallowances upon identifying improper payments under federal audits beyond Payment Error Rate Measurement (PERM), as well as, at the option of the Secretary, state audits.

Effective Date: October 1, 2029

Impact:

CMS may claw back federal funds from CA, even if the state is implementing a corrective action plan to reduce errors, increasing financial risk.

All numbers are estimates and subject to change.

Immigrant Coverage Limitations

Reduction in FMAP for Emergency Medi-Cal

Section 71110: Prohibits states from receiving the 90% enhanced matching rate for emergency services provided to individuals who, but for their immigration status, would have qualified for the ACA optional adult expansion group. Also applies to emergency care provided to refugees, asylees, and other lawfully residing individuals.

Effective Date: October 1, 2026

Impact:

- CA will lose the 90% federal match for emergency Medicaid services, requiring increased General Fund spending and/or a rollback of services covered under the emergency Medicaid benefit.
- May increase financial pressure on safety-net providers, particularly hospitals that deliver high volumes of emergency care to noncitizens.

All numbers are estimates and subject to change.

Restrictions on Lawful Immigrant Eligibility for Medi-Cal

Section 71109: Ends the availability of full-scope federal Medicaid and CHIP funding for most refugees, asylees, victims of human trafficking, certain individuals whose deportation is being withheld or who were granted conditional entry, or individuals who received humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.

Effective Date: October 1, 2026

Impact:

Approximately **200,000 immigrant Medi-Cal members** will shift from satisfactory immigration status (SIS), which is eligible for full Federal Financial Participation (FFP), to unsatisfactory immigration status (UIS), which is only eligible for emergency and pregnancy-related FFP – at the newly reduced rates noted in prior slide.

All numbers are estimates and subject to change.

Abortion Providers Ban

One-year Ban on Federal Funding for "Prohibited Entities" that Provide Abortion Services

Section 71113: Bars Medicaid participation by certain providers of abortion services, including Planned Parenthood, for the one-year period following enactment (through July 2026).

Effective Date: Effective immediately.

***Note: At the end of July, two preliminary injunctions were issued that blocks the Trump Administration from implementing this provision nationwide for certain providers.*

Impact:

- In CA, roughly 80% of Planned Parenthood patients rely on Medi-Cal, meaning this proposal would effectively strip $305 million in federal funding from one of the state's largest providers of reproductive health care.
- Loss of federal Medicaid funding may force Planned Parenthood to reduce services, limit appointments, or close centers—particularly in underserved areas.

All numbers are estimates and subject to change.

Behavioral Health (BH) Update

Paula Willhelm
Deputy Director

DHCS

Update on Implementation of Traditional Healers and Natural Helpers

Agenda

- Implementation Updates
- Next Steps
- Resources
- Q&A

Traditional Health Care Practices

Background

Timeline

» **October 16, 2024**

CMS approves traditional health care practices through Medi-Cal

» **March 21, 2025**

DHCS releases guidance (BHIN 25-007)

» **April 2025**

TA activities begin; Post-BHIN release webinar

» **June-July 2025**

FAQs published; additional implementation webinars hosted

» **Fall 2025**

DHCS releases updated residential facility billing guidance

» **2025-2026**

Ongoing technical assistance for IHCPs and DMC-ODS Counties

Implementation Updates

Opt-in Package Update

- As of 8/26, DHCS has received **11 opt-in submissions from IHCPs:** 7 are approved; 4 are in progress.

IHCP	Status
Indian Health Center of Santa Clara Valley (IHCSCV)	Approved
Santa Ynez Tribal Health Clinic	Approved
American Indian Health & Services, Inc.	Approved
Friendship House	Approved
United Indian Health Services, Inc	Approved
Southern Indian Health Council	Approved
Native American Health Center	Approved
Fresno American Indian Health Project	Pending submission of additional materials
K'ima:w Medical Center	Pending submission of additional materials
Pit River Health Service	Pending submission of additional materials
Bakersfield American Indian Health Project	Pending DHCS review

THCPs in Residential Facilities

- **DHCS is finalizing policy guidance on billing and claiming for THCPs provided in residential treatment settings.**
- The draft policy is informed by Tribal partners and will be posted for feedback in the coming weeks.
- Draft policy highlights:
  - Traditional Healer/Natural Helper (TH/NH) services may be delivered as part of a Medi-Cal covered treatment program in an approved IHCP that provides residential SUD treatment and bills a daily rate for residential treatment services.
  - Approved IHCPs that offer residential SUD treatment may also bill for additional (supplemental) Traditional Healer/Natural Helper (TH/NH) services for eligible members.
  - DHCS will cover up to 12 supplemental TH/NH services per month, with exceptions for medical necessity.
  - These supplemental services may be billed in addition to the daily residential rate.

Draft policy/Pre-decisional – subject to change

Post-implementation policy clarifications

DHCS continues clarifying guidance via FAQs posted to the webpage. In response to stakeholder questions, DHCS has clarified the following:

- **Eligible facilities**: Indian Health Care Providers (IHCPs), including Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations (Tribal facilities) under the Indian Self-Determination and Education Assistance Act (ISDEAA), and Urban Indian Organizations (UIOs).
- **Provider requirements**: Taxonomy codes/NPIs are not required for individual Traditional Healer/Natural Helper practitioners (unless eligible/seeking to bill at the IHS All-Inclusive Rate).

DHCS will continue to clarify via updated FAQs, as needed.

Technical Assistance Overview

DHCS continues to coordinate with Technical Assistance (TA) Tribal partners CCUIH, CRIHB, and Kauffman & Associates to facilitate and coordinate TA. TA provided since March 2025 includes:

- **Webinars/presentations:** *Post-BHIN release webinar (April 2025), IHCP Working Session (June 2025), County Webinar (June 2025), and numerous community presentations.*
- **Published 20+ FAQs** with an additional 12 FAQs posting soon.
- **1:1** TA support for IHCPs navigating opt-in and implementation process.
- **Ongoing support** for IHCPs and counties requesting support via the THCP inbox and TA portal.

TA is available at no additional cost to interested IHCPs and counties. To request assistance, reach out to the THCP inbox at TraditionalHealing@dhcs.ca.gov or use the Technical Assistance portal (operated by Kauffman and Associates).

Waiver Evaluation and Monitoring

- **CMS will conduct ongoing monitoring of the state's implementation based on DHCS reporting, and DHCS is working with an independent evaluator (University of Southern California (USC)) to evaluate demonstration outcomes.**
  - Evaluation goals: Examining whether the initiative increases access to culturally appropriate care for members served by IHCPs.
  - DHCS will monitor data related to the delivery of traditional health care practices (e.g., # of participating IHCPs; # of members served), as required by CMS.
  - ***Metrics are not intended to determine effectiveness of services or specific traditional practices.***
  - DHCS and USC are coordinating with CMS, Tribes, Tribal partners and DMC-ODS counties to develop and finalize evaluation design for submission to CMS 8/29.
  - Once approved, DHCS will post on webpage within 30 days.

DRAFT Evaluation Design: Potential Evaluation Questions

- Did THCP implementation improve access to culturally responsive care for AI/AN Medi-Cal members?
  - How many facilities and practitioners are providing THCP under the demonstration?
  - How many American Indian and Alaska Native (AIAN) and/or other Medi-Cal members who meet DMC-ODS access criteria received THCP?
- Did THCP implementation improve or sustain perceived health and well-being of Medi-Cal members with SUD or suspected SUD?

DRAFT Evaluation Design: Potential Metrics (not exhaustive)

- Number of IHS, Tribal, and Urban Indian Organization facilities providing THCPs
  - Survey data on barriers to participation for ICHPs
- Number of practitioners offering THCPs
- Number and percentage of individuals receiving THCPs
  - Qualitative survey data on different practices offered
- Self-reported well-being and health, spirituality, and feelings of cultural connectedness
- Levels of member satisfaction with THCP services
- Engagement in other DMC-ODS services/connectedness to healthcare system

Draft policy/Pre-decisional – subject to change

Next Steps

Summary and Next Steps for Traditional Health Care Practices

- **Additional TA:** DHCS will continue to coordinate with Tribal TA partners to offer TA, including targeted 1:1 support to IHCPs and DMC-ODS counties.
- **THCPs in Residential Settings Policy:** An amended BHIN will be released for feedback prior to being finalized and published in fall 2025.
- **FAQs:** FAQs are posted and will be updated as needed based on stakeholder questions and feedback
- **Evaluation:** The evaluation design will be posted once approved by DHCS.

Resources

Resources

- Traditional health care practices webpage
  - Includes Frequently Asked Questions, previous presentations, approved IHCPs, DMC-ODS County points of contact and other guidance materials and resources.
- BHIN 25-007
- TraditionalHealing@dhcs.ca.gov
- Technical Assistance (TA) Portal

Questions?

TraditionalHealing@dhcs.ca.gov

DHCS Traditional Health Care Practices Webpage

Technical Assistance (TA) Portal

California's Naloxone Distribution Project

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Agenda

- Summary of the Naloxone Distribution Project (NDP)
- NDP Outcomes
- Applying to the NDP
- Reminder for upcoming webinar

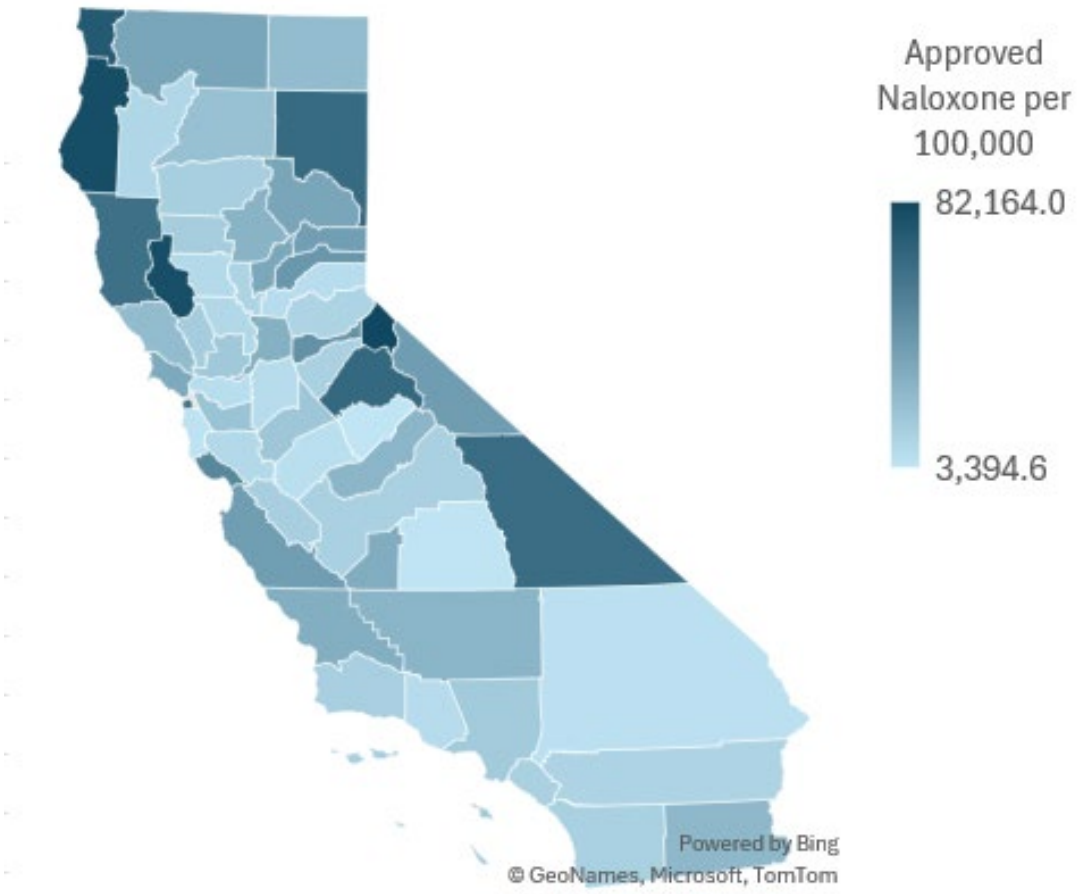
The Naloxone Distribution Project (NDP)

- In 2018, DHCS created the Naloxone Distribution Project (NDP) to combat opioid overdose-related deaths throughout California.
- The NDP aims to address the opioid crisis by reducing opioid overdose deaths through the provision of free naloxone and fentanyl test strips (FTS).
- The NDP distributes naloxone and FTS directly to organizations across California.
  - 4mg nasal naloxone spray (2 doses per kit)
  - 0.4mg/mL intramuscular naloxone (1 dose per kit)
  - FTS kits that include a weighing spoon and sterile water reservoir with measurement markers

NDP Outcomes

Since 2018, the NDP has:

- Distributed more than **6,811,800 naloxone kits** to
- More than **5,000 unique organizations**
- In all **58 California counties** resulting in
- Over **381,100 reported opioid overdose reversals**



How to Apply For and Receive Naloxone and FTS

- To apply for naloxone and FTS through the NDP:
  - Gather the required supplemental materials.
  - Complete the NDP online application form.
  - Agree to the Terms and Conditions.
  - Submit the application and supplemental materials via the NDP online application form.
- Manufacturers ship approved naloxone and FTS directly to applicants.

How Can I Receive Naloxone/FTS? Through the Online Application Form!

DHCS

NDP Application Process Summary

SELECT PRODUCT (NALOXONE, FTS, OR BOTH).

ENTER ORGANIZATION INFORMATION.

UPLOAD ANY REQUIRED SUPPLEMENTAL DOCUMENTS.

AGREE TO THE TERMS AND CONDITIONS.

SUBMIT THE REQUEST.*

***Tip:** Your browser will notify you that the application was successfully submitted – you will not receive a separate email confirmation from NDP staff.

Reminder

Webinar Date: Thursday, September 18th

Time: 1:00 PM to 2:00 PM

Registration for Webinar:

https://events.gcc.teams.microsoft.com/event/d7f70cc9-07b7-4bc6-877b-753c0f8b6846@265c2dcd-2a6e-43aa-b2e8-26421a8c8526

<<<< QR Code for Registration <<<<<<<

Questions?

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DHCS

Office of Tribal Affairs Update

Andrea Zubiate
Chief

DHCS

Why Data Matters

- DHCS is working to improve how American Indian/Alaska Native (AI/AN) enrollment in Medi-Cal is counted.
- Accurate data is essential for:
  - Equitable access to services and funding
  - Proper representation in policy and planning
  - Improved health outcomes for AI/AN communities
- Current data shows a significant gap:
  - **ACS Estimate:** ~355,000 AI/AN individuals report Medi-Cal coverage
  - **DHCS Data:** ~50,000 enrollees identifying as AI/AN alone
  - Multiracial AI/AN individuals are not currently captured in reported data

Addressing the Data Gaps

» DHCS is taking several steps to close the gap:

- Reviewing all available data sources
- Exploring expanded definitions of AI/AN to include multiracial identities
- Identifying special use cases for broader inclusion
- Engaging Tribal partners to validate approaches

Moving Forward Together

- DHCS is committed to:
  - Developing AI/AN-specific Medi-Cal dashboards
  - Increasing transparency in data collection and reporting
  - Continuing collaboration with Tribal communities
- The next slides will:
  - Review currently available AI/AN data
  - Explore data options for how AI/AN individuals are reflected in DHCS systems
  - Present a potential approach for incorporating data on registered AI/AN individuals served by Tribal health programs

Medi-Cal Certified Eligibles by Various Characteristics

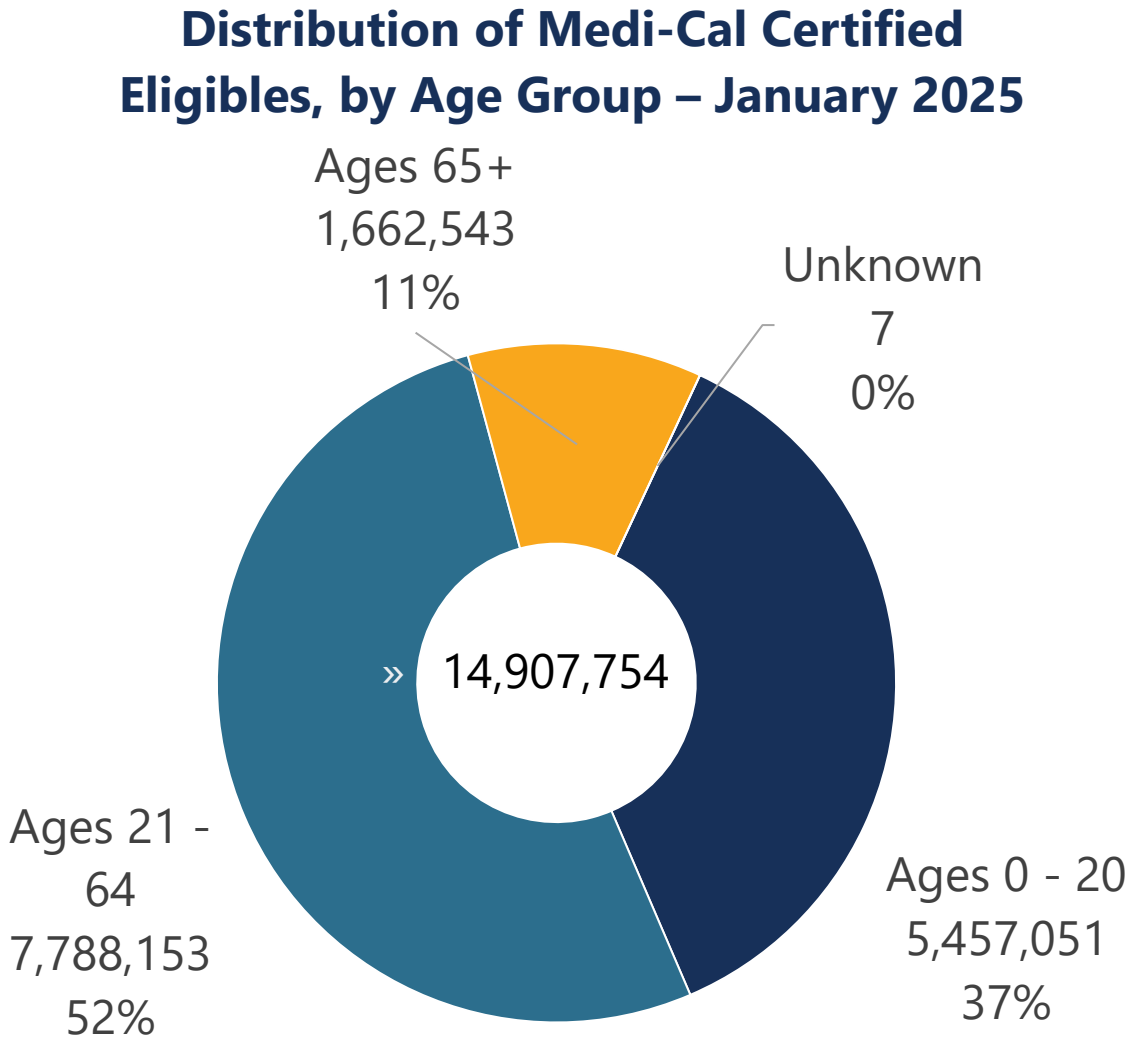
Certified Eligibles in Medi-Cal

- "Certified eligible" refers to Medi-Cal members who have been officially approved for coverage. It does **not** include people who might qualify but haven't enrolled yet or are still going through the process.

- Also, this only counts members who are actually eligible to receive Medi-Cal services during the month. For example, if someone has a share of cost (SOC) and hasn't met it for the month, they aren't included in the count.

Medi-Cal Population by Age Group

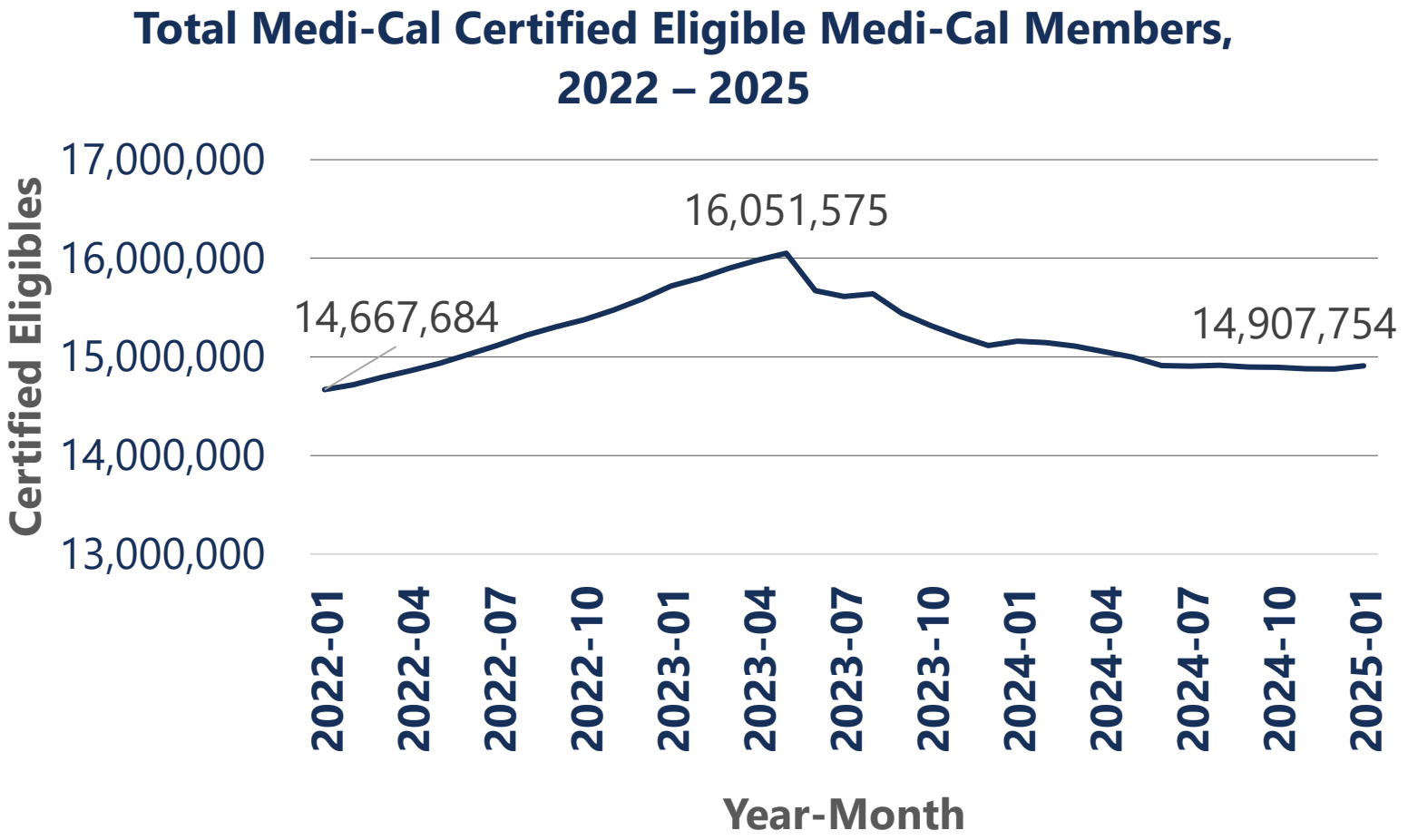
- 14.9 million Californians
  - 5.5 million children up to age 20
  - 7.8 million adults ages 21-64
  - 1.7 million adults ages 65+
- This distribution is consistent with previous years' reports



Data Source: Department of Health Care Services, April 2025. Medi-Cal Monthly Eligible Fast Facts, January 2025 as of the MEDS Cut-off for April 2025. California Department of Health Care Services.

Trend in Medi-Cal Enrollment

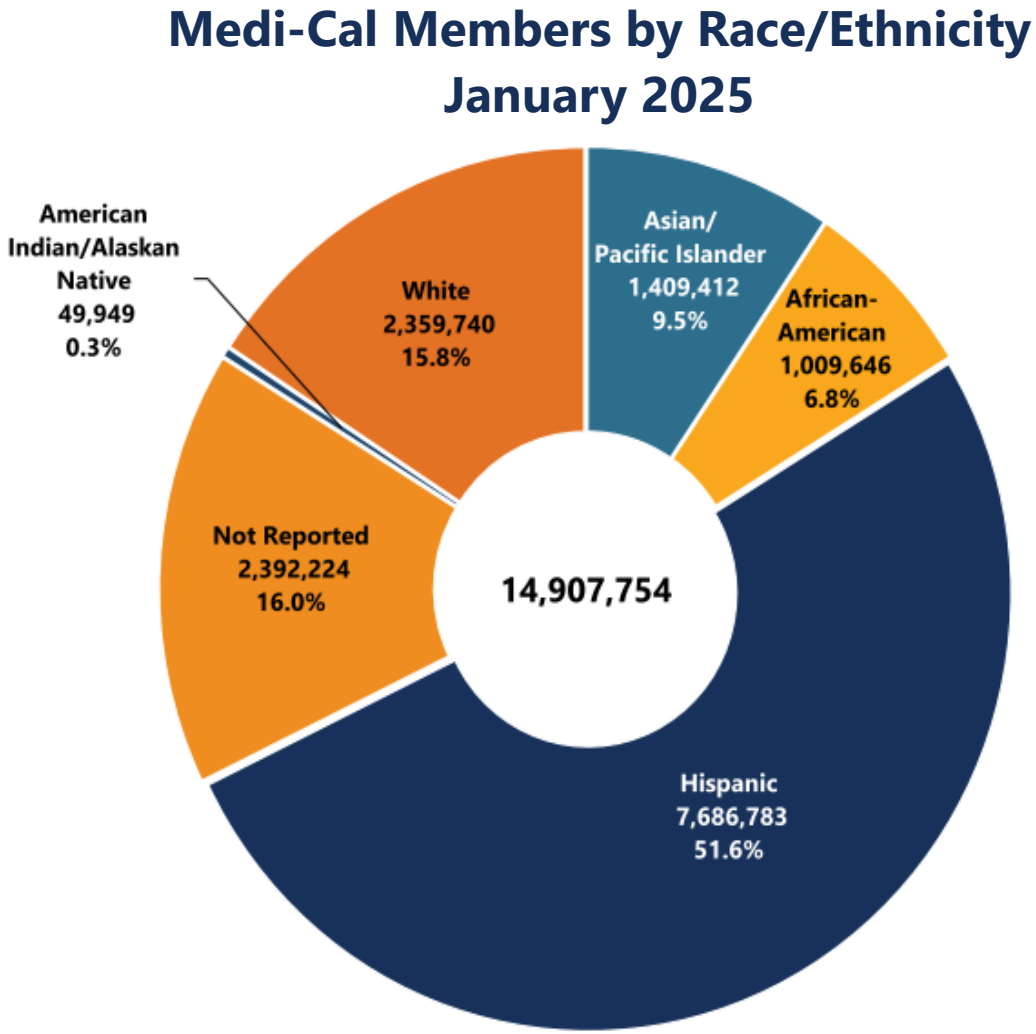
- Medi-Cal reached its highest enrollment numbers in May 2023 when the Public Health Emergency ended, and then redetermination of members resumed
- As of January 2025, there are 14.9 million certified eligible Medi-Cal members



Data Source: Department of Health Care Services, April 2025. Medi-Cal Monthly Eligible Fast Facts, January 2025 as of the MEDS Cut-off for April 2025. California Department of Health Care Services.

Medi-Cal Population by Race/Ethnicity

- Total number of Medi-Cal members who self-identified as American Indian/ Alaskan Native (AI/AN) was 49,949
- This accounted for 0.3% of the total Medi-Cal population in January 2025



Data Source: Department of Health Care Services, April 2025. Medi-Cal Monthly Eligible Fast Facts, January 2025 as of the MEDS Cut-off for April 2025. California Department of Health Care Services.

How to Identify AI/AN Population?

Methodology of Identifying AI/AN Population

- In Medi-Cal, identification of race/ethnicity groups aligns with the Centers for Medicare & Medicaid Services (CMS)
  - Multi-race and Hispanic groups will also possibly include those who self-identified themselves as AI/AN

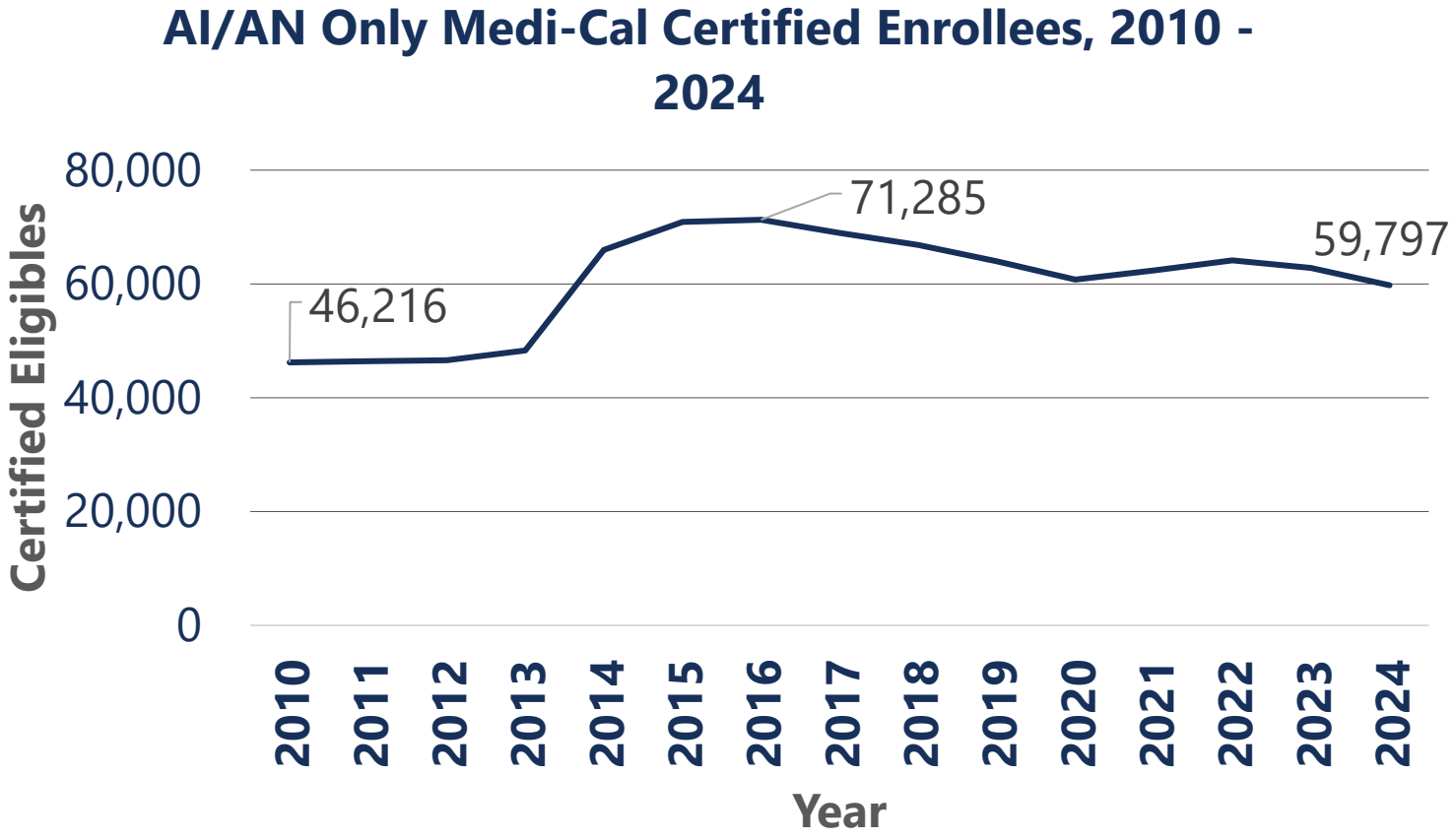
- DHCS is interested in exploring a more inclusive and accurate methodology to identify the AI/AN population in Medi-Cal

3 Definitions of AI/AN Populations

- **AI/AN Only- #1**
  - Those that self-reported being AI/AN and no other race nor Hispanic ethnicity
- **Any AI/AN - #2**
  - Those that self-reported being AI/AN only or in combination with another race or Hispanic ethnicity
- **Any AI/AN and/or Registered AI/AN - #3**
  - Those that were reported by a Tribal health program to DHCS as a being a Tribal member in addition to those in the "Any AI/AN category"

Self Reported AI/AN Only (Group #1) Enrollment Trend

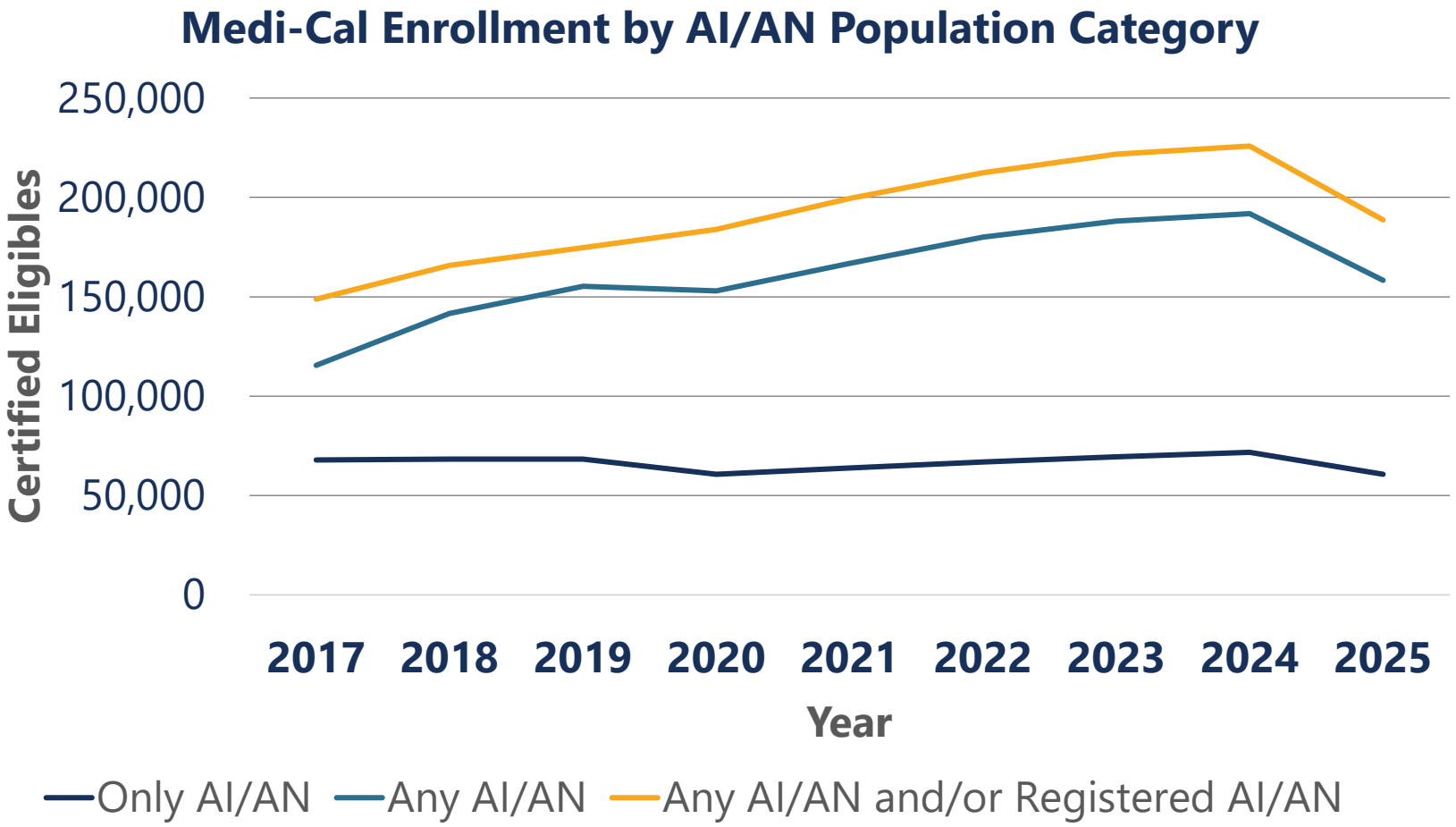
AI/AN enrollment in 2024 was higher than it was in 2010, but still lower than the peak in 2016



Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Trend of AI/AN Members by Three Definitions

Medi-Cal enrollment in AI/AN definition #3 is about 3 times as high as definition #1, which DHCS currently uses



Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Medi-Cal Expenditure and Utilization by Indian Health Care Providers

Indian Health Care Providers (IHCPs)

- There are a total of 145 IHCP sites in California serving American Indians including:
  - 67 Indian Health Service Memorandum of Agreement (IHS-MOA) – Prover Type (PT) 75
  - 78 Tribal Federally Qualified Health Centers (FQHC) – PT 96
  - 15 Urban Indian Federally Qualified Health Center Clinic sites - PT 35
- Additionally, there are 7 Youth Regional Treatment Centers (YRTCs) enrolled in Medi-Cal

Source: DHCS-OTA

Fee for Service Payments: 2020 to 2024

	2020	2021	2022	2023	2024
Urban Indian Federally Qualified Health Center Clinic Sites – PT 35	$ 42,593,633	$ 49,256,970	$ 50,985,113	$ 62,703,966	$ 74,522,176
Indian Health Service Memorandu of Agreement (IHS-MOA) – PT 75	$ 84,559,944	$ 112,017,047	$ 65,438,105	$ 68,161,036	$ 63,271,193
Tribal Federally Qualified Health Centers – PT 96	N/A	$ 1,100,496	$ 81,877,103	$ 94,205,152	$ 119,334,002
Total	**$ 127,153,577**	**$ 162,374,513**	**$ 198,300,321**	**$ 225,070,153**	**$ 257,127,371**

Note: In 2020, DHCS established PT 96 that designates some Tribal health programs as Tribal Federally Qualified Health Centers.

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Utilization by IHS-MOA (PT 75): 2020-2024

	Users	Visits	# of Average Visits per User per Year
CY 2020	102,649	460,787	4.5
CY 2021	104,560	452,789	4.3
CY 2022	61,605	298,637	4.8
CY 2023	66,434	318,570	4.8
CY 2024	63,323	318,617	5.0

Note: A user may be represented in more than one clinic type.

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Utilization by Tribal FQHC (PT 96): 2021-2024*

	Users	Visits	# of Average Visits per User per Year
CY 2021	40,178	118,011	2.9
CY 2022	59,753	281,561	4.7
CY 2023	65,267	317,997	4.9
CY 2024	78,009	407,412	5.2

*This provider type was created in 2021
Note: A user may be represented in more than one clinic type.

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Utilization by Urban Indian FQHC (PT 35): 2020-2024

	Users	Visits	# of Average Visits per User per Year
CY 2020	42,638	188,153	4.4
CY 2021	46,112	207,491	4.5
CY 2022	47,810	212,547	4.4
CY 2023	49,321	238,019	4.8
CY 2024	54,011	274,145	5.1

Note: A user may be represented in more than one clinic type.

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Top Ten Visit Utilization Classifications in 2024

Used CCSR to Define Utilization Categories

- The Clinical Classifications Software Refined (CCSR) is used to define utilization categories since CCSR aggregates more than 70,000 diagnosis codes into just over 530 categories

- Because diagnosis codes can be very specific, this allows for more meaningful analysis of which conditions are most common on claims

Top Ten Visit Utilizations by PT 75 in 2024

Rank	CCSR Description	Users	Claims & Encounter Count	Claims Amount
1	Any dental condition including traumatic injury	21,469	54,223	$ 37,641,669
2	Other general signs and symptoms	3,694	20,802	$ 24,831
3	Medical examination/evaluation	12,933	15,815	$ 559,763
4	Musculoskeletal pain, not low back pain	5,186	13,556	$ 195,253
5	Anxiety and fear-related disorders	3,694	12,956	$ 233,488
6	Trauma- and stressor-related disorders	2,395	11,884	$ 235,679
7	Depressive disorders	2,704	11,634	$ 296,350
8	Encounter for observation and examination for conditions ruled out (excludes infectious disease, neoplasm, mental disorders)	6,361	10,951	$ 7,557,103
9	Spondylopathies/spondyloarthropathy (including infective)	2,462	10,141	$ 84,843
10	Other specified upper respiratory infections	4,828	6,410	$ 131,553

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Top Ten Utilization by PT 96 in 2024

Rank	CCSR Description	Users	Claims & Encounter Count	Claims Amount
1	Any dental condition including traumatic injury	39,680	122,708	$ 90,056,298
2	Medical examination/evaluation	18,505	24,574	$ 1,823,234
3	Anxiety and fear-related disorders	4,730	16,997	$ 1,084,182
4	Depressive disorders	3,345	15,687	$ 1,020,583
5	Trauma- and stressor-related disorders	2,792	14,756	$ 1,054,411
6	Encounter for observation and examination for conditions ruled out (excludes infectious disease, neoplasm, mental disorders)	10,089	14,089	$ 9,883,682
7	Musculoskeletal pain, not low back pain	5,305	11,397	$ 509,356
8	Spondylopathies/spondyloarthropathy (including infective)	2,956	8,551	$ 301,897
9	Neurodevelopmental disorders	2,077	7,203	$ 486,563
10	Biomechanical lesions	1,633	6,544	$ 295,905

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Top Ten Utilization by PT 35 in 2024

Rank	CCSR Description	Users	Claims & Encounter Count	Claims Amount
1	Any dental condition including traumatic injury	26,806	78,638	$ 25,843,947
2	Medical examination/evaluation	16,014	20,628	$ 4,886,850
3	Depressive disorders	2,358	13,431	$ 3,531,433
4	Anxiety and fear-related disorders	2,341	11,043	$ 2,850,485
5	Trauma- and stressor-related disorders	1,580	9,651	$ 2,732,251
6	Essential hypertension	3,438	7,838	$ 1,493,386
7	Exposure, encounters, screening or contact with infectious disease	4,774	5,984	$ 395,184
8	Musculoskeletal pain, not low back pain	3,455	5,611	$ 1,455,927
9	Uncomplicated pregnancy, delivery or puerperium	712	5,269	$ 1,734,079
10	Diabetes mellitus with complication	1,903	4,842	$ 1,177,307

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Comparison of Number of Visits by Tribal Health Clinics and by AI/AN Populations

Comparison of Visits by Any AI/AN and Non-AI/AN in 2024

Tribal Health Clinics (IHS-MOA) – PT 75

Number of Instances of Medi-Cal Members Being Seen by Number of Visit Types Per Day by Race, 2024			
Number of Visits per Day	**Any AI/AN**	**Non -AI/AN**	**Total**
1	34,544	125,786	160,330
2	369	1,007	1,376
3	1	9	10

Tribal Federally Qualified Health Centers – PT 96

Number of Instances of Medi-Cal Members Being Seen by Number of Visit Types Per Day by Race, 2024			
Number of Visits per Day	**Any AI/AN**	**Non -AI/AN**	**Total**
1	39,978	194,446	234,424
2	1,577	3,601	5,178
3	30	49	79

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 17, 2025, from the DHCS MIS/DSS data warehouse.

Comparison of Visit Types by Any AI/AN and Non-AI/AN in 2024

Tribal Health Clinics (IHS-MOA) – PT 75

Number of Total Visits by Visit Type and Race, 2024			
Visit Type	**Any AI/AN**	**Non-AI/AN**	**Total**
Ambulatory/Dental	19,157	57,313	76,470
Medical	12,596	61,834	74,430
Mental Health	3,532	8,680	12,212

Tribal Federally Qualified Health Centers – PT 96

Number of Total Visits by Visit Type and Race, 2024			
Visit Type	**Any AI/AN**	**Non-AI/AN**	**Total**
Ambulatory	2,228	10,606	12,834
Dental	19,213	102,383	121,596
Medical	15,328	70,488	85,816
Mental Health	6,453	18,318	24,771

Comparison of Visits by Registered AI/AN and Non-Registered AI/AN in 2024

Tribal Health Clinics (IHS-MOA) – PT 75

Number of Instances of Medi-Cal Members Being Seen by Number of Visit Types Per Day by Race, 2024			
Number of Visits per Day	**Registered AI/AN**	**Non-Registered AI/AN**	**Total**
1	47,317	113,013	160,330
2	478	898	1,376
3	4	6	10

Tribal Federally Qualified Health Centers – PT 96

Number of Instances of Medi-Cal Members Being Seen by Number of Visit Types Per Day by Race, 2024			
Number of Visits per Day	**Registered AI/AN**	**Non-Registered AI/AN**	**Total**
1	50,470	183,954	234,424
2	1,964	3,214	5,178
3	45	34	79

Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Program Data Reporting Division (PDRD)/ Eligibility and Benefits Data Section (EBDS). Data were extracted on July 11, 2025, from the DHCS MIS/DSS data warehouse.

Comparison of Visit Types by Registered AI/AN and Non-Registered AI/AN in 2024

Tribal Health Clinics (IHS-MOA) – PT 75

Number of Total Visits by Visit Type and Race, 2024			
Visit Type	**Registered AI**	**Non-Registered AI/AN**	**Total**
Ambulatory/Dental	25,305	51,165	76,470
Medical	18,112	56,318	74,430
Mental Health	4,868	7,344	12,212

Tribal Federally Qualified Health Centers – PT 96

Number of Total Visits by Visit Type and Race, 2024			
Visit Type	**Registered AI**	**Non-Registered AI/AN**	**Total**
Ambulatory	2,525	10,309	12,834
Dental	26,580	95,016	121,596
Medical	17,179	68,637	85,816
Mental Health	8,249	16,522	24,771

Quality Measures Comparison

Why Quality Measures and Data Matter

- Quality measures help assess how well Medi-Cal is serving AI/AN communities.
- Accurate and complete data is essential to:
  - Identify disparities in care and outcomes
  - Monitor progress toward health equity
  - Inform culturally responsive policy and program decisions
- Small population sizes, like AI/AN communities, require:
  - Extra care to avoid data suppression or misinterpretation
  - Robust methods to ensure visibility and statistical reliability

Strategies to Reduce Data Suppressions for AI/AN Population

- **Use of Aggregated or Multi-Year Data**
  Combining data across years or regions can increase sample sizes and reduce suppression.
- **Expanded Race/Ethnicity Definitions**
  Including multiracial AI/AN individuals helps capture a fuller picture of the population.
- **Tribal Health Program Data Integration**
  Leveraging data from Tribal health programs can supplement existing Medi-Cal data.
- **Tailored Reporting Thresholds**
  Exploring alternative thresholds or statistical techniques to responsibly report small population data.
- **Community Engagement**
  Working with Tribal partners to validate methods and ensure data use reflects community values and priorities.

Targets and Benchmarks for Quality Measures

- Quality Measure: To measure the effectiveness of care and access to care
- Government Performance and Results Act (GPRA) sets different targets for every quality measure to check its performance
- Minimum Performance Level (MPL) is the 50th percentile from the National Committee for Quality Assurance (NCQA) Quality Compass and is currently used by DHCS as benchmarks for quality measures for Managed Care Plans

Inclusion Criteria for Population

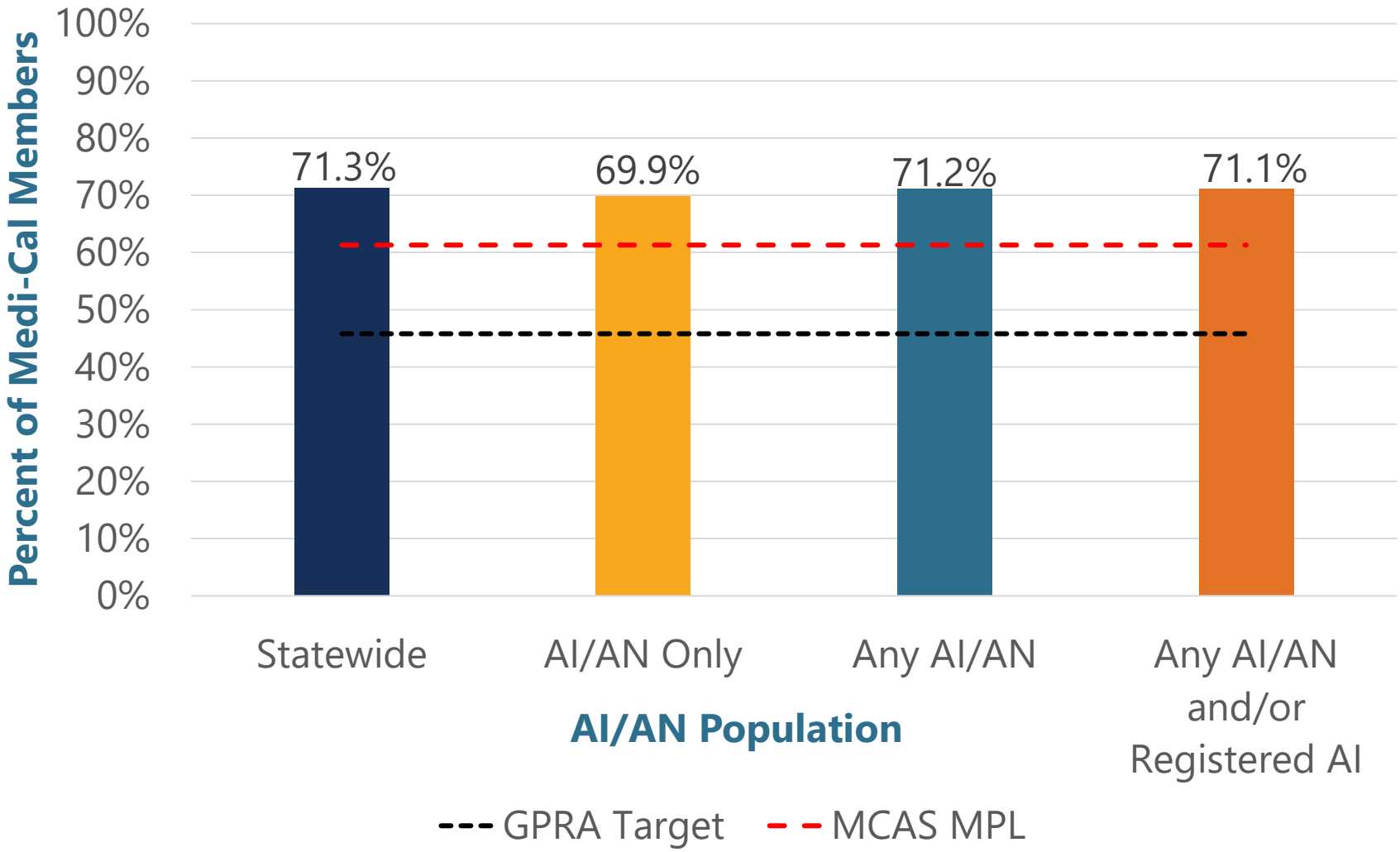
- Statewide population include
  - Managed Care utilization only
  - No Fee-for-Service utilization

- American Indians/ Alaskan Natives (AI/AN) include
  - AI/AN only
  - Any AI/AN
  - Any AI/AN and registered AI/AN

- Does not categorize by provider types

Controlling High Blood Pressure

All populations performed better than the GPRA target and the MPL

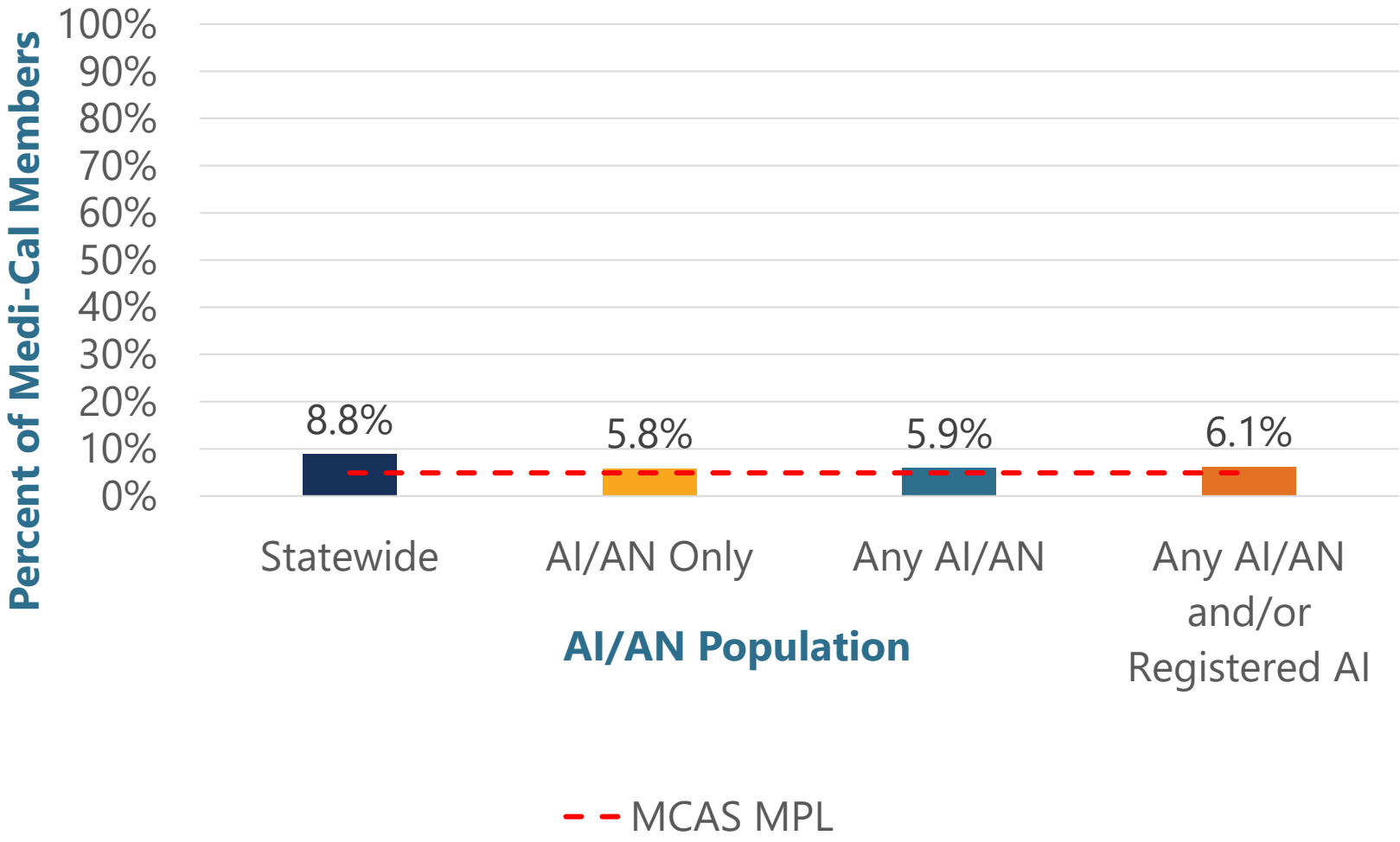


Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Data Analytics Division (DAD)/ Clinical Quality and Performance Reporting Section (CQPRS). Data were extracted on June 24, 2025, from the DHCS MIS/DSS data warehouse and the 2023 Medi-Cal Managed Care Accountability Set (MCAS) dataset).

Depression Screening for Adolescents and Adults

All populations performed better than the MPL

GPRA uses different methodology so not compatible for this measure



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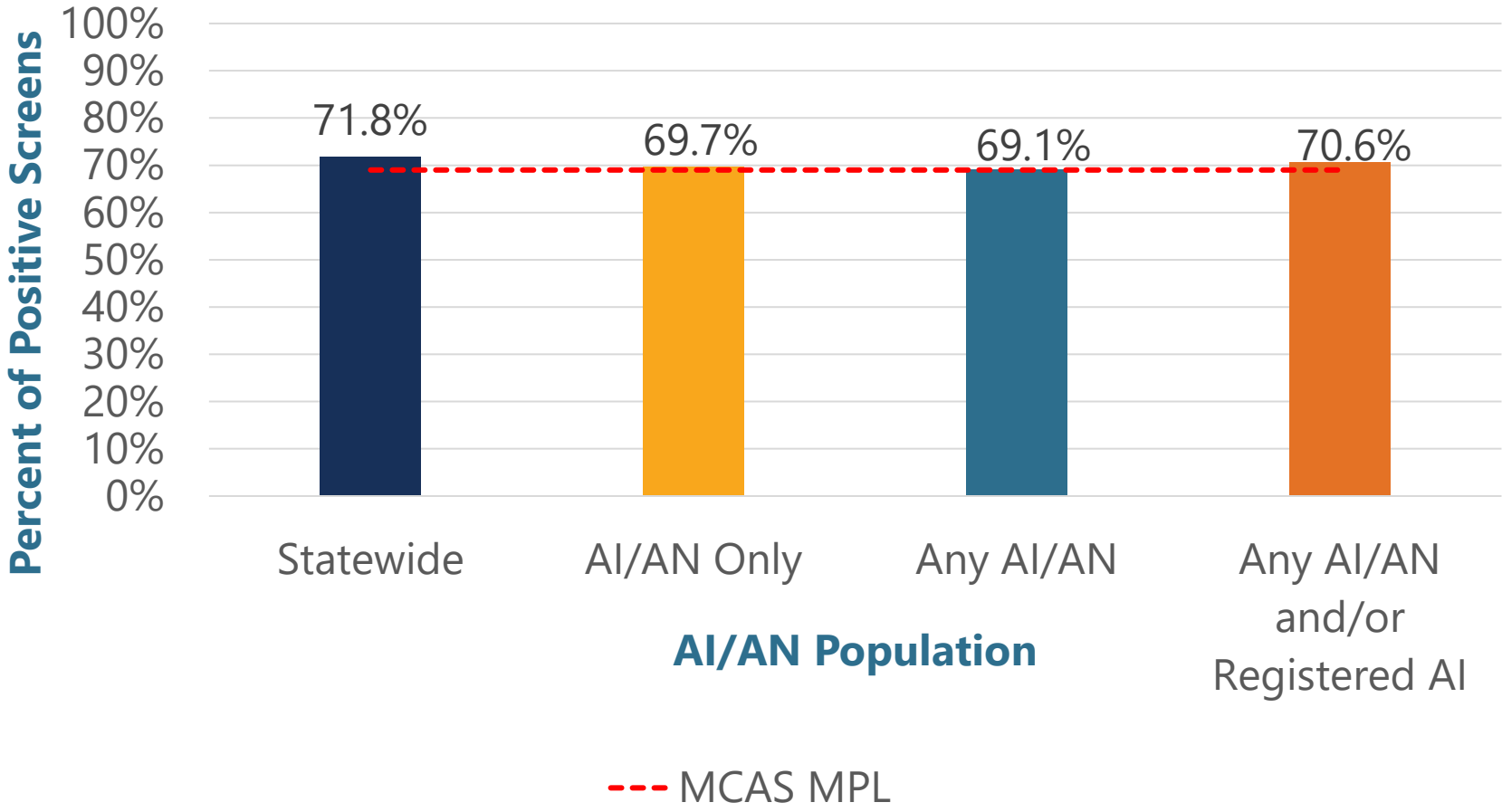
Follow-Up on Positive Depression Screening for Adolescents and Adults

All populations performed better than the MPL

GPRA uses different methodology so not compatible for this measure



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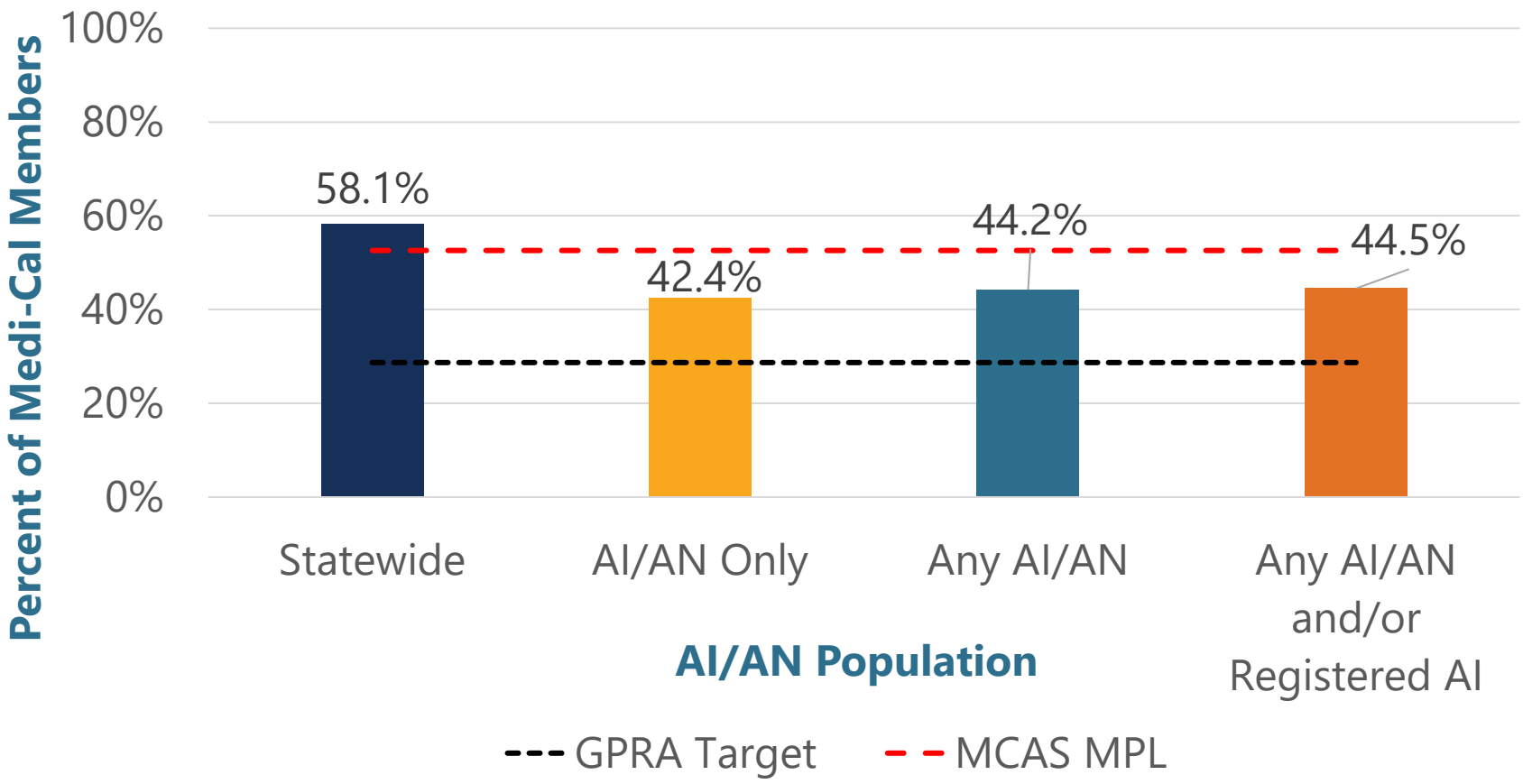
Breast Cancer Screening Results

All populations performed better than the GPRA target, however, only the Statewide Population performed better than the MPL



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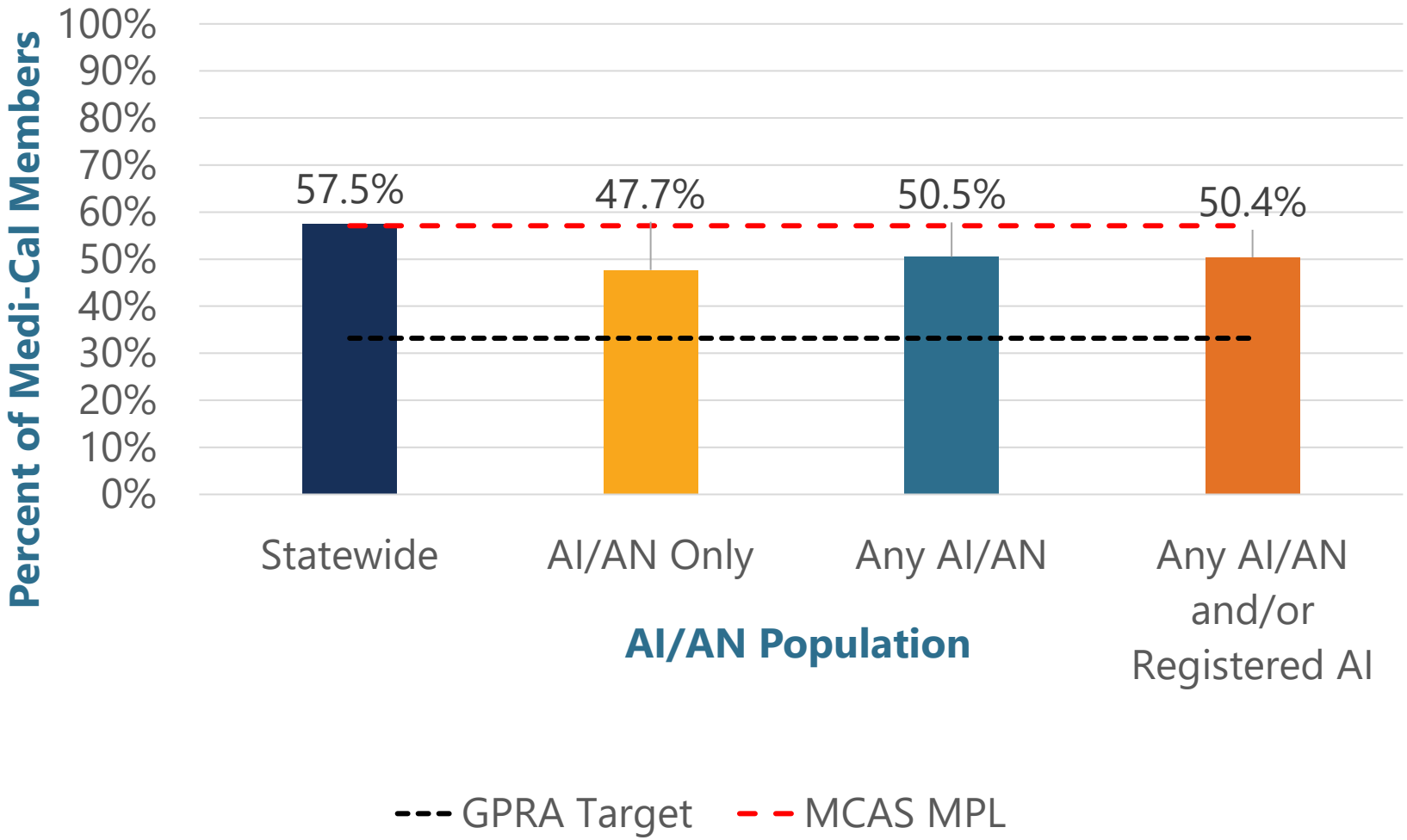
Cervical Cancer Screening

All populations performed better than the GPRA target, however, only the Statewide Population performed better than the MPL



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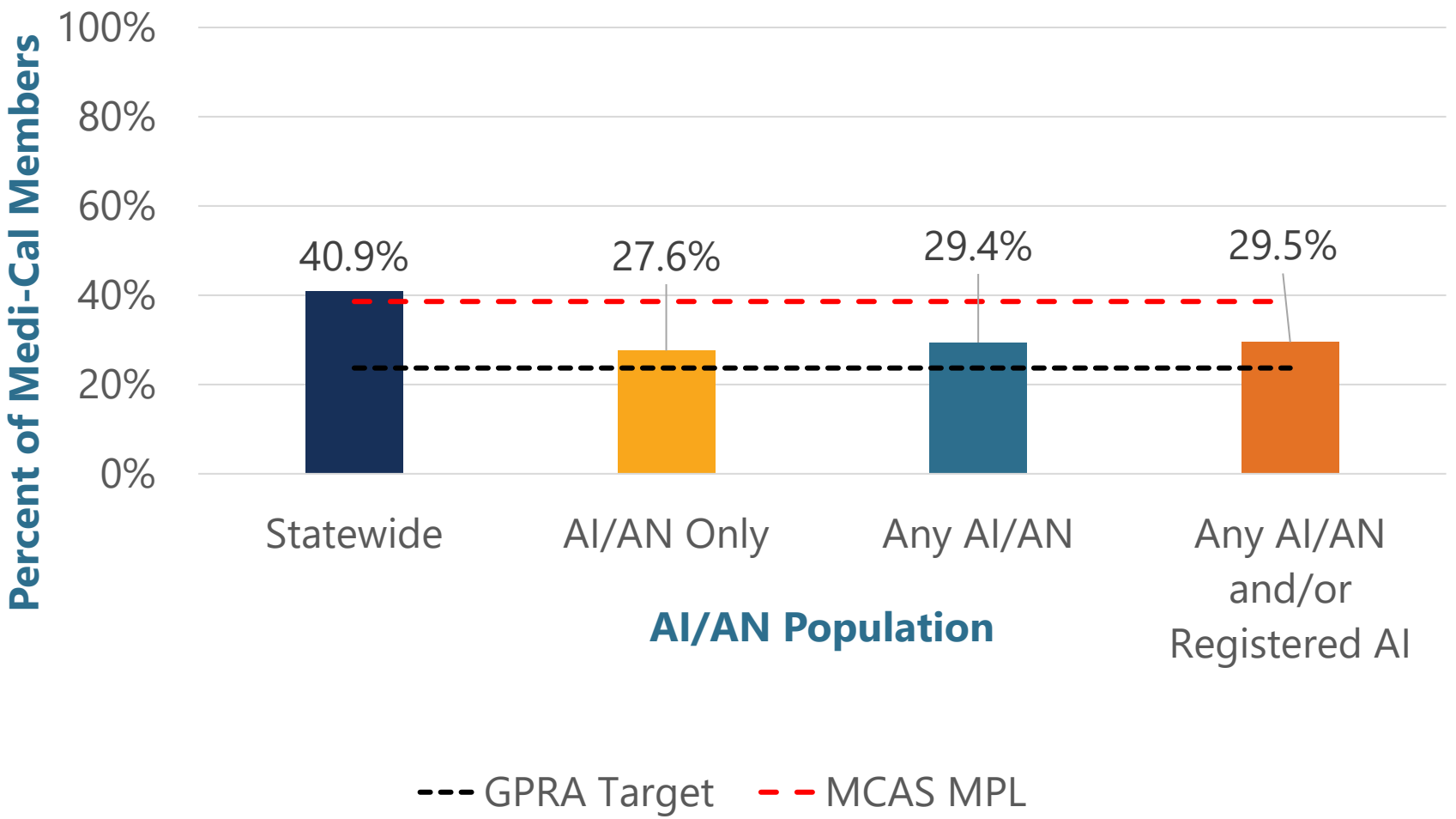
Colorectal Cancer Screening

All populations performed better than the GPRA target, however, only the Statewide Population performed better than the MPL



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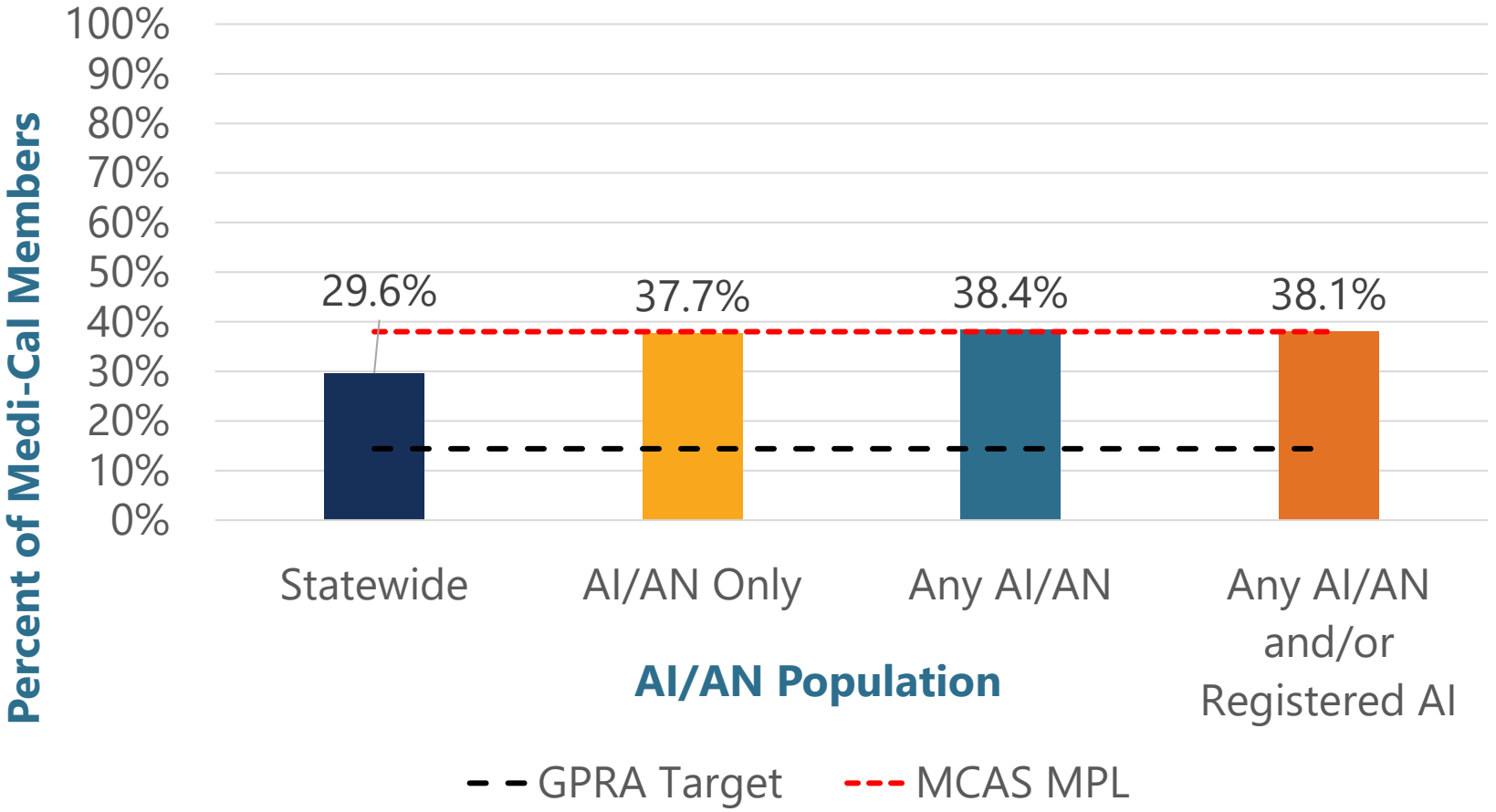
Poor HbA1C Control for Patients with Diabetes (>9%)

Statewide population and AI/AN Only performed better than MPL

All populations failed to meet the GPRA target

(lower rate means better performance)



Data Source: DHCS/Enterprise Data and Information Management (EDIM)/ Data Analytics Division (DAD)/ Clinical Quality and Performance Reporting Section (CQPRS). Data were extracted on June 24, 2025, from the DHCS MIS/DSS data warehouse and the 2023 Medi-Cal Managed Care Accountability Set (MCAS) dataset).

Conclusions

Enrollment and Provider Trends

- Medi-Cal certified population distribution has remained stable over the past year.
- Broader AI/AN identification methods (including registered AI/AN) show nearly 3x higher enrollment than self-identified AI/AN alone.
- Provider trends:
  - **PT 75**: Decrease in users and visits
  - **PT 35 & PT 96**: Increase in users and visits
  - Many providers have transitioned from PT 75 to PT 96

Utilization Patterns and Quality Outcomes for AI/AN Members

- **Visit Patterns:**
  - Most members have only one visit per provider per day for PT 75 and PT 96.
  - Less than 1% have three visits in a single day.
- **Quality Measures (7 total):**
  - 4 measures exceed GPRA targets
  - 3 measures exceed MPL
  - HbA1c control is the only measure below GPRA target
  - AI/AN results are lower than MPL for:
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Colorectal Cancer Screening
    - HbA1c Poor Control (>9%) for definitions #2 and #3

Looking Ahead-Leveraging Data to Strengthen AI/AN Representation in Medi-Cal

- DHCS has historically used registered AI/AN data to draw down 100% FMAP (Federal Medical Assistance Percentage).
- Expanding the use of this data beyond FMAP can help:
  - **Address persistent data gaps** and better reflect the AI/AN experience in Medi-Cal.
  - **Reduce data suppression** for small populations by increasing visibility in reporting.
  - **Inform Medi-Cal Connect**, supporting more accurate and inclusive data integration (topic of our next presentation).
  - **Support policy decisions**, such as ensuring AI/AN individuals are correctly identified and exempted from work requirements where applicable.

Partnering for Progress on AI/AN Data

» **DHCS Invites Tribal Partners to Collaborate On:**

- Shaping the Future of AI/AN Data Use
- Co-Designing Data Dashboards that Reflect Tribal Priorities
- Ensuring Data Sovereignty and Cultural Relevance
- Building Transparent, Trust-Based Data Practices

» **Why Your Voice Matters**

- Tribal insights ensure data reflects the lived experiences and priorities of Tribal communities
- Together, we can build tools that empower decision-making and support Tribal health and well-being

How to Contact DHCS' OTA

- Contact Information:

  Andrea Zubiate, Chief
  Office of Tribal Affairs
  Andrea.Zubiate@dhcs.ca.gov
  916-713-8623 (direct line)

- Requests for Assistance:

  TribalAffairs@dhcs.ca.gov

Add me to your contacts by taking a picture with your smart phone.

THANK YOU!

California Population Health Management Service: Medi-Cal Connect Update

Hope Neighbor
Division Chief

DHCS

Agenda

Objectives:

- Provide a refresh of Medi-Cal Connect Vision and Goals
- Provide an update on recent priority progression, shifts, and Tribal engagements to date
- Explore data dashboards and how IHP indicator can support Medi-Cal Connect

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Topics:

- Medi-Cal Connect Vision & Goals
- Release Schedule & Priority Shifts
- Engagements Completed to Date
- IHP Indicator and Medi-Cal Connect
- Questions

Population Health Management (PHM)

PHM is a core initiative of DHCS' CalAIM transformation

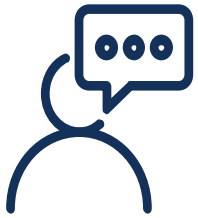
Medi-Cal Connect will enable DHCS and our partners to accelerate progress in improving health outcomes for the people we serve

Medi-Cal Connect
A Core CalAIM Initiative

The Medi-Cal Connect vision is to:

- **Improve the health of Medi-Cal members** and **reduce disparities** by providing a data-driven solution that supports whole-person care and population health functions.
- **Integrate information** from diverse sources, enabling multi-party data access and sharing to inform policy and enhance the member care experience.

We Have Four Primary Goals Supported By Ten Core Objectives

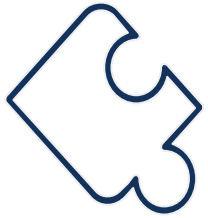


Member Experience

1. Empower cross-sector collaboration
2. Anticipate member needs
3. Provide proactive, personalized care

Whole Person Care

4. View member's risks & unmet needs
5. Utilize statewide RSST* algorithm
6. Reduce gaps in services



Population Level Insights

7. Facilitate data aggregation & integration
8. Act on population-level health trends

Informed Policymaking

9. Strengthen Medi-Cal oversight & monitoring
10. Leverage analytics & insights

**Risk Stratification Segmentation and Tiering*

Medi-Cal Connect Stakeholder Release Timeline

- The PHM Service, "**Medi-Cal Connect**", will be rolled out in six releases to allow feedback, refinement, and implementation of its capabilities.

Release 1 7/24/24*	Release 2 3/3/2025*	Release 3 7/18/2025	Release 4 Q4 2025	Release 5 Q2 2026**	Release 6 Q4 2026	Release 7 Q4 2026
» DHCS (limited user group)	» DHCS (full user group)	» Medi-Cal Managed Care Plans	» County Behavioral Health Plans » State Partners & Agencies	» Develop and deliver Behavioral Health Measures	» Local County Partners » PHM Program Services & Supports » Healthcare Delivery Partners » **Tribal Partners**	» Members

***Go-Live Complete**
****Contract amendment under CMS review**

Tribes and Tribal Partners Engagement

Engagements Completed to Date

Over the past 18 months, a DHCS team supporting Tribes & Tribal Partner engagement gathered insights that have shaped Medi-Cal Connect

Engagement Type	Engagement Description	Stakeholder	Date
Webinar	Medi-Cal Connect Tribes and Tribal Partners Webinar	PHMS Tribal Partners	12/9/2024
Webinar	Medi-Cal Connect Early Adopter Webinars 1, 2 & 3	All Early Adopters	5/29/24, 10/3/2024 and 2/6/2025
Survey	Gather feedback from Tribal Partners on member and provider experiences, needs, and barriers.	Tribal & Urban Indian Organizations	Survey period 1/9/25 to 2/7/25
Small Group Discussions	Overview of Medi-Cal Connect Dashboards and Portal	2 Discussions with Tribal Organizations 1 Discussion Urban Indian Organizations	3/24/25, 3/26/25 and 4/21/2025

What We Heard from Tribal Partners

- Tribal organizations view receiving updated contact and demographic info from tribal members as the top priority in Medi-Cal Connect, with healthcare data access coming in as a close second. Desire to understand Data Exchange Framework was also a key theme.
- Tribal Organizations indicated a stakeholder portal with access to Dashboards and LMR is a top priority. Additionally, a member portal connecting eligible members to social benefits was a key theme.
- Tribal Partners believe a member portal will remove barriers to care for AIANs, but concerns remain about access to technology, connectivity and ease of use.
- Communications must be authentic and come from the community to drive user adoption.
- Medi-Cal Connect presents opportunities to identify underreporting of AIAN disease prevalence and gaps in coverage for AIAN communities.

IHP Indicator & Medi-Cal Connect

Tribes and Tribal Partners

Tribal Data Sovereignty and Medi-Cal Connect

*Indian Health Program-Indicator (**IHP-IND**) Data Flag is **owned** by Tribes and **provided** to DHCS for a specific purpose. If used in Medi-Cal Connect, it could support whole person care, population level insights and informed policy making to help improve health outcomes for AIAN members.*

- **Background:** IHP-IND Data
  - Flagged for AIAN Medi-Cal members whose **Tribal identity** has been verified by a THP
  - Provided to DHCS to recoup **100% Federal Medical Assistance Percentage (FMAP)**
  - Data submitted on a quarterly basis to DHCS from Indian Health Care Providers (IHCPs)
  - IHP-IND Definition of Indian is based on IHS California Indian definition
- **If used in Medi-Cal Connect,** the IHP-IND flag could:
  - **Improve** AIAN member attribution
  - **Identify** IHCPs
  - Provide more **in-depth analysis on health status** of Tribal communities
  - **Assist with care coordination for services** not available at an IHCP, such as maternal care

Dashboard Preview

Tribes and Tribal Partners and Medi-Cal Connect

- Tribes and Tribal Partners are active across the spectrum of health care delivery and can all benefit from various aspects of Medi-Cal Connect.

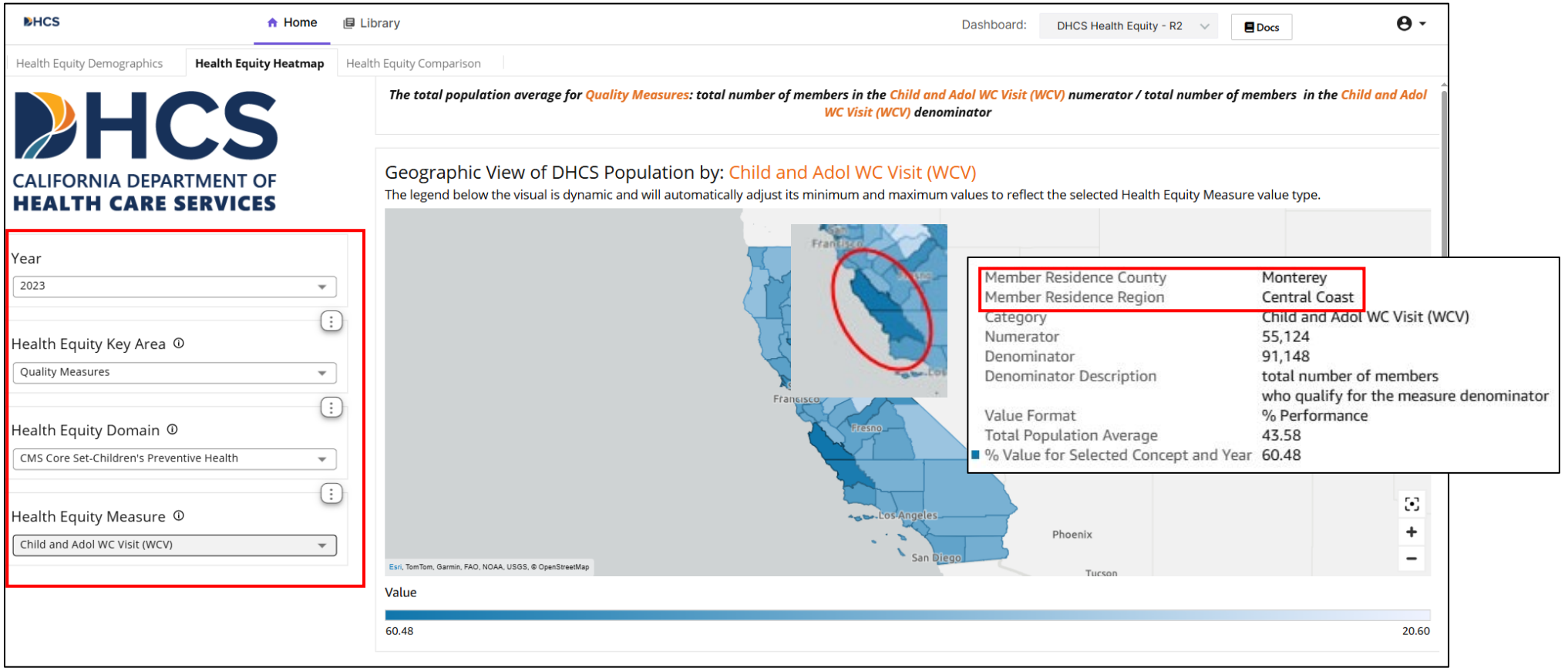
Tribal Health Programs (THPs) can benefit from the Care Management tools provided by Medi-Cal Connect

Indian Health Organizations such as the California Rural Indian Health Board (CRIHB), California Consortium for Urban Indian Health (CCUIH), and the California Tribal Epidemiology Center (CTEC) can benefit from various dashboards included in Medi-Cal Connect

American Indian and Alaska Native (AI/AN) Medi-Cal members can experience longer, healthier lives and more equitable outcomes because Medi-Cal Connect helps providers, care managers, and agencies collaborate more deeply, anticipate needs, and deliver more personalized, timely, and proactive medical and behavioral health care

Real World Scenario #1

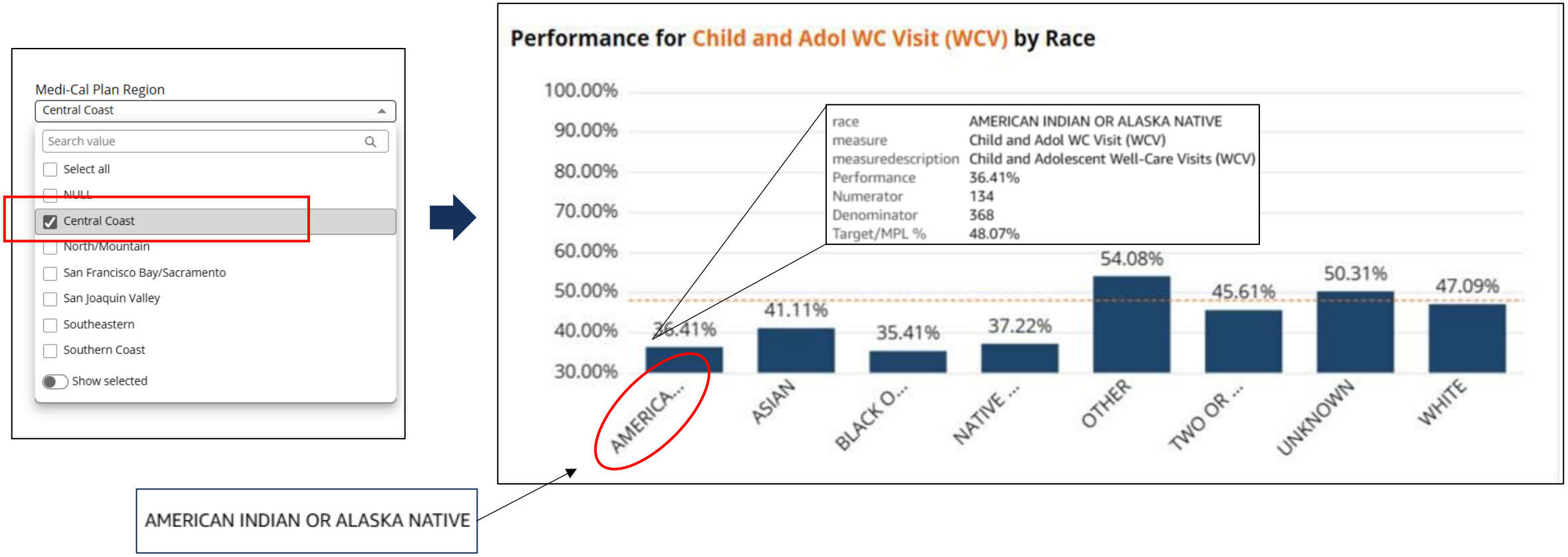
"I want a geographic view of quality measure performance to bright spot counties/regions of interest."



Health Equity Dashboard

Real World Scenario #1 (cont.)

"I want to zoom into quality measure performance by AI/AN demographics."



Quality Measures Dashboard

Real World Scenario #2

"I want to explore the prevalence of Diabetes among the AI/AN population."

Whole Population

Members by Condition Category for 2023

Click on a condition category in the table below to filter the visuals to the right.

Condition Category	Members with Condition	DHCS Population for 2023	% Condition Prevalence	% Previous Year Variance
NO CONDITION	11,002,659	17,552,733	62.68%	-0.74%
CARDIOVASCULAR	2,512,179	17,552,733	14.31%	5.01%
PSYCHIATRIC	1,776,901	17,552,733	10.12%	2.38%
SKELETAL	1,503,668	17,552,733	8.57%	7.97%
PULMONARY	1,388,375	17,552,733	7.91%	0.44%
GASTROINTESTINAL	1,360,455	17,552,733	7.75%	7.87%
DIABETES, TYPE 2	1,274,825	17,552,733	7.26%	5.87%
CENTRAL NERVOUS SYSTEM	752,773	17,552,733	4.29%	4.51%

Emergency Room Visits Per 1K: 2023

765.79

vs. 402

Population filtered by AI/AN

Members by Condition Category for 2023

Click on a condition category in the table below to filter the visuals to the right.

Condition Category	Members with Condition	DHCS Population for 2023	% Condition Prevalence	% Previous Year Variance
NO CONDITION	33,616	61,936	54.28%	-1.63%
CARDIOVASCULAR	10,848	61,936	17.51%	4.85%
PSYCHIATRIC	9,428	61,936	15.22%	5%
SKELETAL	6,823	61,936	11.02%	5.76%
PULMONARY	6,705	61,936	10.83%	0.4%
GASTROINTESTINAL	5,960	61,936	9.62%	6.66%
DIABETES, TYPE 2	5,827	61,936	9.41%	6.07%
SUBSTANCE ABUSE	5,589	61,936	9.02%	2.16%

Emergency Room Visits Per 1K: 2023

1,001.28

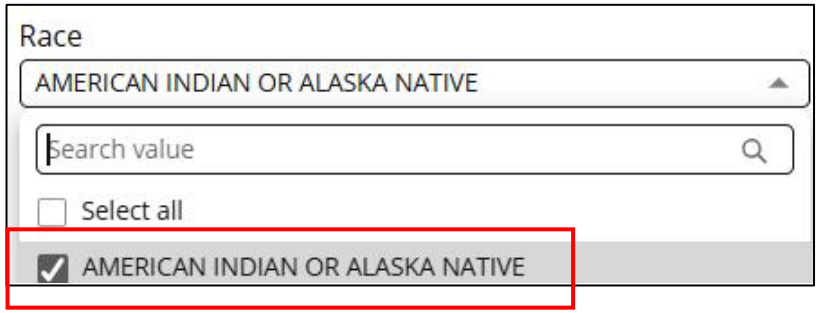
vs. 402

31% greater emergency room utilization rate for AI/AN population than for whole pop.

Condition Prevalence Dashboard

Real World Scenario #3

"I want to zoom in on Diabetes measure performance by AI/AN demographics."



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Measurement Year
2023

Initiative
CMS Core Set (Centers for Medicare and M...

Domain
Care of Acute and Chronic Conditions

3 Quality Measures Exceeded Target

12 Quality Measures At or Below Target

Overall Performance of Quality Measures for CMS Core Set (Centers for Medicare and Medicaid Services) - Care of Acute and Chronic Conditions

Click on a measure in the table below to filter the visuals.

Quality Measure	Numerator	Denominator	Performance	Target/MPL %	To Target/MPL
Asthm Med Ratio (AMR-CH)	98	147	66.66%	73.10%	10
Concurrrent Use Opioid (COB)	96	1,247	7.69%	13.30%	70
Control High Blood Press (CBP)	681	4,126	16.50%	61.31%	1,849
DM HbA1c <8% (HBD)	229	4,963	4.61%	52.31%	2,368
DM HbA1c >9% (HBD)	4,684	4,963	94.37%	37.96%	Target Exceeded
ED Utilization (AMB-CH)	34,999	194,778	17.96%	57.10%	76,225
HIV Viral Load Supp (HVL-AD)	0	184	0.00%	0.00%	No Target
Opioid Use Hi Dosage (OHD)	20	487	4.10%	6.70%	13

Quality Measures Dashboard

Real World Scenario #4

"I want to view behavioral health quality measure performance by AI/AN demographics."

Quality Measures Dashboard

Filtered for AI/AN Demographics Only

American Sign Language

Comments and Questions?

Appendix

Discussion: Opportunities to Deepen Tribal Engagement & Advocacy

How can Medi-Cal Connect better engage Tribal communities?

In what ways could Medi-Cal Connect support advocacy efforts?

DHCS' Comprehensive Quality Strategy and Health Equity Strategy: A Look Behind and Ahead

Palav Babaria, M.D., MHS, Chief Quality & Medical Officer, Deputy Director

Quality & Population Health Management

DHCS

Defining the Vision

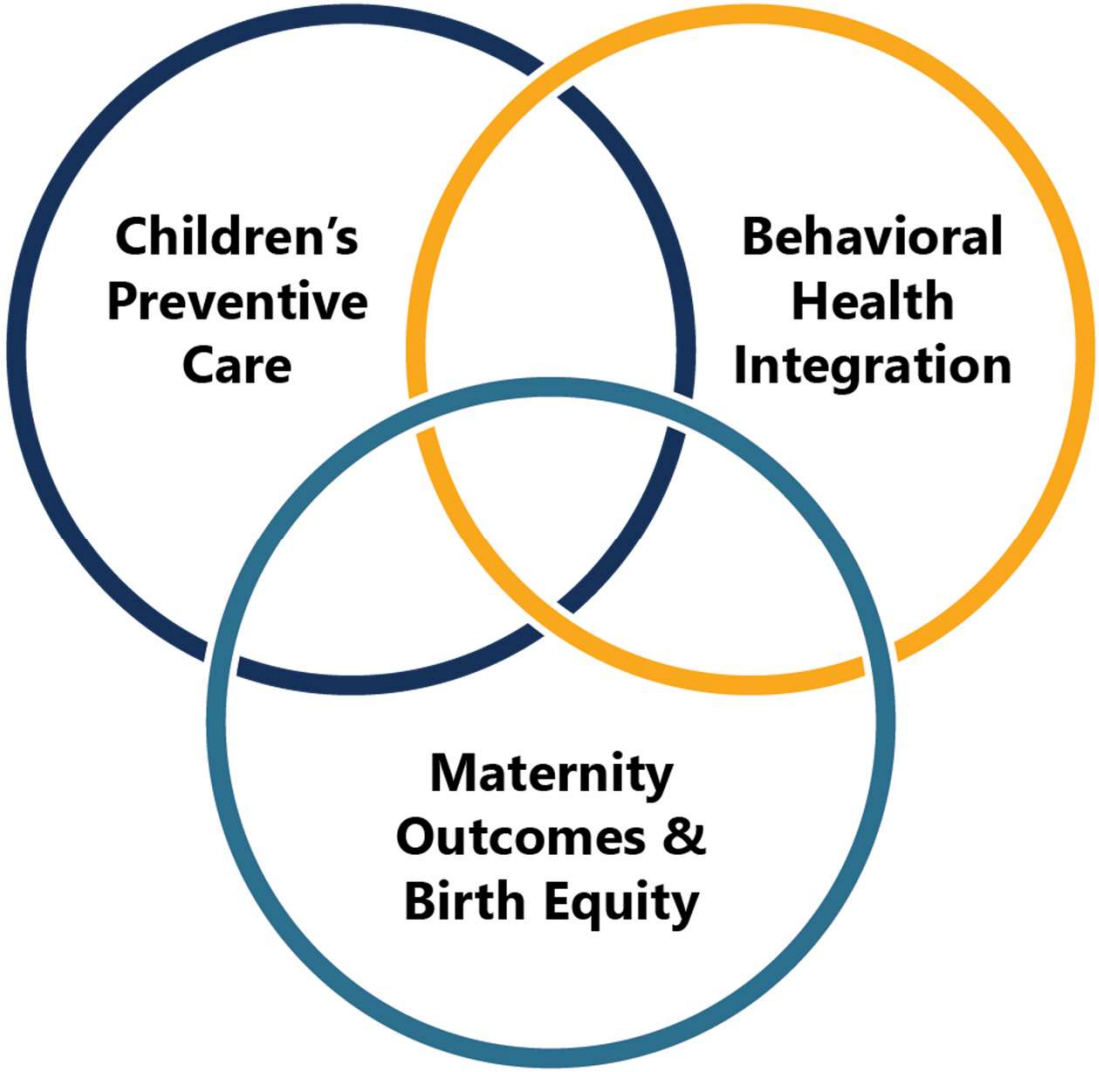
Quality Strategy Goals

- Engaging members as owners of their own care.
- Keeping families and communities healthy via prevention.
- Providing early interventions for rising risk and patient-centered chronic disease management.
- Providing whole person care for high-risk populations, addressing social drivers of health.

Quality Strategy Guiding Principles

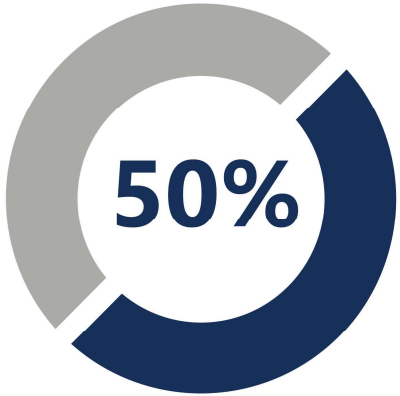
- Eliminating health disparities through anti-racism and community-based partnerships.
- Data-driven improvements that address the whole person.
- Transparency, accountability, and member involvement.

The Long View of Health and Wellness in California



Thinking Big

BOLD GOALS:
50x2025



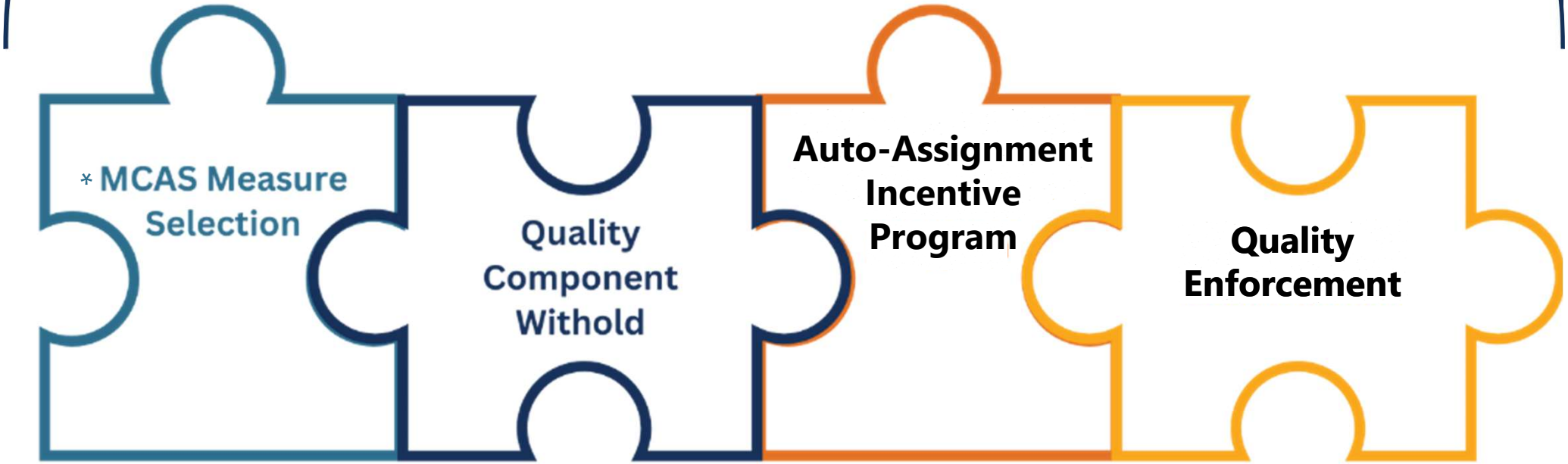
STATE LEVEL

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

- Ensure all MCPs exceed the 50th percentile for all children's preventive care measures

Our Strategic Framework

Managed Care Advancing Quality and Equity Portfolio

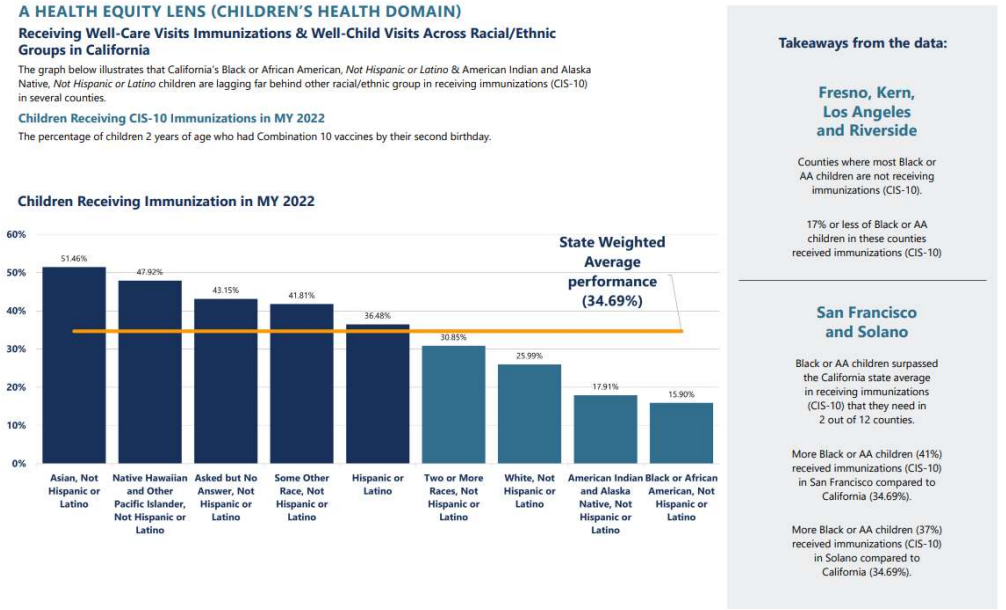


**Managed Care Accountability Sets (MCAS)*

What have we accomplished?

Improved Transparency

- CalAIM Dashboard
- Quarterly ECM/CS ArcGIS Report
- Managed Care Accountability Set Fact Sheets
- Behavioral Health Accountability Fact Sheets



Improved Accountability

- MCAS Measure Selection
  - Focus on children's preventive, maternity and behavioral health measures.
- Quality Withhold and Incentive Program
  - Launched in 2024 with 0.5% capitated rates withhold.
  - Increased to 1.0% capitated rates withhold in 2025.
- Auto-Assignment Incentive Program
  - Focused only on quality measures starting in 2024.
  - Revised methodology based on VBP best practices in 2025.

Improved Accountability

- Enforcement APL 23-012 with specific formula for sanctions calculations with HPI adjustment.
- MCP Quality Sanctions levied for MY 2021.
- MCP Quality Sanctions levied for MY 2022.
- MCP Quality Sanctions levied for MY 2023.
- Quality Measures & Improvement BHIN 24-004 with BHP Quality Sanctions planned for MY 2024.

Improved Member Involvement

- DHCS Medi-Cal Member Advisory Committee launched.
- Health Equity Roadmap.
- Member voice workgroups for Birthing Care Pathway.

New Communities of Practice

- MCP-DHCS Quality & Health Equity Think Tank.
- Quarterly joint CMO-CHEO meetings.
- Quarterly BH Directors meetings.
- Annual MCP-BH joint meeting.
- Institute for Healthcare Improvement Children's and BH learning collaboratives.
- CMS learning collaboratives.

Results

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022-23 Rate Difference
Children's Health Domain				
Child and Adolescent Well-Care Visits – Total	47.51%	**47.02%** ↓	49.50%	2. 48▲
Childhood Immunization Status – Combination 10	**36.63%** ↓	**34.69%** ↓	**30.64** ↓	- 4.05 ▽
*Developmental Screening in the First Three Years of Life – Total**	—	32.33%	40.34%	8.01 ▲
Immunizations for Adolescents – Combination 2	39.23%	39.97%	41.36%	1.39 ▲
Lead Screening in Children	—	54.57%	**58.46%** ↓	3.89 ▲

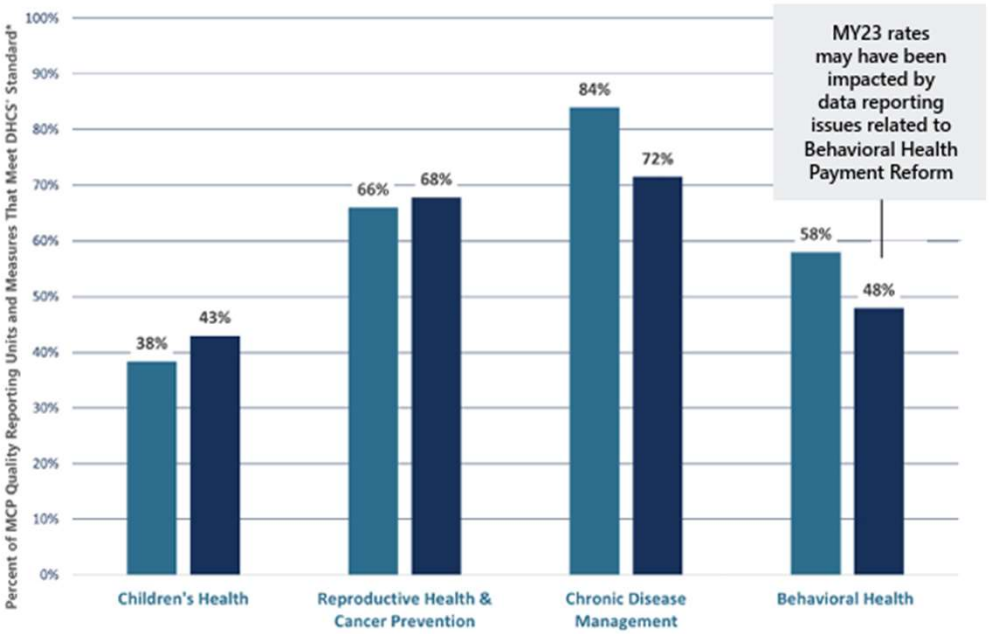
Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022-23 Rate Difference
Children's Health Domain				
*Topical Fluoride for Children – Dental or Oral Health Services – Total**	—	9.75%	**18.17%** ↓	8.42▲
Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months – Six or More Well-Child Visits	**40.23%** ↓	**49.56%** ↓	**53.56%** ↓	4.00 ▲
Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Age 15 Months to 30 Months – Two or More Well-Child Visits	**60.28 %** ↓	**64.33%** ↓	**66.65%** ↓	2.32 ▲

Where are we going?

The Continued Gaps in Quality

Figure 1: Overall Quality by Domain

Measurement Years (MY) 2022, 2023



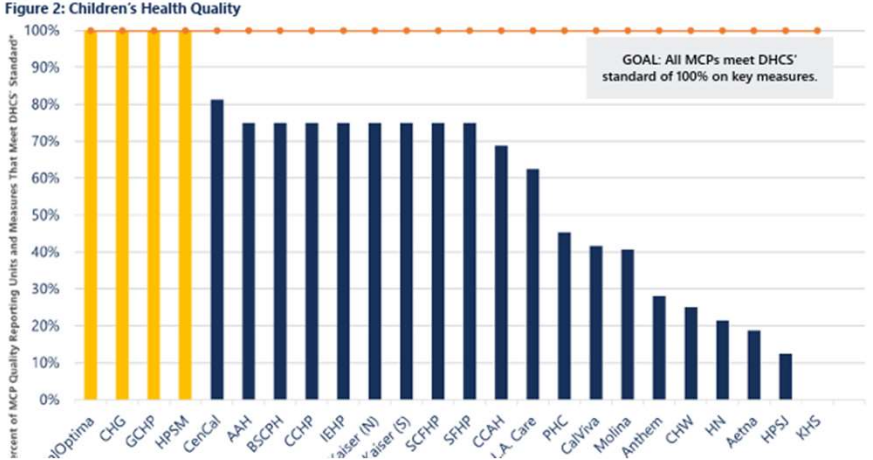
CHILDREN'S HEALTH: HOW DO MEDI-CAL MCPS COMPARE IN QUALITY?

There are eight key measures in the Children's Health Domain:

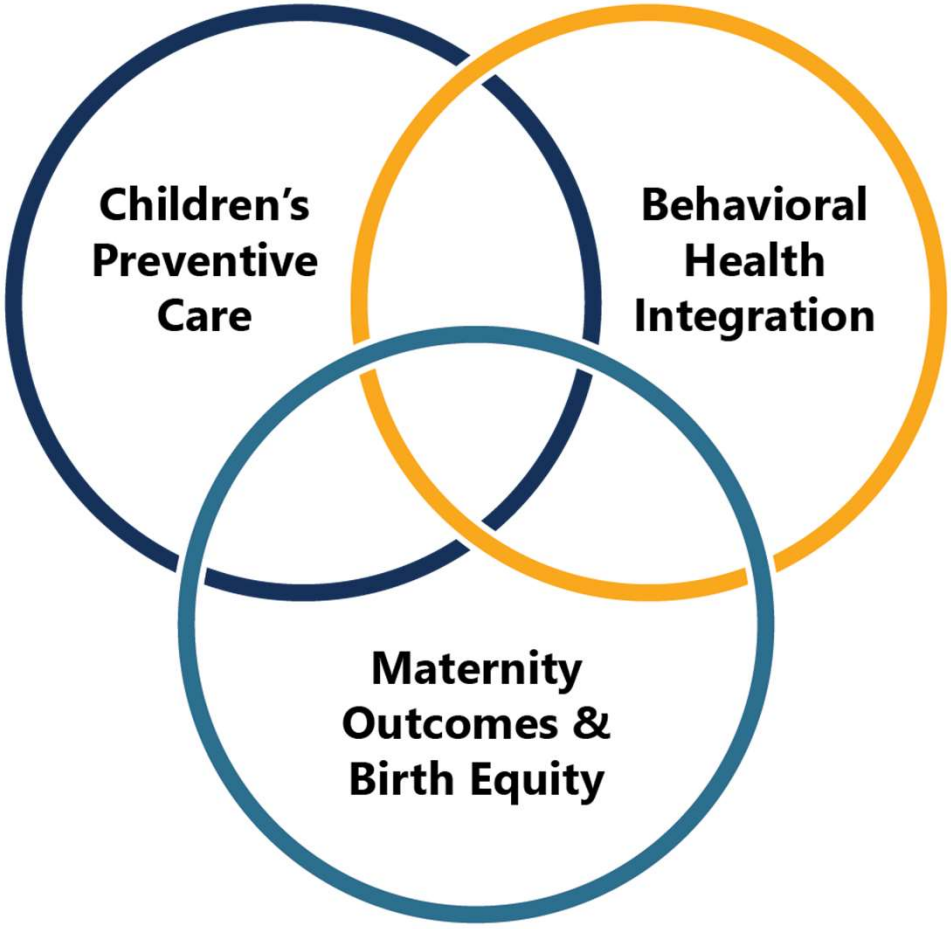
1. Child and Adolescent Well-Care Visits (WCV)
2. Childhood Immunization Status (CIS-10)
3. Developmental Screening in the First Three Years of Life (DEV), **new for MY 2023**
4. Immunizations for Adolescents (IMA-2)
5. Lead Screening in Children (LSC)
6. Topical Fluoride for Children (TFL-CH), **new for MY 2023**
7. Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6+)
8. Well-Child Visits in the First 30 Months of Life –15 to 30 Months – Two or More Well-Child Visits (W30-2+)

To assess overall quality, DHCS evaluates if MCP Quality Reporting Units for each MCP meets or exceeds the established standard for each key measure. Figure 2 shows the percentage of MCP Quality Reporting Units within each MCP that successfully meet these standards across all key measures for Children's Health.

Figure 2: Children's Health Quality

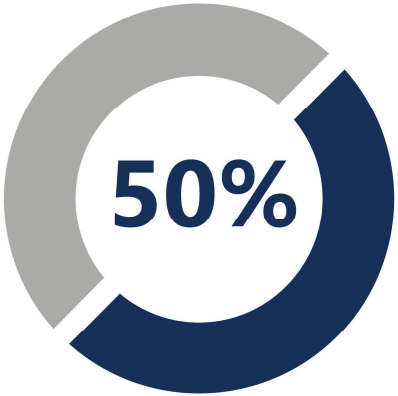


Maintaining Our Priority Populations



Achieving the Bold Goals

BOLD GOALS:
50x2025



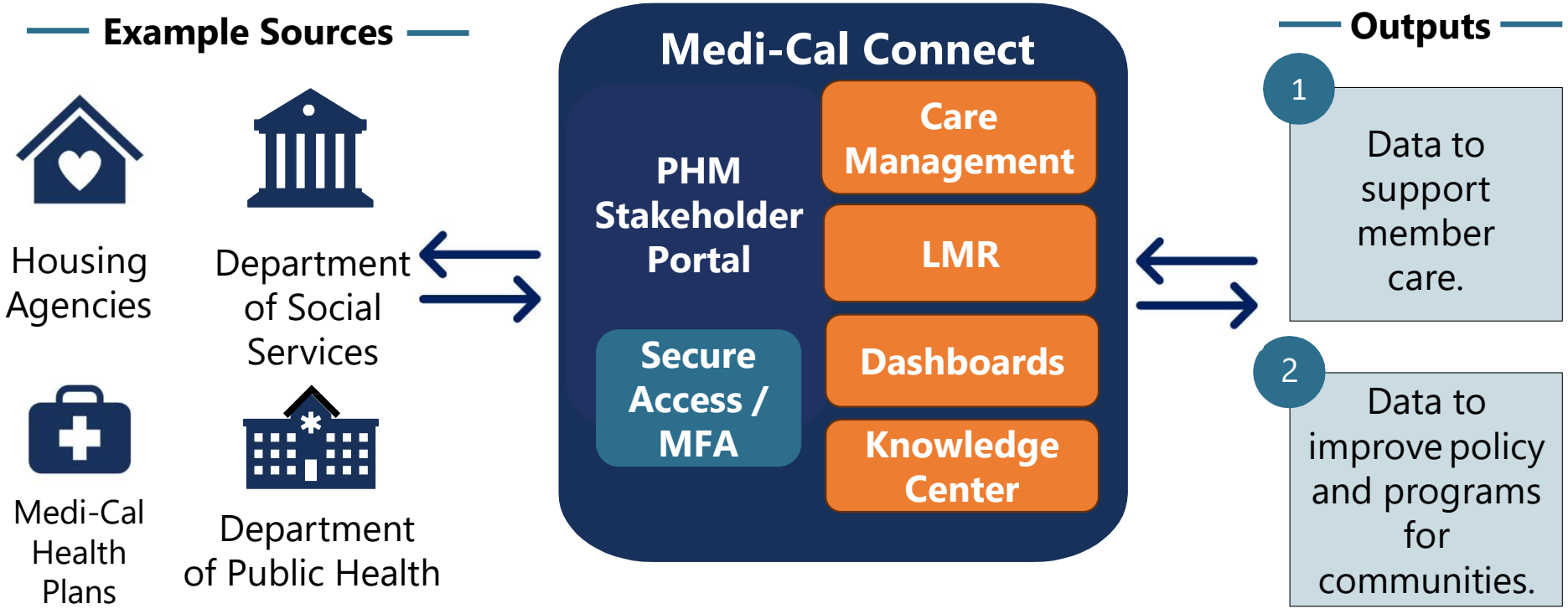
STATE LEVEL

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

- Ensure all MCPs exceed the 50th percentile for all children's preventive care measures

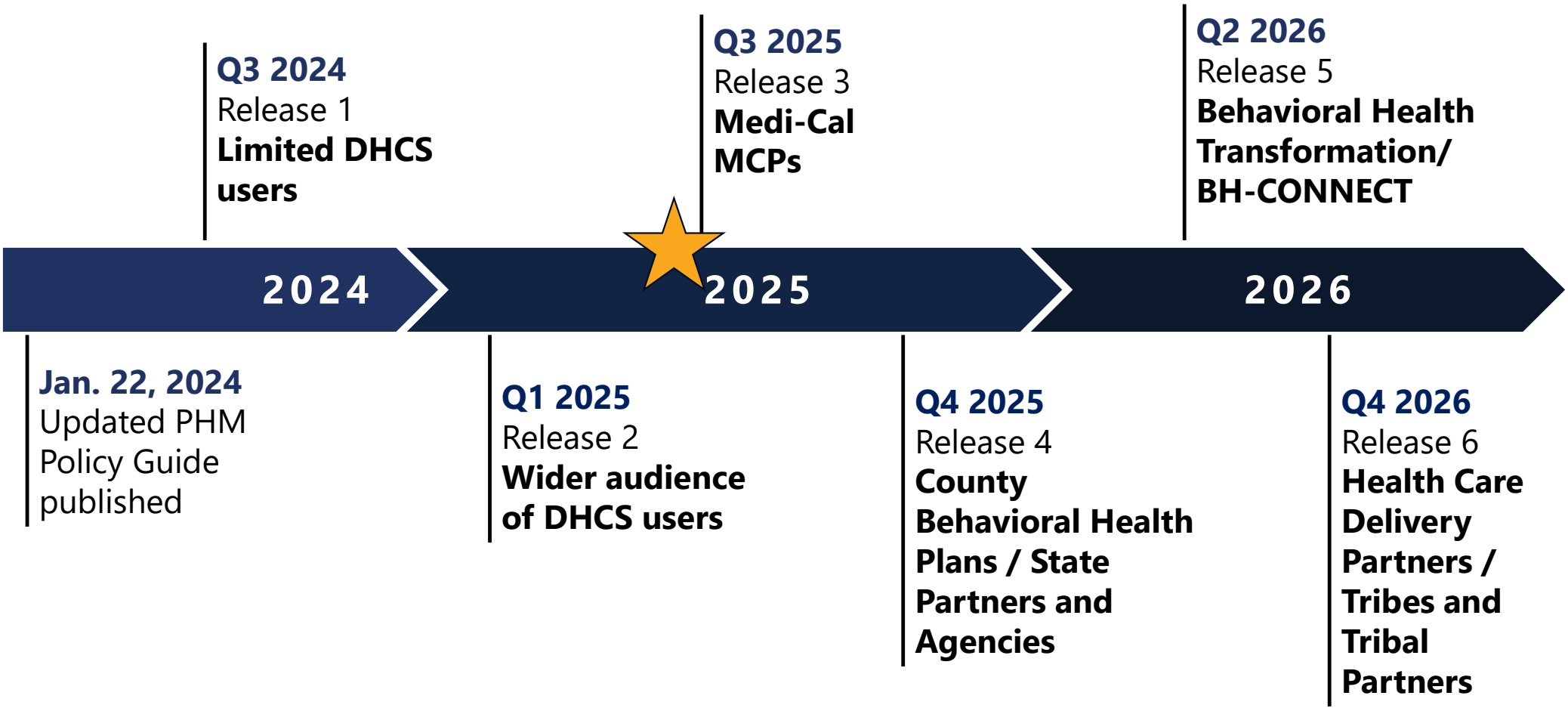
Accelerating Transformation with Medi-Cal Connect

Medi-Cal Connect will aggregate health and social information from many sources to support members and communities.



**Medi-Cal Connect provides identity and consent management capabilities through the PHM Stakeholder Portal.*

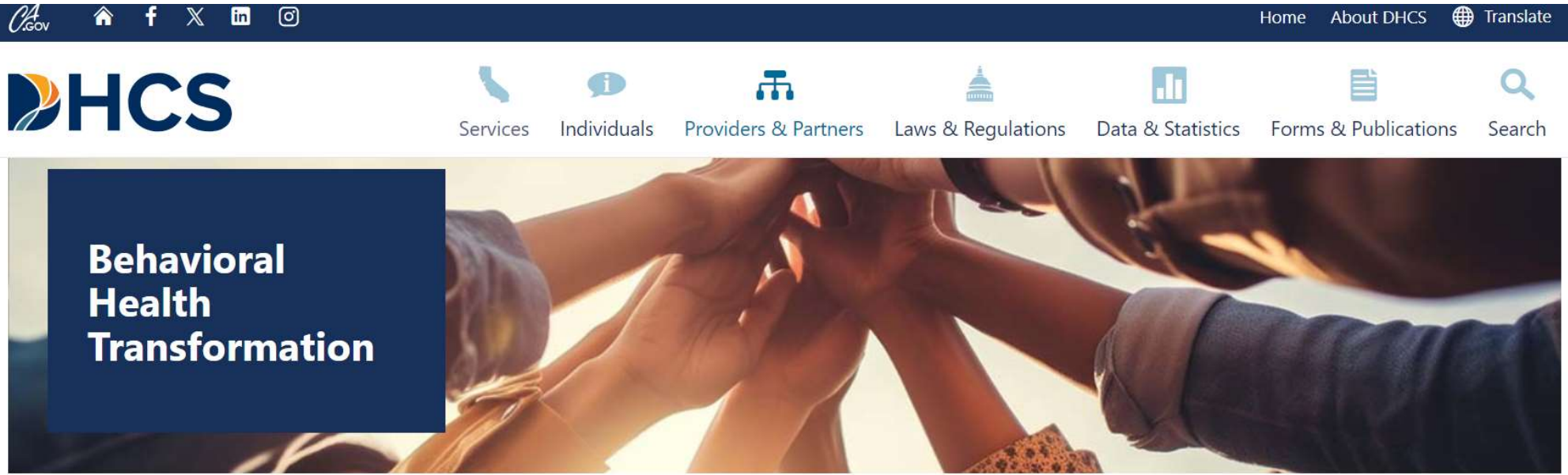
Medi-Cal Connect Timeline



DHCS Birthing Care Pathway

- DHCS developed a comprehensive Birthing Care Pathway to cover the journey of a Medi-Cal member from conception through 12 months postpartum. The Birthing Care Pathway is for **all Medi-Cal members who are pregnant or postpartum.**
- The Birthing Care Pathway is a care model that addresses the **physical, behavioral, and health-related social needs** for pregnant and postpartum members in Medi-Cal. DHCS is creating this care model by:
  - Improving access to licensed and non-licensed providers;
  - Strengthening clinical care and care coordination across the care continuum;
  - Providing whole-person care; and
  - Modernizing how Medi-Cal pays for maternity care.
- The goal of the Birthing Care Pathway is to **reduce maternal morbidity and mortality and address the significant racial and ethnic disparities** in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander individuals.

Developing a Population Health Approach to Behavioral Health Quality & Equity



Continued Commitment to Value Based Payment

2021/2022

- Incentive Programs
- (e.g. Quality Incentive Pool, Vaccine Incentives, Behavioral Health Quality Improvement Program (BHQIP), CalAIM ECM/ILOS)

2023/2024

- Rate adjustment with Quality & Health Equity outcomes (Quality Withhold Incentive Program)
- Revised Auto-Assignment incentive program
- Equity & Practice Transformation Payments
- Federally Qualified Health Centers Alternative Payment Methodology (FQHC APM)
- Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)

2025 and Beyond

- BH-CONNECT Incentive Programs
- Primary Care Spending Targets
- APM Contract Targets

Continued Commitment to Health Equity

- Managed Care/FFS (including CCS)
- Dental
- Behavioral Health
- School Based Services
- HCBS/1915c Delivery System
- CalAIM & Quality Strategy
- Alignment with Public Health

Questions?

Birthing Care Pathway Updates

August 2025

Omnibus Perinatal All-Plan Letter (APL) Overview

Omnibus Perinatal All Plan Letter

- DHCS is developing an omnibus perinatal all plan letter (APL) to serve as the **"one-stop shop" on Medi-Cal perinatal guidance for managed care plans (MCPs)**.

- DHCS committed to developing this APL in the Birthing Care Pathway Report, published in February 2025.

- The omnibus perinatal APL encompasses **28 unique APLs and Policy Letters (PLs)**. Of those 28 APLs and PLs, some will be:
  - **Fully sunset** with the release of the omnibus perinatal APL
  - **Updated and incorporated** in the omnibus perinatal APL
  - **Referenced** in the omnibus perinatal APL (but will remain standalone APLs)
- The omnibus perinatal APL is divided into multiple policy sub-sections that cover the spectrum of prenatal to postpartum care, including:
  - Risk Assessments for Pregnant Members
  - Access to Perinatal Providers
  - Lactation Services
  - Behavioral Health During Prenatal & Postpartum Periods

DHCS will release a draft of the omnibus perinatal APL for public comment in **Fall 2025.**
We welcome consultation and feedback from Tribal and Indian Health Program representatives.

Provider Guide Overview: Leave, Pay and Accommodations for Pregnant and Postpartum Workers in California

Provider Guide: Leave, Pay, & Accommodations for Pregnant and Postpartum Workers in California

In January 2025, Legal Aid at Work (LAAW) and the California Employment Development Department (EDD) developed a two-page **guide** **for health care and social services providers** on the different types of **leave, pay, and accommodations for pregnant and postpartum workers** in California.

- The guide specifies **pregnant and postpartum workers' rights,** including:
  - Time off work to attend prenatal care appointments and for pregnancy-related symptoms
  - Reasonable pregnancy accommodations or changes at work to maintain a healthy pregnancy
  - Paid and unpaid leave from work before and after birth & to bond with their baby
  - Lactation accommodations at work
- The guide also includes **guidance for providers** on when medical notes or medical certifications are or are not required, what level of detail to include in the notes, and sample certifications and notes for providers to use.

DHCS encourages Tribes and IHP Representatives to share this guide with other Tribal health and social service providers.

PHM Transitional Care Services (TCS) Policy Framework for Pregnant and Postpartum Members

Purpose and Agenda

Under the Birthing Care Pathway, DHCS is proposing new Transitional Care Services (TCS) policy requirements for pregnant and postpartum Medi-Cal members based on their needs and preferences. As part of this effort, DHCS is seeking this group's recommendations for engaging Tribal health partners for ongoing feedback.

- **Background:** Current TCS Policy for Pregnant and Postpartum Members
- **TCS Policy Framework:** Goals and Key Components of Updated TCS Policy
- **Discussion:** Recommendations for engaging Tribal Health providers serving pregnant and postpartum members at September 29 DHCS meeting

Context: TCS Policy for Pregnant and Postpartum Members

Severe Maternal Morbidity (SMM) rates in California are higher among pregnant individuals enrolled in Medi-Cal compared to other types of insurance. Pregnant and postpartum Medi-Cal members often experience unmet health related social needs and expressed that they do not understand the various Medi-Cal and public/social service benefits available to them in pregnancy or during the postpartum period.

DHCS is committed to addressing maternal morbidity and supporting pregnant and postpartum members during times of transition:

- The 2022 Comprehensive Quality Strategy and accompanying Bold Goals 50x2025 initiative comprises a set of five goals to improve clinical and health equity outcomes by 50 percent by 2025. Two of the five goals are specific to maternal health.
- DHCS' **Birthing Care Pathway** is a **comprehensive policy and care model roadmap** that covers the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum and includes a series of policy solutions that address members' physical, behavioral, and health-related social needs
- One of the Birthing Care Pathway policy solutions is **creating guidance for MCPs** on supporting pregnant and postpartum members transferring to different care settings and levels of care.
- As outlined in the Birthing Care Pathway, DHCS is **tailoring TCS requirements** for pregnant and postpartum Medi-Cal members based on their **needs** and **preferences**.

Transitional Care Services (TCS)

PHM is a Medi-Cal managed care program that ensures all members, including pregnant and postpartum members have access to a comprehensive set of services based on their needs and preferences across the continuum of care. Under PHM, MCPs are accountable for providing TCS to support transitions of care.

Transitions of care occur when a pregnant or postpartum member **transfers from one setting or level of care to another**, including but not limited to discharges from hospitals to home or community-based settings, or Community Supports.

Current TCS Requirements for Pregnant and Postpartum Members

In January 2024, MCPs implemented TCS for all members to ensure they are supported from discharge planning until they have been successfully connected to all needed services and supports. Pregnant and postpartum members are currently defined as "high risk" for TCS support.

TCS Services*

- Ensure the completion of the discharging facility's discharge planning process, including medication reconciliation
- Ensure follow up coordination with post-discharge providers, including primary care, behavioral health or specialty care providers who can provide follow up care.
- Ensure referrals to Community Supports, ECM, WIC, CalFresh and other services.

High-Risk TCS Services for Pregnant and Postpartum Members**

- For all pregnant and postpartum members, MCPs must ensure the Member has a **single point of contact** who proactively supports members for the duration of the transition and provides all TCS services outlined on the left.

* MCPs are responsible for knowing when a Member is admitted/discharged/transferred (A/D/T), ensuring timely prior authorizations, and identifying high vs. low-risk members and assigning single point of contacts for high-risk members.
** Other "high-risk" transitioning members include those with LTSS needs; SMH/SUD population, those in or entering CCM/ECM, members transitioning to or from SNFs, children with special health care needs, Seniors and persons with disabilities, members identified as high-risk by RSST or a discharging facility.

Purpose: Updated TCS Policy for Pregnant and Postpartum Members

Since the launch of TCS, members have received additional supports at the time of discharge. However, DHCS has heard feedback that further specificity and design is needed to address the unique needs of pregnant and postpartum members. In response, DHCS is updating their policy and introducing a tailored TCS category for this population to achieve the goals listed below.

Design of TCS support for pregnant and postpartum Medi-Cal members is intended to:

- **Improve care** and **outcomes**
- **Connect** members **to specific resources** needed during the pregnancy and postpartum period.
- **Strengthen relationships with members and local** pregnancy providers.
- **Target MCP** and **provider resources** appropriately, maximizing impact.

Updated Pregnancy and Postpartum TCS Policy: Key Features

Given the significant need in the pregnant and postpartum population, DHCS will continue its current TCS policy so that no pregnant and postpartum Medi-Cal member is low risk. However, additional policy design is focused on stratifying and providing targeted and tailored resources for high- vs. moderate risk pregnant and postpartum members.

Updated TCS policy will:

- Introduce **risk stratification** to better **tailor TCS requirements** based on members' risk levels, including introducing a **moderate risk category** of pregnant and postpartum members
- Institute **new requirements** that are aligned with **member preferences** and address their **unique needs** during the pregnancy and postpartum periods
  - Introduce the "**TCS Birthing Supports Checklist**" to ensure all members who are pregnant or postpartum and their infants are connected to a minimum standard of **appropriate medical**, **behavioral, and whole person services** and **supports** (e.g, referral and warm handoff (to the extent possible) to AIMSS)
- Clarify DHCS's **oversight** and **monitoring** efforts related to TCS

NEW Moderate-Risk TCS Category for Pregnant and Postpartum Members

- **MCPs may choose to fulfill the care coordination responsibilities of TCS through a single contracted entity** (e.g., doula, clinic, tribal health clinic, or a care team), while retaining responsibility for other TCS components. **These services can be done as part of normal perinatal care provided by the contracted entity**

Discussion

DHCS is focused on including more existing pregnancy providers into TCS. As we prepare to host a briefing and feedback session on the updated pregnancy and postpartum TCS policy on September 29th with a broad group of maternal health partners—including pregnancy providers and hospital representatives.

Who are the key entities serving the pregnant and postpartum tribal population that you recommend we engage to join this meeting?

MY26 Quality Enforcement Measure Selection (QEMS) Overview

Quality Enforcement Measure Selection Context Comprehensive Quality Strategy (CQS)

- DHCS used a data-driven approach to determine key clinical areas of focus to address significant quality and health equity gaps in care.
- Progress is informed by MCAS and BHAS data reported by Medi-Cal Managed Care Plans (MCPs) and Behavioral Health Plans (BHPs) annually.
- For simplicity, BHAS/MCAS measure selection will be referred to as Quality Enforcement Measure Selection (QEMS) in this presentation.

Reference: DHCS Comprehensive Quality Strategy

QEMS Alignment with Comprehensive Quality Strategy (CQS)

- **Clinical Focus Area: Children's Preventive Care**
  - Infant, child, and adolescent well-care visits
  - Childhood and adolescent immunizations
  - Adolescent and adult depression screening and follow-up
  - Blood lead and developmental screening
- **Clinical Focus Area: Maternity Outcomes & Birth Equity**
  - Prenatal and postpartum care
  - Prenatal and postpartum depression screening
- **Clinical Focus Area: Behavioral Health Integration**
  - Follow-up after emergency department visit for mental illness
  - Follow-up after emergency department visit for SUD

QEMS Timeline/Milestones

Tribal Comment Period

- An opportunity for Tribal community input on BHAS and MCAS measure selection will be announced soon.
- While BHPs and MCPs are the reporting entities for BHAS and MCAS quality measures, our aim is to better understand how these measures may intersect with your current practices in clinical performance monitoring and improvement.
- Please send questions to QualityMeasures@dhcs.ca.gov

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar