Department of Health Care Services (DHCS)
Medi-Cal Tribal and Indian Health Program Designee Meeting
May 5, 2017

DHCS Indian Health Update

1. **Question:** Regarding State Plan Amendment (SPA) for the 340B program, the information is vague, and there is no trailer bill language, is there additional language in the governor's budget?

   DHCS Response: Yes. The original intent of the SPA in January was for reimbursement purposes for 340B entities that is similar to the process for Medi-Cal Fee-For-Service (FFS). 340B entities that acquire drugs through the 340B authority, including managed care entities, will be reimbursed at an amount greater than the cost paid to acquire the drugs. DHCS understands the sensitivity of this policy area and held sessions with stakeholders for input that was included in the policy.

2. **Question:** Regarding the federal legislation on healthcare, is there a back-up plan if the American Health Care Act (AHCA) is approved? What are DHCS thoughts if the Affordable Care Act (ACA) goes away?

   DHCS Response: DHCS provided an assessment on the impact of the federal healthcare proposal (AHCA) in March of 2017. The assessment is available on the DHCS website at:
   http://www.dhcs.ca.gov/Documents/3.21.17_AHCA_Fiscal_Analysis.pd.pdf

   DHCS Update: DHCS periodically posts analyses of federal legislation on the DHCS website at: http://www.dhcs.ca.gov/Pages/default.aspx

3. **Question:** What are the counties described in the presentation providing perinatal services for the Maternal and Child Health program?

   DHCS Response: San Diego, Riverside/San Bernardino, Humboldt, Sacramento

4. **Question:** Is the state aware of the disparities that exist in Maternal and Child Health and infant mortality amongst native children in urban vs. rural areas? Is information available from the study of differences between the two groups? Access to and communication around perinatal service is a challenge, especially in rural communities it is a lot harder to get care, is there anything to DHCS is doing to assist rural areas?

   DHCS Response: DHCS is working with the Public Health Institute to finalize the report and expand the research to more current data throughout the state. When complete, information will be available to clinics of service area.

5. **Question:** In regards to the SPA allowing three visits per day, will this apply to urban FQHC sites or only Indian Health Services Memorandum of Agreement (IHS/MOA) sites?

   DHCS Response: No, it is only for IHS/MOA sites.

6. **Question:** Is there anything planned for urban FQHC providers to increase the number of visits to three per day?

   DHCS Response: No, not at this time.

7. **Question:** Will the information presented today be available online?

   DHCS Response: Yes, the presentations will be posted on the DHCS Indian Health Program website at: http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx

8. **Question:** Are quality improvement style incentives like the Dental Transformation Initiative (DTI) recoverable under the DHCS Audits and Investigations (A&I) reconciliation process?

   DHCS Response: No, they are not.

9. **Question:** Chemehuevi Indian Clinic located in Needles, California, across from Lake Havasu is concerned about transportation, as patients have to travel long distances to receive services. How do tribes access Tribal Medicaid Administrative Activities (TMAA) for transportation services?

   DHCS Response: Under the Medi-Cal program, the California Rural Indian Health Board (CRIHB) handles TMAA. DHCS will check if TMAA can be extended to out of state providers.

DHCS Update and Discussion

10. **Question:** Thank you so much for coming here and being very transparent. This is my 13th year, in Indian health care, and in all of these years, there is not sufficient funding to provide care. We asked Indian Health Service (IHS) to protect us with funding changes and IHS came back with the suggestion that we see non-native patients. With Medi-Cal optional benefits exclusions in 2009, tribal health providers were treated like every other clinic. With the new changes coming, how can DHCS offer us the help in protecting or isolating the tribal clinics from these changes?

    DHCS Update: The American Health Care Act (AHCA) did not pass. As such, there have been no changes to the Medi-Cal program to date.

11. **Question:** Will there be a six months to a year transition time to implement the AHCA if passed?

    DHCS Update: The AHCA did not pass. As such, there is no plans for implementation.

12. **Question:** How will DHCS work with us regarding opioids?

    DHCS Response: It will be similar to what is being proposed for rural health. Marlies Perez will present later this afternoon and will go over in more detail.

13. **DHCS Comment:** DHCS received a request last year to look at the reimbursement of MOA clinics in managed care and the issues of having to wait for the reconciliation process to receive the full Office of Management and Budgets (OMB) rate. DHCS is working towards that process with an effective date of July. DHCS looked at other states to understand how best to structure the process. DHCS will continue to provide information as this develops and the input received thus far from our tribal providers is greatly appreciated.

    DHCS Update: DHCS disseminated a memo in May 2017 providing an update to the implementation date of the new payment arrangement to January 2018.

Audit and Investigations Update

14. **Question:** Is there a way to shorten the reconciliation process, a process that can take up to three years to complete.

    DHCS Response: If reconciliation reports with correct data and complete information is submitted, a tentative settlement (TRA) for 60% is issued. In statute, DHCS has three years to complete the reconciliation; however, currently reconciliations are taking 1 – 3 months. Requests for an expedite or any questions may be sent to clinics@dhcs.ca.gov

15. **Question:** Can you provide clarification of the proposal for OMB reimbursement, are all managed care plans (MCPs) included? Will the clinic bill the plan and still be required to submit reconciliations for Code 18?

    DHCS Response: All plans are included. With direct payment from the MCPs, code 18 reconciliations will not be required; however, reconciliations will still be required for code 2-Medicare crossover claims, and code 20 Capitated Medicare Advantage Care Plan claims.

    Question: Will DHCS notify the managed care plans of the change of direct billing and receiving full payment?

    DHCS Response: Yes.

16. **Question:** We have an intermittent clinic under the umbrella of one of our enrolled Medi-Cal facilities that is open two days a week. The clinic is not able to bill under the parent clinic as instructed by DHCS and Conduent. Can DHCS provide a contact person familiar with IHS that can assist and resolve these issues?

    DHCS Response: Tribal health clinics that choose not to maintain a primary care clinic license must complete a full enrollment package for intermittent sites.

17. **Question:** What is the status of adding the tribal health clinics as FQHCs?

    DHCS Response: DHCS is in conversations with our CMS federal partners. CMS is working with that policy that allows tribal clinics to bill for services outside of the four-

walls; however, until additional information is received, the implementation by DHCS is on hold. Prior to implementation, a SPA will be submitted to CMS and DHCS will send a tribal notice for review and comments. Additionally, the SPA will be presented at the quarterly Primary, Rural, and Indian Health Division (PRIHD) webinar.

18. **Question:** Is it possible Conduent can provide an onsite training rather than a webinar that is specific for Out-Of-State (OOS) and border providers.

    DHCS Response: Yes, submit your request to the clinics email inbox and we can follow-up.

Drug Medi-Cal Organized Delivery System Waiver Update

19. **Question:** Will the Expression of Interest for an Administrative Entity go out to all health plans and tribal entities?

    DHCS Response: Yes, it will go out to all tribes and plans.

20. **Question:** Medication is only one part of the treatment process. Our providers need to understand the issues, prescribe the medications to patients, and get them into an appropriate treatment program. There are opportunities for systems in place, perhaps through the Drug Medi-Cal grant, to provide other important elements like Substance Use Disorder (SUD) services, counseling, nursing services, these are important roles and we need to figure out how to support and fund to be successful. Do you see that working?

    DHCS Response: Both with the waiver and the Medication Assisted Treatment (MAT) grant, counseling is required. With the waiver, there are other wrap-around services like case management, while recovery services are built into the grant. DHCS could do that for the Indian Health Services Program in Part II design.

Medi-Cal Managed Care Update

21. **Question:** Why is DHCS adding two new plans in one county?

    DHCS Response: The GMC market has not been procured for a very long time, DHCS felt an obligation to re-open the market, as there has been a lot of interest in California and with a new procurement, and DHCS can identify what is available from a competition standpoint. The procurement is an application process, not the highest winner wins, and will affect the current market with more choice and more competition.

22. **Question:** At the pre-managed care meeting on May 4, 2017, many issues were identified with River City Medical Group (RCMG), a subcontractor of Blue Cross. If Blue Cross was unable to handle the patient load, why not add a new plan rather than have Blue Cross obtain a subcontractor?

    DHCS Response: Yes, DHCS was made aware of the many issues with RCMG and are looking into those. Procurement occurred in 2013 with an eight-year commitment. DHCS is required to maintain those commitments until the end of 2022. DHCS must

allow plans to make corrections first; however, DHCS has the authority to terminate a contract but there are many steps that have to be taken before prior to termination.

23. **Question:** Regarding what was discussed at the previous meeting last year and the FAQs recently posted, DHCS stated that it would look into auto assignment of the American Indian (AI) population, not the entire population. Is there an update to this request? Additionally, for AIs that want to sign up with a specific clinic, how can they do that and not be auto-assigned?

    DHCS Response: These issues were discussed at the pre-managed care meeting on May 4, 2017; DHCS will bring these issues to the plans. Plans may review claims to see where patients are going before assigning as utilization data is needed when making assignments. Information regarding contracted vs. non-contracted, as a contracted provider, and being able to be assigned as a primary care level provider is important to the discussion, DHCS continues to work with this issue of when and how, including for those that are not contracted. Once a patient is assigned to a plan, DHCS provides the plan with patient information on a monthly basis, including FFS, this is already in place, and plans are provided data that can be used by the plan to determine assignment.

24. **Question:** In Yuba county, Rideout Memorial Hospital has not entered into an agreement with California Health and Wellness (CH&W), we only have two plans, Blue Cross and CH&W. In our service area, we have one hospital; and must send patients to Enloe Hospital in Chico, or to a hospital in Woodland or Sacramento. Where can the clinic send patients? There is nowhere to send them. Patients have to travel hundreds of miles now to find a place to take their resources.

    DHCS Response: There is not a lot DHCS can do to force participation in Medi-Cal. Health Plans are required to ensure access that includes out of network providers, and transportation. The protocol is to first work directly with the MCPs; then to bring your concerns to DHCS to look at if you do not receive resolution from the MCP. DHCS cannot create access to care; however, the department must ensure the providers know where to go to get services. The Department of Managed Care (DMC) reviews alternate access standards and network access. DHCS developed a process that mirrors the DMC. Managed Care staff will check on the regional area for infractions. With applications, now coming in there may be a health plan that has applied in that region and if approved it becomes under our control.

25. **Question:** Did I hear you say there is a radius and that radius is required to have a hospital?

    DHCS Response: Yes, that is correct. It is 30 minutes or 10 miles.

26. **Question:** Is there some way to publish information with contact numbers to allow patients to choose? Clinics need contact information to assist with looking for patient care, especially in emergencies; it is difficult to know whom to call.

    DHCS Response: DHCS is in the process of updating the list and can provide the MCP contacts to this group when completed. First contact should be Provider Relations

or care management. An email to submit your issues directly to us will be included with the updated MCP contact list.

27. **Question:** Can you speak to the criteria for Alternative Access Standards?

    DHCS Response: DHCS sends a questionnaire to MCPs that requires encounter data, the MCPs must show they put out a good faith effort and DHCS reviews to see if it is reasonable. In addition, DHCS has multiple data to look at; Medicare data is available, look at medical providers in area to ensure contract efforts have taken place. DHCS will review accuracy to ensure efforts have taken place within their service area.

28. **Question:** What about making a tribal health program list available to the plans, this is the same issue brought up in November, what is the status of this request?

    DHCS Response: California is unlike other states, if a list of Indian Health Services/Tribal/Urban Indian Health (I/T/Us) were provided to the MCPs, the information will not filter down or through to the subcontractors; it would have no impact on issues brought to the table today. The issues described today are not at the health plan level, the issues brought forward are at the subcontractor level and the subcontractors are the entities receiving the claims. DHCS can work on these issues to ensure everything pushes down, that everything works at all levels, not just the plans.

29. **Question:** In the new managed care rules there are special rules or opportunities that apply to Native Americans for referrals from I/T/Us to managed care network providers our clinic is not contracted with. With the new rule, clinics are to receive payment for these services, how can DHCS assist enforcing this?

    DHCS Response: DHCS will add to the MCP contracts more detailed language that will mirror what you see in the federal regulations effective July 1, 2017 and will work with plans to have them work with groups to follow rules. DHCS is not waiting until July 1, DHCS is working with the plans now, and this is not new policy. The boilerplate language is being updated and will be posted on the DHCS website. The key is to work together to resolve any issues. In regards to an audit, DHCS audit health plans every calendar year, with the new language in the final rule, audits will be more formal and part of a vender audit process with enhanced oversight of that particular section.

30. **Question:** Are the managed care contracts available?

    DHCS Response: Boilerplate contract language is available on the DHCS website at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

31. **Question:** With issues of Medi-Cal plans not paying, should the clinic contact Medi-Cal Managed Care Division (MMCD) for assistance?

    DHCS Response: Yes, absolutely; however, providers are encouraged to work with the plan first and if that does not work then contact MMCD. DHCS will bring issues back to the managed care group and will provide an update. Emails to MMCD will be responded to individually.

Question: Can you provide a specific contact person for Tribal health programs for issues with the managed care programs to resolve directly before it gets to you?

DHCS Response: Yes, DHCS will provide a list of Health Plan contacts for first contact and will provide the process to follow with instructions and contact information.

Medi-Cal Health Homes Program (HHP)

32. **Question:** Community Based Care Management Entities (CB-CMEs), Tribal clinics are not listed as eligible entities, are they eligible?

    DHCS Response: Yes, they are eligible.

33. **Question:** Can you describe the difference between Targeted Case Management (TCM) and the HHP?

    DHCS Response: Yes, HHP eligibility may be different than TCM. Although, there are many similarities, TCM is administered through the county and services would be duplicative. It is up to the beneficiary to decide which program they want to participate in, a beneficiary cannot have both.

34. **Question:** How are rates determined? Do they require cost reports?

    DHCS Response: Mercer will work with DHCS, other clinical experts, and other state programs within the state to determine rates that are paid to Managed Care Plans. Going forward, DHCS will rely on utilization (reported through encounters submitted by providers to MCPs), and some additional quality reporting.

35. **Question:** How is DHCS working with the participating HHPs to ensure Native Americans are proportionately represented as part of their caseload? What are the plans doing to make sure people are getting through the door to participate in the program?

    DHCS Response: DHCS will have a targeting engagement list from our administrative data that includes people eligible for the HHP; there will be specific requirements, a rigorous process on how the HHPs engage those members on the list to participate. Report requirements will be in place to check on the enrollment/engagement process, can check demographics to see who is getting services and who is not. There are also requirements on the beneficiary to participate in their care coordination.

36. **Question:** What about the rest of the counties not listed; do we know when Alpine county will be in the schedule?

    DHCS Response: The process includes a request for information to MHPs on who want to participate and when will they be ready. DHCS must ensure there is network sufficiency, and all MHPs in a county must be signed-on and ready to provide the services. Additional counties may be added if these requirements are met.

Dental Transformation Initiative (DTI) Update

37. **Question:** In regards to Washoe Tribal Health, looking at Domain 3, continuity of care, number 15 slide. Letters were sent and, we are not included here, as our county is not listed, would out-of-state (OOS) counties participate under Domain 4 where the tribes are coming in under the CRIHB? Will OOS providers be able to participate?

    DHCS Response: All Medi-Cal providers have the ability to participate in Domain 1; others are county specific. For Domain 4, if you are part of the application as a participating provider for the lead entities submitting the application for participation, you would be included there.

38. **Question:** Does the CRIHB funding include all California tribes or just the Tribes that are members of CRIHB?

    DHCS Response: DHCS provided outreach and training on all DTI domains. For Domain 4, DHCS reached out to any tribe to come to the table and submit an application to participate. DHCS is transparent in our work efforts and the opportunities.

Third Party Liability (TPL) Presentation

39. **Question:** Can you give a definition of on or near a reservation?

    DHCS Response: This is also in federal law in protections of property from Medicaid estate recovery. In conversations with colleagues at CMS, it was noted that the term Rancheria is not in the listing of AI properties nor is it included in the definition of "on or near". DHCS has been in discussion with trust asset staff at the Bureau of Indian Affairs (BIA) in Sacramento and they pointed to federal case determination that identifies Rancherias as small reservations. DHCS is working with BIA to get clarification on how trust property is managed at the BIA with the tribes. Additionally, DHCS is working with the American Indian Liaison at the state Attorney General's office, looking at judgements that are not consistent with California practice, and if it is a civil rights issue with California Indians as compared to Indians in other states because the intent of the federal law is to cover trust properties. DHCS will finalize by the time our proposed regulations are released for comments.

40. **Question:** Who does the hardship waiver apply to?

    DHCS Response: The person inheriting the property.

41. **Question:** We are aware there are issues with Rancherias being considered as reservations. The Indian Gaming Regulatory Act, Rancherias are reservations would it be helpful to provide this research to you?

    DHCS Response: Interesting, case law for definition of small reservation was with dog licensing, this was tested in California and determined Rancherias were not reservations; however, the federal case determined Rancherias are small reservations. TPL is working closely with PRIHD on the legislation and change to the regulations.

42. **Question:** On the federal side, there is the ability to grant AI exemptions. Can the state do this hardship exception in addition to the specific property exemptions for the AI population?

    DHCS Response: DHCS will have to follow federal government law first. Not sure about that, it would have to be based on statute.

43. **Question:** Will this be in state plan?

    DHCS Response: Yes

Provider Enrollment Update

44. **Question:** Is there a requirement to have a California license for enrollment in Medi-Cal for tribal health programs enrolled in Medi-Cal as IHS/MOA 638 Clinics?

    DHCS Response: No

45. **Question from telephone:** Is there a requirement for medical, dental, and behavioral health providers in an urban Federally Qualified Health Center (FQHC) to enroll?

    DHCS Response: What is presented here today is only for tribal health providers. We will partner with other divisions as we move forward. Any questions, you can forward to Edith Chavez or Virginia Coffey at:

    Edith.Chavez@dhcs.ca.gov or Maria.Coffey@dhcs.ca.gov

Medi-Cal FFS Pharmacy Reimbursement Methodology: Proposed Changes

46. **Question:** Is it possible to pay the IHS/MOA encounter rate instead of estimated or actual cost, was this considered in the SPA? We will lose if we are reimbursed at the actual cost rather than estimated cost factor.

    DHCS Update: No. There have been no discussions to date about moving reimbursement for drugs provided by tribal entities into a "bundled rate" in California. Tribal pharmacies will be reimbursed the same way that other retail community pharmacies are reimbursed, unless they are 340B entities, in which case the same rules that apply to other 340B entities will apply.