

Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services
September 14, 2026

Welcome, Introduction of Tribal Leaders, and Review of Agenda

Yingjia Huang, Deputy Director
Health Care Benefits & Eligibility

Welcome and Webinar Logistics

» Microsoft Teams Tips

- Everyone will be automatically muted upon entry
- Use the Chat box to submit comments or questions
- Please use the Chat box for any technical issues related to the webinar

Feedback Guidance for Participants

- » **Chat Box.** Please feel free to utilize the chat box 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
 - Alternately 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

Agenda

- » "DHCS Director's and Medi-Cal Update"
 - Open Discussion
- » H.R. 1 Update
 - Open Discussion
- » Order, Referring, Prescribing (ORP) Provider Update
- » Behavioral Health Update
- » Closing Remarks

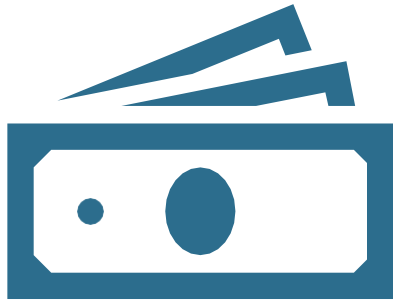
DHCS Director's Update

Michelle Baass, DHCS Director

2026-27 Budget Act Overview



2026-27 Budget Act



- » The Budget Act includes \$337.7 billion in total funds for all health and human services programs.
 - The Budget includes **\$226.3 billion in total funds** and **4,765.5 positions for DHCS**.
- » Of this amount, \$1.5 billion is State Operations (DHCS operations), while \$224.7 billion is Local Assistance (program costs, partners and administration).
- » The proposed budget continues to support the Department's purpose to provide equitable access to quality health care.

DHCS Major Budget Issues: Managed Care Organization (MCO) Tax

- » The budget includes tax revenue of \$2.5 billion in 2026-27 to support payment increases relative to calendar year 2024.
- » The MCO tax renewal is effective January 1, 2027, and conforms to the new H.R. 1 federal requirements.
 - The budget includes net revenue of:
 - \$575 million in 2026-27
 - \$2.3 billion in each of 2027-28 and 2028-29
 - \$1.7 billion in 2029-30
 - This renewed MCO tax supports the Medi-Cal program and maintains targeted rate increases for primary, maternal and non-specialty mental health care

DHCS Major Budget Issues: Unsatisfactory Immigration Status (UIS) to Fee-For-Service (FFS)

- » Beginning January 1, 2027, members with UIS will transition to the FFS delivery system.
- » The budget includes cost reductions for current year and ongoing:
 - 2026-27 \$637.1 million (\$524.9 million General Fund)
 - Ongoing \$1.6 billion (\$1.3 billion General Fund)
- » The budget includes \$39 million to provide care coordination and navigation services to this population.

DHCS Major Budget Issues: H.R. 1

- » The Budget includes the following H.R. 1 (2025) highlights:
 - **Affordable Care Act (ACA) Adult Expansion with UIS Federal Medical Assistance Percentage (FMAP) adjustment for Emergency Services.**
 - Results in an additional General Fund (GF) cost of \$669 million in 2026-27.
 - **Work and Community Engagement Requirement.**
 - Results in a cost reduction of \$357.6 million in total funds (\$90.3 million GF) in 2026-27 and \$9.6 billion (\$2.4 billion GF) by 2029-30. Projected disenrollments are 43,000 in 2026-27 and 1.1 million by 2029-30.
 - **ACA Adult Expansion Population Six-Month Redetermination.**
 - Results in a cost reduction of \$747.3 million in total funds (\$186.4 million GF) in 2027-28 and \$2.5 billion (\$633 million GF) by 2029-30. Projected disenrollments are estimated to be zero in 5 2026-27 and approximately 278,600 in 2029-30.
 - **Restrictions on Immigrant Eligibility.**
 - Full-scope Medi-Cal cost is projected to be \$365 million GF in the budget year for a delayed July 1, 2027, transition to restricted-scope Medi-Cal.

DHCS Major Budget Issues 1 of 2

- » **County Medi-Cal Administration Augmentation** - \$709 million (\$196.8 million GF) one-time augmentation in 2026-27 to support H.R. 1 implementation. The budget includes a total of \$3.3 billion (\$828.2 million GF) for the Medi-Cal county administration in 2026-27.
- » **Community Mobile Crisis Services** - \$42.2 million in GF to extend the community-based mobile crisis response services benefit until June 30, 2027.
- » The Budget includes additional funding for the following programs:
 - **988 and Behavioral Health Crisis Continuum** - \$25.9 million in total funds.
 - **Behavioral Health Transformation** - \$41.8 million in total funds for Behavioral Health Services Act (BHSA) ongoing implementation oversight and monitoring.

DHCS Major Budget Issues 2 of 2

- » Refines criteria for **Enhanced Care Management** (ECM) and **Community Supports** including eligibility criteria, service definitions and utilization management criteria. The Budget includes General Fund savings of \$41.4 million in 2026-27 and \$99.2 million ongoing related to the ECM changes and General Fund savings of \$26.9 million in 2026-27, \$58.8 million in 2027-28, and \$51.0 million ongoing related to the Community Supports changes.
- » Includes a General Fund reduction of \$68 million in 2026-27 increasing to \$552 million in 2029-30 to strengthen utilization management controls for **applied behavioral health analysis** and **transportation** in the Medi-Cal program and eliminates the incentive component of the quality with hold and incentive program in Medi-Cal.
- » Redirects the **Medical Loss Ratio** remittances to the General Fund to achieve a \$25 million savings.

DHCS Major Budget Issues: Delay of 2025 Budget Act Actions

- » The Budget includes increased costs due to the delay of the following 2025 Budget Act General Fund Solutions:
 - Delays elimination of **state-only prospective payment system (PPS) payments** to Federally Qualified Health Centers and Rural Health Clinics from July 1, 2026, to July 1, 2027.
 - Delays elimination of **dental benefits** for UIS and of **Dental Supplemental Payments** from July 1, 2026, to July 1, 2027.

DHCS Major Budget Issues

- » Maintains the current **Medi-Cal asset limit** that went into effect January 1, 2026, and also reinstates the asset limit for seniors and adults with disabilities to \$21,000 for an individual or \$31,000 for a couple, effective no sooner than July 1, 2027.
- » Includes General Fund savings of approximately \$427.3 million in 2027-28, decreasing to approximately \$314.3 million annually in 2029-30 from increasing **monthly premiums for adults with unsatisfactory immigration status** to \$50, effective July 1, 2027, subject to a determination in the 2027-28 May Revision.

DHCS Major Budget Issues: One-Time Funding

- » The Budget includes one-time funding for the following policies:
 - Support for **Designated Public Hospitals** in the amount of \$250 million General Fund for grants to support health care expenditures.
 - **Proposition 36** funding for grants to county behavioral health departments in the amount of \$20 million General Fund over three-years.
 - One-time increases for **Private Duty Nursing**, \$30 million General Fund, and **Congregate Living Health Facility**, \$7.7 million General Fund.
 - **Anosognosia Pilot Program** funding in the amount of \$5 million General Fund for a one-time direct payment to CenCal Health to establish a pilot program for the treatment of severe schizophrenia or anosognosia.

Additional Information and Resources



- » DHCS Website - [**Governor's Budget Documents 2026-27**](#)
 - [**DHCS FY 2026-27 Budget Act Highlights**](#)
 - [**What Medi-Cal Members Need to Know**](#)
- » Statewide Budget Website – [**ebudget.ca.gov**](#)
- » Department of Finance Website - [**https://dof.ca.gov/**](#)
 - Budget Change Proposals - [**Governor's Budget BCPs**](#)
 - Trailer Bill Language - [**DOF Trailer Bill Language**](#)

Open Discussion



H.R. 1 Updates

Summary of Key Provisions and AI/AN Exemptions

Yingjia Huang, Deputy Director
Health Care Benefits & Eligibility

New Work and Community Engagement Requirements in Medi-Cal

- » **H.R. 1** establishes Medicaid **work and community engagement requirements** as a new condition of eligibility for members in the “New Adult Group.”
- » California must implement work and community engagement requirements by **January 1, 2027**, meaning individuals in this group must demonstrate compliance with or meet an exclusion or exception from the requirements to be determined eligible for Medi-Cal.
- » **CMS issued an interim final rule** on June 1 that establishes the operational framework for work and community engagement requirements. The rule became final on July 31.

Individuals in the New Adult Group:

- (1) Ages 19-64
- (2) Not pregnant
- (3) Not enrolled in or entitled to Medicare Part A or B
- (4) Not otherwise eligible for another mandatory Medi-Cal eligibility group
- (5) Have income less than 138% of the federal poverty level, which is \$22,025 for an individual and \$45,540 for a family of four.

DHCS Implementation Guiding Principles

- » **Automate to Protect Coverage.** Maximize the use of data sources to confirm eligibility without burdening members and counties. Reduce paperwork, streamline verifications, and safeguard coverage stability.
- » **Communicate with Clarity and Connection.** Implement an outreach and education campaign that is culturally relevant, linguistically accurate, and written in plain language to build trust and help members, their families, and caregivers understand the changes.
- » **Simplify the Renewal Experience.** Modernize and streamline the Medi-Cal renewal process with clearer, member-friendly forms (first in the New Adult Group, and later for all members) and with six-month renewal steps that are easier to navigate.
- » **Educate and Train Those Who Serve Medi-Cal Members.** Deliver comprehensive training on all H.R. 1 provisions for county eligibility workers. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties, plans, providers and DHCS Coverage Ambassadors can confidently support members and avoid error on member cases.
- » **Provide Timely and Transparent Communication to Members.** Share information on H.R. 1 changes early on and via multiple channels (mail, text, outbound phone calls, etc.) so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

Key Guidance Under the Interim Final Rule (1 of 2)



- » **Defines Qualifying Activities:** Provides more granular definitions for each qualifying compliance activity in more detail (e.g., defines community service, adds in-kind and unpaid to work definition, and explains how half-time education will be calculated).
- » **States Must Screen for Specified Exclusion First:** Before applying work requirements, states must check whether someone qualifies for an exclusion, such as being medically frail or a parent of a child under age 14.
- » **Medical Frailty:** Departs from statutory definition and narrows medical frailty exclusion by requiring that qualifying conditions “significantly impair” an individual’s ability to work.

Key Guidance Under the Interim Final Rule (2 of 2)

- » **Short-Term Hardship Exceptions:** Establishes a lookback period (one month in California) for these exceptions and provides more granular definitions.
- » **Self-Attestation:** Allows states to accept self-attestation in 2027, but limits use in 2028 and beyond.
- » **Noticing and Outreach:** Specifies when and under what circumstances states must conduct noticing and outreach to members.
- » **Good Faith Waivers:** Clarifies that CMS may approve good faith waivers for up to six months at a time and projects approving these requests in only two states.

Required Process for Evaluating if an Individual is Required to Demonstrate Compliance with Work and Community Engagement Requirements

Step 1

Before applying work and community engagement requirements, states must check whether someone qualifies for an exclusion, such as being medically frail, an American Indian/Alaska Native, parent of a child under age 14, or compliant with Temporary Assistance for Needy Families.

Step 2

Individuals who are subject to work and community engagement requirements may be excepted under:

- » *Mandatory Exceptions:* For example, under age 19 or incarcerated in the last three months); OR
- » *Short-Term Hardship Exceptions.*

Step 3

If an individual does not meet a mandatory or short-term hardship exception, they must demonstrate compliance with a qualifying activity (e.g., work, community engagement, work program, or half-time educational program).

Specified Excluded Individuals

(not subject to WCER; evaluated in month of application)

- » **Medically frail individuals**
- » **Participants in a drug addiction or alcohol treatment and rehabilitation program**
- » Parents, guardians, caretaker relatives, or family caregivers of a dependent child under age 14, or of a disabled individual
- » Veterans with a disability rated as total under 38 U.S.C. § 1155
- » Members of a household receiving Supplemental Nutrition Assistance Program (SNAP) and not exempt from SNAP work requirements
- » Individuals compliant with Temporary Assistance for Needy Families (TANF) work reporting requirements
- » American Indians and Alaska Natives
- » Former foster care youth under age 26 [i.e., individuals eligible under the former foster care youth (FFCY) eligibility group]
- » Inmates of a public institution
- » Pregnant individuals or those entitled to postpartum Medi-Cal coverage

Applicable Individuals

(subject to WCER)

» **Exceptions** *[evaluated in lookback month(s)]*

- **Mandatory Exceptions:**

- Under age 19
- Entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B
- Described in a mandatory eligibility group (e.g., parents/caretaker relatives within certain incomes, individuals receiving Supplemental Security Income)
- Incarcerated at some point in the three-month period prior to the relevant month
- Specified excluded individuals (if relevant during the lookback month)

- **Optional Short-Term Hardships Exceptions:**

- **Receiving inpatient or institutional care***
- **Travel outside one's community for medical care for themselves or a dependent***
- Living in a county with a federal emergency or disaster declaration
- Living in a county with high local unemployment

**Individual must request exception.*

Applicable Individuals (cont.)

(subject to WCER)

» **Qualifying Activities** *[evaluated in lookback month(s)]*

- Work (at least 80 hours)
- Community service (at least 80 hours)
- Participation in a work program (at least 80 hours)
- Educational enrollment (at least half time)
- Any combination of the above listed activities (for a total of at least 80 hours)
- Income of at least \$580/month (or for seasonal workers, an average \$580/month income over a six-month period)

AI/AN Exemptions Under H.R. 1

- » AI/AN, California Indians, and I/T/U-eligible individuals are exempt from all three Medicaid changes.
 - Recognizes federal trust and treaty responsibilities
 - Supports Medicaid's role in fulfilling obligations

AI/AN-Specific Provisions

- » Use existing Medicaid definition of 'Indian'
 - Prohibit reverification of AI/AN status
 - AI/AN exempt from 6-month determinations
 - Prioritize AI/AN exempt category
 - Use ex parte verification requirements
 - Preclude reverification of exemption status

Medical Frailty Exclusion

- » The rule confirms that states must use medical codes and other reliable data to identify medically frail individuals; however, **medical codes and claims do not convey information about ability to work.**
- » **Further guidance from CMS is needed** to build out processes that link the severity of the condition to the individual's ability to work.
- » With the narrowing of the definition, **eligible individuals may lose coverage** if they cannot readily access a provider or obtain the required documentation.

NOTE:

- » *Medical Frailty Self-Attestation:*
 - Allowable in 2027.
 - In 2028 and beyond, allowable once per enrollment period, with documentation required thereafter if data is unavailable.
- » *Verification Period:*
 - At state discretion, medical frailty can be reverified for up to 12 months at a time.

Short-Term Hardship Exception

California will offer all short-term hardship exceptions.

- » Inpatient (and Similar) Care
- » Medical Travel
- » Declared Emergency
- » High Unemployment

- » **Individuals must request** the inpatient (and similar) care and medical travel exceptions.
- » **California must automate** the declared emergency and high unemployment exceptions and grant them to individuals based on residence.
- » **The rule requires a lookback period for these exceptions**, which could lead to gaps in coverage.
 - For example, an individual hospitalized in July who applies for Medi-Cal and requests a short-term hardship exception must demonstrate that they met an exception or complied with work and community engagement requirements in June to be eligible for coverage in July.

Verification Standards

Verifying	In 2027	In 2028 and Beyond
Specified Excluded Individual	If data are unavailable, may require documentation or accept other information (e.g., self-attestation).	» If available data are not enough, require documentation (when reasonably available). » If documentation is not available, accept other information to verify eligibility (e.g., self-attestation). State cannot deny or terminate coverage solely due to lack of documents.
		<i>For Medical Frailty Only:</i> Self-attestation allowed once per enrollment period; after that, require documentation if data are unavailable.
Applicable Individual Exceptions	If application or renewal form indicates the person qualifies for an exception (including a specified exclusion), may accept self-attestation . <i>This option does not apply to all specified excluded individuals (e.g., medically frail, inmates, or veterans with a disability rated as total).</i>	
Applicable Individual Compliance	If data are unavailable, may require documentation or accept other information (e.g., self-attestation).	» If available data are not enough, require documentation (when reasonably available). » If documentation is not available, accept other information to verify eligibility. Do not deny or terminate coverage solely due to lack of documents.

Noticing and Outreach

The Interim Final Rule notes that states must conduct multiple-modality,* targeted outreach to all individuals eligible for and enrolled in the New Adult Group and provides specific guidance on content to include.

- » **Initial Outreach:** Four months prior to the work and community engagement requirements implementation date (8/31/2026).
- » **Outreach Upon Enrollment:** For individuals enrolled after the initial outreach is sent, but before the state implements work and community engagement requirements.
- » **Periodic Outreach:** On an ongoing basis following enrollment, tied to certain events (e.g., to provide 10-days' advance notice upon the loss of specified excluded status for a member).
- » **Ad Hoc Outreach:** On an ad hoc or routine basis.

**Via mail (or e-mail if elected by the individual) and one other modality.*

Good Faith Waivers

The Interim Final Rule outlines how states may seek approval for a good faith waiver to temporarily delay implementation for up to six months at a time through December 31, 2028.

Note: CMS has not provided guidance or submission instructions for the good faith waiver.

CMS will consider the following when reviewing waiver requests:

- » **Progress the state has made** toward implementing work reporting requirements.
- » **Key barriers or challenges**, including funding, design, development, procurement, or system readiness.
- » The state's **implementation plan**, including timeline and milestones.
- » Any **exigent circumstances** (e.g., administrative or external emergencies) affecting implementation.

The rule anticipates that ten states will submit waiver requests and that CMS will only approve two.

How to Identify 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"

Open Discussion



Ordering, Referring, and Prescribing (ORP) Provider Enrollment: Tribal Partner Discussion

Mistie Chiddick, Division Chief

Amber De La Rosa, Division Chief

Bassant Khalil, Assistant Division Chief

Agenda

- » Overview of Federal Regulations for ORP Providers
- » Potential Impacts and Mitigation Efforts
- » Call to Action: How Key Partners Can Help
- » ORP Provider Enrollment Timeline
- » What ORP Providers Must Do
- » Q&A

Overview of Federal Regulations for ORP Providers



Overview of Federal Regulations and ORP

- » Federal Medicaid rules ([42 CFR 455.410](#) and [455.440](#)) require all ORP providers to be enrolled in Medicaid and have a Type 1 (individual) National Provider Indicator (NPI).
- » DHCS is launching a multi-year approach to implement enforcement of federal ORP provider requirements.
- » Enrollment will be verified with claim edits applied across pharmacy, medical, and behavioral health (Short-Doyle) claim systems.

Overview of Federal Regulations and ORP: Definitions (1 of 2)

» **Ordering Provider:**

A licensed provider who directs specific services or supplies to be furnished to a Medi-Cal member. Some typically ordered services include, but are not limited to, laboratory tests, durable medical equipment (DME), and home health services..

» **Referring Provider:**

A licensed provider who sends a Medi-Cal member to another provider or facility for services, typically evaluation or treatment, that the referring provider cannot perform (for example, a primary care practitioner refers a Medi-Cal member to a gastroenterologist).

» **Prescribing Provider:**

A licensed provider (e.g., a physician, nurse practitioner, or pharmacist) who writes a prescription for a medication or other pharmacy-dispensed item within their scope of practice.

Overview of Federal Regulations and ORP: Definitions (2 of 2)

- » **Type 1 NPI (Individual):** For individual health care providers, such as physicians, nurse practitioners, pharmacists, and sole proprietors. Individuals are only eligible for one NPI.
- » **Type 2 NPI (Entity):** For health care organizations, such as hospitals, nursing homes, and physician groups not organized as a sole proprietor group. Organizations can have multiple NPIs.

Overview of ORP Regulations: Why Compliance Matters

- » Federal law requires providers who order, refer, or prescribe services to be **enrolled** with Medi-Cal and **identified on claims**.
 - Consistent with federal requirements, (1) when ORP provider information is not included on a claim, (2) it is inaccurate, (3) or the ORP provider is not enrolled, the claim submitted by the billing provider should not be paid by Medi-Cal.
- » However, these rules are not currently uniformly enforced across systems due to technical and operational challenges.
- » DHCS' 2023 Payment Error Rate Measurement (PERM) audit, administered by CMS and which measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP), identified errors resulting from missing required NPI information and claims submitted by ORP providers who were not enrolled.
- » DHCS must correct these issues to maintain compliance with federal regulations.

Overview of Federal Regulations and ORP: Why Enforcement Matters (1 of 2)

- » Helps ensure program integrity and improves fraud prevention.
- » Supports enhanced utilization management controls, audits, and overpayment recovery, and identifies improper billing practices.
- » Protects **state** funding by preventing improper payments and mitigates False Claim Act violations and recoveries, as ORP provider enrollment helps validate that services are being authorized by qualified providers within their scope of practice, and services are medically necessary.

Overview of Federal Regulations and ORP: Why Enforcement Matters (2 of 2)

- » Protects **federal** funding and ensures federal compliance, which helps ensure federal financial participation remains available and reduces the risk of future federal deferrals or disallowances.
- » Supports greater accountability and oversight by improving data quality, increasing transparency, and uniformly applying the ORP provider enrollment requirement.

Potential Impacts and Mitigation Efforts



Mitigation Efforts to Address Potential Impacts

Potential Impacts

- » Medi-Cal members may face delays accessing medical and pharmacy benefits if their provider is not enrolled.
- » Some Medi-Cal members may need to select a new ORP provider who is enrolled with Medi-Cal with their Type 1 NPI.
- » Billing providers, including pharmacies, may experience claim denials if ORP provider information on the claim is not present/valid.
- » Some ORP providers may choose not to enroll due to the perceived administrative burden.

Mitigation Efforts

- » DHCS is performing early and targeted outreach to non-enrolled ORP providers, promoting early enrollment, and will gradually implement and enforce system edits.
- » DHCS is coordinating with MCPs and the DHCS Helpline to aid members needing to find another provider.
- » DHCS will provide clear billing guidance to reduce administrative burden and help prevent downstream claim denials.
- » DHCS is providing education and support to assist ORP providers with the enrollment process.

Approach to Implementation

- » **Multi-year** approach.
- » Balancing the need for compliance with the need to **minimize disruption to members and providers**.
- » An approach **driven by data**.
- » Early and frequent **communication** with stakeholders.

Call to Action



Call to Action: (1 of 3)

- » **Distribute DHCS-provided ORP provider enrollment reminders** through newsletters, listservs, and call centers, reaching ORP providers who may not receive DHCS bulletins directly or would benefit from reminder messaging.
- » **Identify and notify** unenrolled ORP providers.
- » **Clarify the requirement for non-billing ORP providers.** Some non-billing ORP providers may assume enrollment does not apply to them since they do not bill Medi-Cal directly. However, this is not true. If they order, refer, or prescribe for Medi-Cal members, the requirement applies.

Call to Action: (2 of 3)

- » Health care organizations, such as hospitals and clinics, should:
 - **Socialize to network providers** what must be done to enroll in Medi-Cal as ORP providers.
 - Establish **regular and proactive outreach** to ORP providers to share information through normal channels and provide technical assistance in navigating these changes.
 - **Use DHCS-provided information** to develop call center scripts, provider articles, member flyers, and other resources to assist ORP providers and members.
 - **Work with members** if/as needed to provide care coordination and assist with finding ORP providers who are enrolled in Medi-Cal.

Call to Action: (3 of 3)

- » **Stay informed** of implementation dates and messaging for ORP providers and members **by accessing updates on the DHCS and Medi-Cal websites.**
- » **Subscribe to DHCS listservs** to stay informed on policy updates and upcoming implementation dates.
- » **Prepare for ORP provider and member calls** for assistance with consistent messaging that aligns with DHCS' messaging.

ORP Provider Enrollment Information

» There are **three basic requirements for enrolling as an ORP provider** for Medi-Cal:

- Must be of the specialty type eligible to order, refer, and prescribe in accordance with State law and applicable scope of practice.
- Must be a provider type that can enroll in the Medi-Cal program.
- Must enroll with an individual (Type 1) NPI.
 - An organizational (Type 2) NPI is unacceptable.

ORP Provider Enrollment Timeline

Don't wait. Avoid delays. Enroll now.

Feedback & Questions

DHCS can respond to your questions and feedback and prepare additional resources to help you.

Manuals & Training Updates

Enhanced provider manuals and training will be available to assist with claims.

**JULY – SEPT.
2026**

**SEPTEMBER
2026**

**OCTOBER
2026**

**NOVEMBER
2026**

**FEBRUARY
2027**

Outreach & Engagement

Town Halls and focused forums for you to learn more about ORP provider enrollment, what is expected from providers, & to ask questions.

ORP Website Available

One consolidated website will be available for you to access resources, Frequently Asked Questions (FAQ), and timelines.

Projected Enforcement Begins

Your patients could be denied access to benefits if you are not enrolled as an ORP provider and the NPI is not on the claim.

Do I need to enroll as an ORP Provider?



If you can answer yes to any of the following questions, **you must enroll** as an ORP provider.

Do you...

» **Order, refer, or prescribe** any of the following?

- lab tests.
- home health services.
- DME.
- imaging or diagnostic services.
- prescriptions filled and billed to Medi-Cal, including Medications for Addiction Treatment (MAT).
- Specialty Mental Health, Drug Medi-Cal, or Drug Medi-Cal Organized Delivery system services as a licensed practitioner.
- referrals to another provider for new or ongoing treatment, and that treatment requires a referral.
- physical, occupational, or speech therapy.

» **Order, refer, or prescribe** anything a Medi-Cal member receives and don't already bill Medi-Cal directly under my own Type 1 (Individual) NPI?

Are you...

- » Enrolled in Medicare, but still order, refer, or prescribe for Medi-Cal?
- » Only seeing Medi-Cal patients through a MCP and do not bill fee-for-service?
- » Supervising, employing, or contracting with other practitioners who list you as the ordering or referring provider?
- » New to a group practice and think the group's enrollment covers you?
- » In your residency program and working under a Postgraduate Training License (PTL)?
- » Filling in for another provider temporarily and your patients' claims go through their name or their facility's billing?

Do I *really* need to enroll as an
ORP Provider?



If you answered yes to any of
the previous questions, **you
must enroll** as an ORP
provider.

Additional Support and Resources

- » For enrollment policy questions, review the [**ORP Enrollment**](#) slide deck, or use the [**Provider Inquiry Form**](#).
- » Medi-Cal Provider Enrollment Help Desk:
 - Phone (866) 252-1949
 - For more information, visit [**Ordering/Referring/Prescribing Only Enrollment Information | DHCS**](#).
- » For medical (CA-MMIS) questions, call the Telephone Service Center at (800) 541-5555 (outside of California, please call (916) 636-1980).
- » Subscribe to [**DHCS Stakeholder e-Notifications**](#).
- » For additional questions, please contact [**ORP@dhcs.ca.gov**](mailto:ORP@dhcs.ca.gov).



Questions and Discussion



Behavioral Health Updates and Discussion

Paula Wilhelm, Deputy Director
Behavioral Health

Ivan Bhardwaj, Division Chief
Medi-Cal Behavioral Health Policy

Behavioral Health Agenda

» Traditional Health Care Practices

- Questions and Discussion

» 988 Suicide and Crisis Lifeline Overview and Tribal Partnerships

- Questions and Discussion

Traditional Health Care Practices

Paula Wilhelm, Deputy Director
Behavioral Health

History and Context

CMS approved DHCS' Traditional Healers and Natural Helpers demonstration amendment (originally proposed in 2017) in October of 2024.

- » Beginning in 2017, DHCS submitted multiple requests for federal approval to cover Traditional Healer and Natural Helper Services under the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- » In October 2024, CMS approved Medicaid coverage of Traditional Health Care Practices in four states (CA, AZ, OR, NM) with a standard framework through Section 1115 demonstration waivers. **California's coverage is currently authorized through December 31, 2026.**
- » Medi-Cal coverage of Traditional Health Care Practices launched in spring 2025. 21 Indian Health Care Providers in California have been approved to provide these services through Medi-Cal.
- » **California is seeking renewal of Traditional Health Care Practices for another five-year demonstration period (2027-2031).**

California's Approach

DHCS received approval from CMS to implement state-specific terms to meet the needs of Medi-Cal members.

- » **Services:** In California, traditional health care practices encompasses **Traditional Healer** and **Natural Helper** services, provided by Traditional Healers and Natural Helpers.
- » **Eligible Members:** DHCS will make these services available to Medi-Cal and CHIP members receiving care delivered by Indian Health Care Providers (IHCPs), including Indian Health Service facilities, Tribal facilities, or Urban Indian Organizations and covered by DMC-ODS counties for treatment of SUDs. Members must be:
 1. Enrolled in Medi-Cal or CHIP in a DMC-ODS County;
 2. Able to receive services delivered by or through an IHCP, as determined by the facility; and
 3. Meet DMC-ODS access criteria for substance use.
- » **Role of Counties:** All DMC-ODS counties will be required to cover Traditional Healer and Natural Helper services. As of September 2026, there are 41 DMC-ODS counties; approximately 96 percent of California's Medi-Cal population are covered within these counties.

DMC-ODS Counties (July 2026)

- » Alameda
- » Contra Costa
- » El Dorado
- » Fresno
- » Humboldt*
- » Imperial
- » Kern
- » Lake
- » Lassen*
- » Los Angeles
- » Madera
- » Marin
- » Mariposa
- » Mendocino*
- » Merced
- » Modoc*
- » Monterey
- » Napa
- » Nevada
- » Orange
- » Placer
- » Riverside
- » Sacramento
- » San Benito
- » San Bernadino
- » San Diego
- » San Francisco
- » San Joaquin
- » San Luis Obispo
- » San Mateo
- » Santa Barbara
- » Santa Clara
- » Santa Cruz
- » Shasta*
- » Siskiyou*
- » Solano*
- » Sonoma
- » Stanislaus
- » Tulare
- » Ventura
- » Yolo

**These counties offer DMC-ODS services through a regional, multi-county model. Partnership Health Plan administers covered SUD services on behalf of the seven counties.*

21 IHCPs Approved to Participate (July 2026)

- » Indian Health Center of Santa Clara Valley
- » Santa Ynez Tribal Health Clinic
- » American Indian Health & Services
- » Friendship House
- » United Indian Health Services, Inc.
- » Southern Indian Health Council
- » Native American Health Center (Oakland)
- » Native American Health Center (SF)
- » K'ímaaw Medical Center
- » Pit River Health Services
- » Indian Health Council
- » Shingle Springs Health & Wellness Center
- » New Life Health Authority
- » Sonoma County Indian Health Project
- » Fresno American Indian Health Project
- » Karuk Human Services
- » Bakersfield American Indian Health Project
- » Feather River Tribal Health
- » Riverside-San Bernadino County Indian Health, Inc.
- » Desert Sage Youth Wellness Center
- » Sacred Oaks Healing Center

THCP Timeline

2017-2021

DHCS requests authority to cover THCP under DMC-ODS

March 21, 2025

DHCS releases [THCP BHIN 25-007](#). Superseded by [25-036](#) in October 2025.

May 2026

DHCS submits [CalAIM 1115 renewal](#)

Summer and Fall 2024

Policy development and official CMS approval

April 2025 - present

Ongoing technical assistance for IHCPs and DMC-ODS counties

Fall/Winter 2026-2027 (if renewed)

Continue implementation. Consider policy updates and expansion opportunities.

Key Resources

- » [Traditional Health Care Practices](#) (landing page)
 - Includes list of participating IHCPs and FAQs
- » [Behavioral Health Information Notice 25-036](#)
 - Core policy guidance
- » [Technical Assistance Portal](#)
- » TraditionalHealing@dhcs.ca.gov

Questions and Discussion



988 Suicide and Crisis Lifeline Overview & Tribal Partnerships

Ivan Bhardwaj, Division Chief
Medi-Cal Behavioral Health Policy

Background

- » Assembly Bill (AB) 988, called the Miles Hall Lifeline and Suicide Prevention Act, was enacted in 2022.
- » DHCS administers and supports California's 988 Network, including funding, training, technical assistance, oversight, and stakeholder coordination.
- » California's 988 approach is part of a broader crisis care continuum designed to improve access to behavioral health support, strengthen coordination with local services, and connect individuals to appropriate follow-up care.

AB 988 Five-Year Implementation Plan

The Building California's Comprehensive 988 Crisis System: Assembly Bill (AB) 988 Five-Year Implementation Plan

Goals Specific to Tribal Engagement

Goal A:

Public Awareness of
988 and Behavioral
Health Crisis
Services

Goal D:

Increase coordination of
behavioral health crisis
services

Goal E.1:

Prioritize inclusion and equity in crisis care service delivery for populations (including American Indian/Alaska Natives) that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs

» California Health & Human Services Agency. Building California's Comprehensive 988-Crisis System: A Strategic Blueprint AB 988 Five-Year Implementation Plan. <https://www.chhs.ca.gov/wp-content/uploads/2025/01/AB-988-Five-Year-Implementation-Plan-Final-ADA-Compliant.pdf>

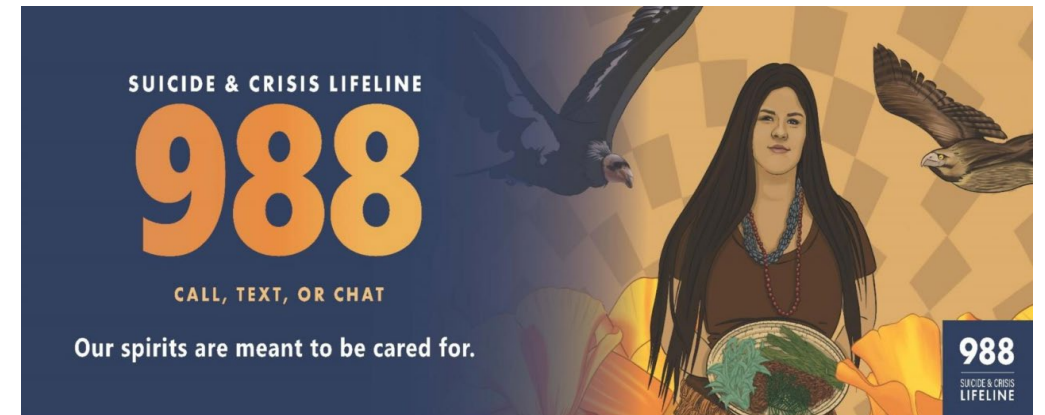
988 Statewide Public Awareness Campaign

988 Statewide Public Awareness Campaign

- » The 988-billboard campaign was launched statewide on September 15, 2025.
- » Additionally, a Tribal 988-billboard campaign was launched statewide in October 2025.
- » The campaign ran through January 31, 2026.
- » As of January 31, 2026, a total of 992 billboards, featuring a mix of media placed throughout California generated approximately 320,500,000 total impressions.



988 Tribal Billboard Examples



Artwork by Monica Zavala, a Native artist

988 Billboard Examples

Governor's Executive Order N-31-25 Supporting Men and Boys



Additional 988 Tribal Efforts

- » 988 Tribal Summits
 - February 3, 2023
 - March 22, 2023
- » California 988 Tribal Engagement Plan
- » Partnered with Office of Tribal Affairs and Kauffman & Associates, Inc. (KAI)
 - Three Tribal-specific trainings to all crisis centers
 - **5/13/25** - [Getting to Know Our Neighbors – Native American Edition CA 988](#)
 - **6/30/25** - [CA 988 - Self, Community, and Spiritual Care Webinar July 2025](#)
 - **8/13/25** - [Trauma in Native American Communities. Understanding, Healing, and Supporting Resilience](#)

Future 988 Tribal Efforts

- » New SAMHSA Grant (September 2026 – September 2029)
 - ~\$20M/year for three years
 - If awarded, this grant would enable DHCS to strengthen 988 Tribal engagement by expanding collaboration with Tribes and Tribal Organizations to co-develop culturally and linguistically appropriate services that meet community needs.
- » Continued and ongoing partnerships with Tribal members.

Questions and Discussion



Thank You

Contact: 988@dhcs.ca.gov

[DHCS 988 Website](#)



Closing Remarks

Andrea Zubiato, Division Chief
Office of Tribal Affairs

Indian Health Program – Grant Program

- » The Indian Health Program – Grant Program supports primary care recruitment and retention in Indian Health Clinics.
- » Since 2022, the Office of Tribal Affairs has awarded \$101.8 million to California Indian Health Programs.
- » For Fiscal Year 2026-2027, OTA awarded \$22.5 million to:
 - 30 Indian Health Programs
 - 4 Traditional Indian Health Programs
- » OTA will release a new Request for Application in early 2027 for the Traditional Indian Health Program, for Fiscal Year 27/28.

Become a Coverage Ambassador

Help your community stay covered.

Many Californians are navigating changes to Medi-Cal. Coverage Ambassadors are trusted messengers who help members stay informed and understand what to do to keep vital health benefits.

Ambassadors:

- Stay up-to-date on Medi-Cal information through regular webinars and newsletters.
- Educate members about key deadlines and upcoming changes.
- Help members understand steps to keep their coverage.
- Share multilingual flyers, FAQs, and social media content.
- Provide feedback on outreach materials.
- Stay connected to CalHHS outreach on coming federal changes to CalFresh, Covered California, data sharing, and public charge.



Join the network: Scan the code or visit www.dhcs.ca.gov/coverage-ambassadors to sign up.

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar