Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services
August 26, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Welcome and Webinar Logistics

WebEx 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 Webex facilitator to unmute the participant to share feedback
  - Alternatively, participants who have raised their hand may unmute their own lines, but DHCS asks that you wait for a facilitator to recognize your request to speak
  - DHCS will take comments or questions first from tribal leaders and then all others in the room and on the webinar
- **If you logged on via phone-only.** Press "*6" on your phone to "raise your hand"

Welcome, Introduction of Tribal Leaders, and Review of Agenda

René Mollow, Deputy Director
Health Care Benefits & Eligibility

DHCS

Director's Update

Michelle Baass, Director

DHCS

Tyler Sadwith,
State Medicaid Director

DHCS

DHCS 2022 Comprehensive Quality Strategy

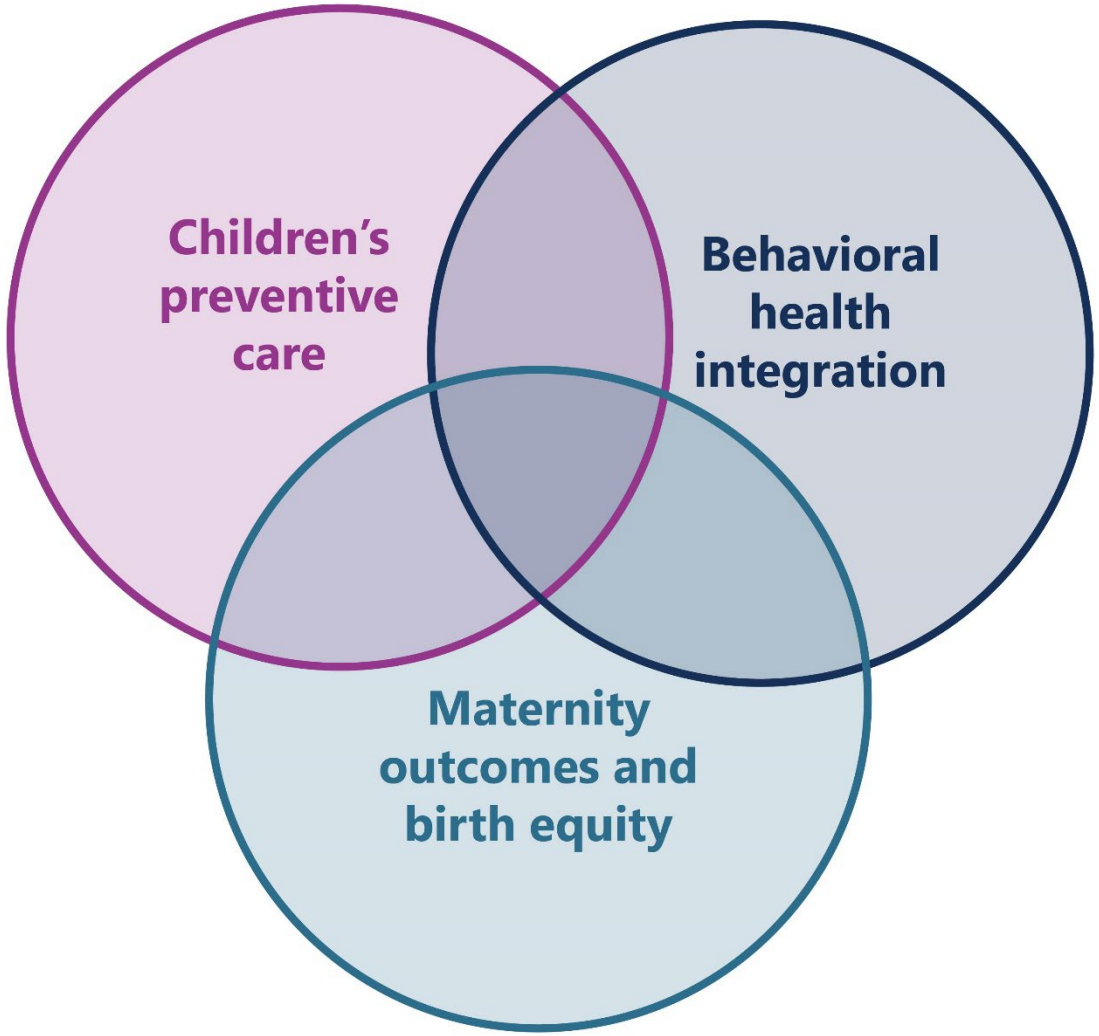
Palav Babaria

Deputy Director & Chief Quality and Medical Officer

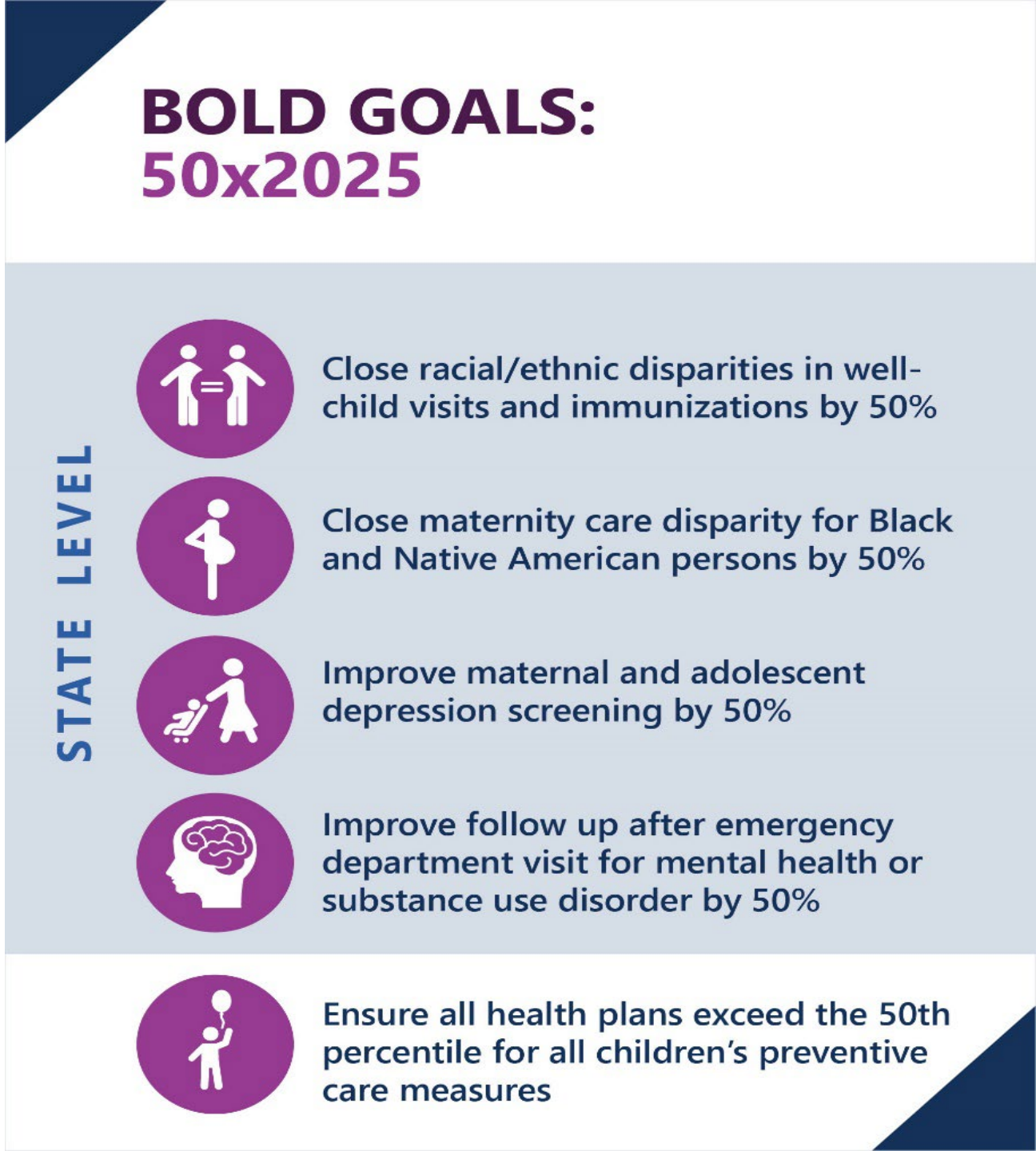
DHCS

Defining the Vision:

The long view of health and wellness in California



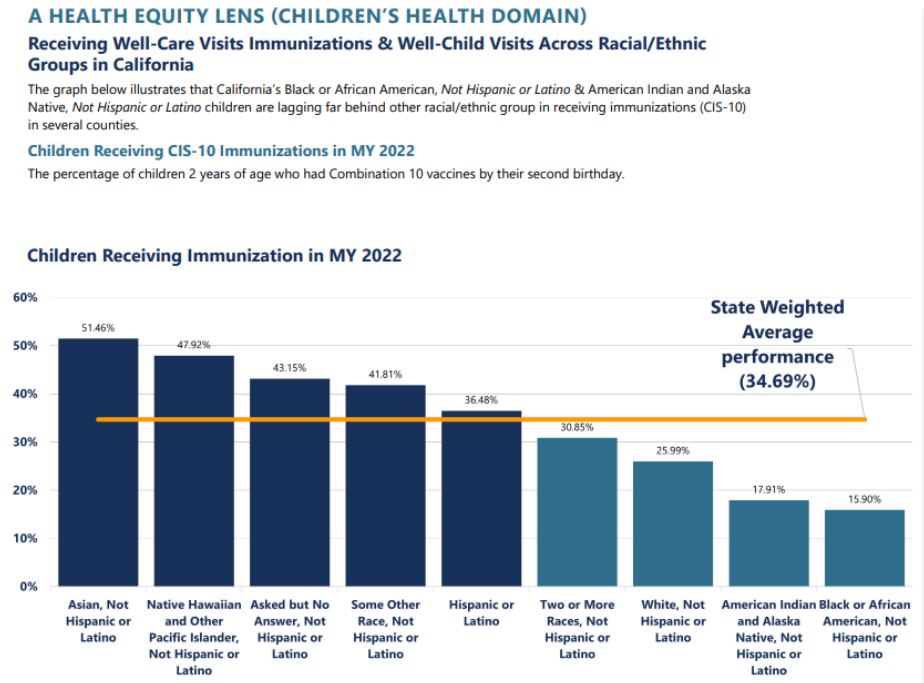
Thinking big:



What have we accomplished?

Improved Transparency

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



Takeaways from the data:

Fresno, Kern, Los Angeles and Riverside

Counties where most Black or AA children are not receiving immunizations (CIS-10).

17% or less of Black or AA children in these counties received immunizations (CIS-10)

San Francisco and Solano

Black or AA children surpassed the California state average in receiving immunizations (CIS-10) that they need in 2 out of 12 counties.

More Black or AA children (41%) received immunizations (CIS-10) in San Francisco compared to California (34.69%).

More Black or AA children (37%) received immunizations (CIS-10) in Solano compared to California (34.69%).

CalAIM Dashboard: Bold Goals

Sign In

DHCS CalAIM

Overview | Initiatives | DHCS CalAIM Home | Contact

CalAIM Bold Goals: 50x2025

The Bold Goals: 50x2025 initiative was launched in 2022 as a focused campaign to improve the quality and equity of care in three focus areas outlined in DHCS' Comprehensive Quality Strategy: children's preventive care, behavioral health integration, and maternity care.

Each Bold Goal is evaluated by a collection of individual quality measures that advance health equity, most of which are found in the Medi-Cal Managed Care Accountability Sets (MCAS) of quality metrics that Medi-Cal managed care plans (MCPs) report on annually.

As data become available, stakeholders can monitor yearly trends at the state and

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
- Quality Measures & Improvement BHIN 24-004

Improved Member Involvement

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

Value Based Payment Roadmap

2021/2022

Incentive Programs

(e.g. QIP, Vaccine Incentives, BH QIP, CalAIM ECM/ILOS)

2023

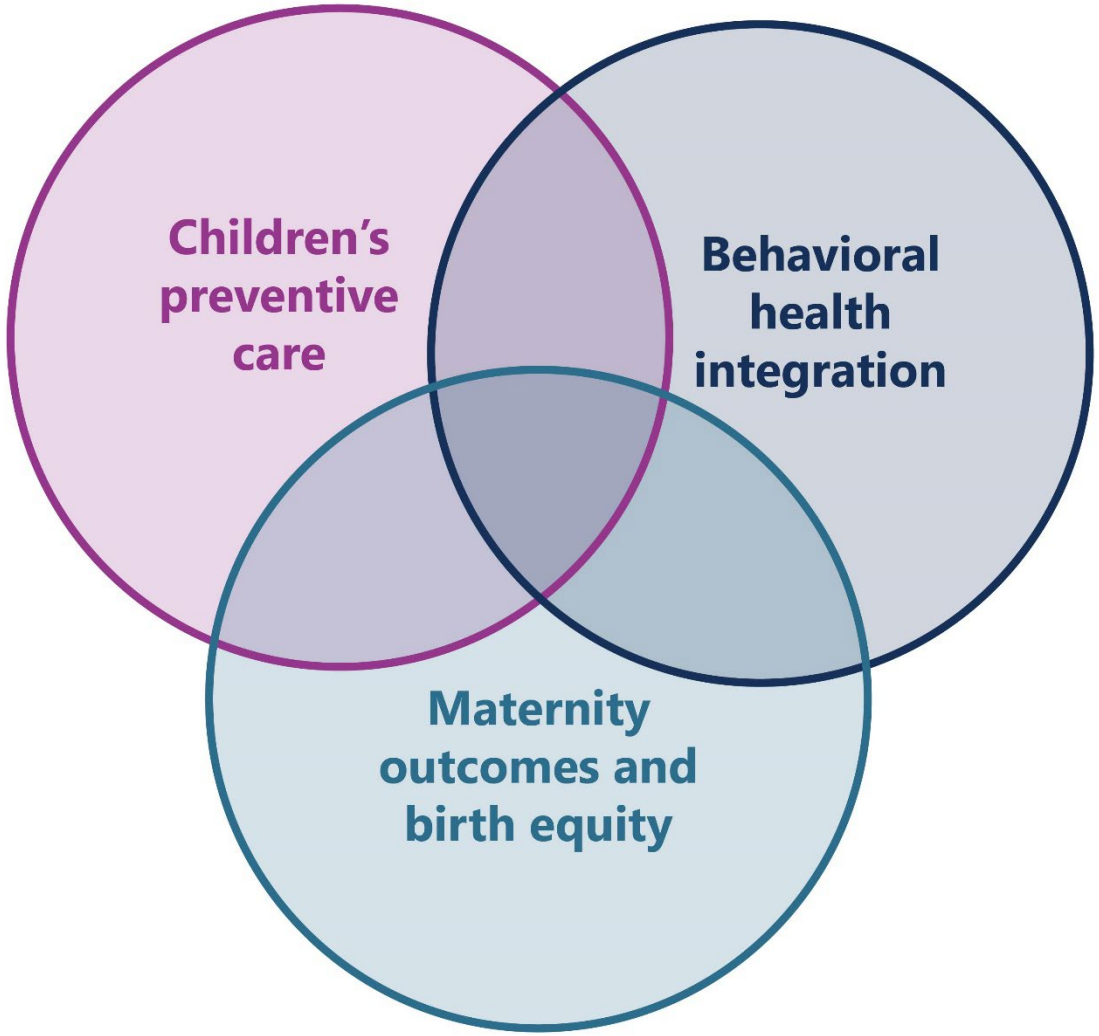
Rate adjustment with Quality & Health Equity outcomes (Quality Withhold)

FQHC APM

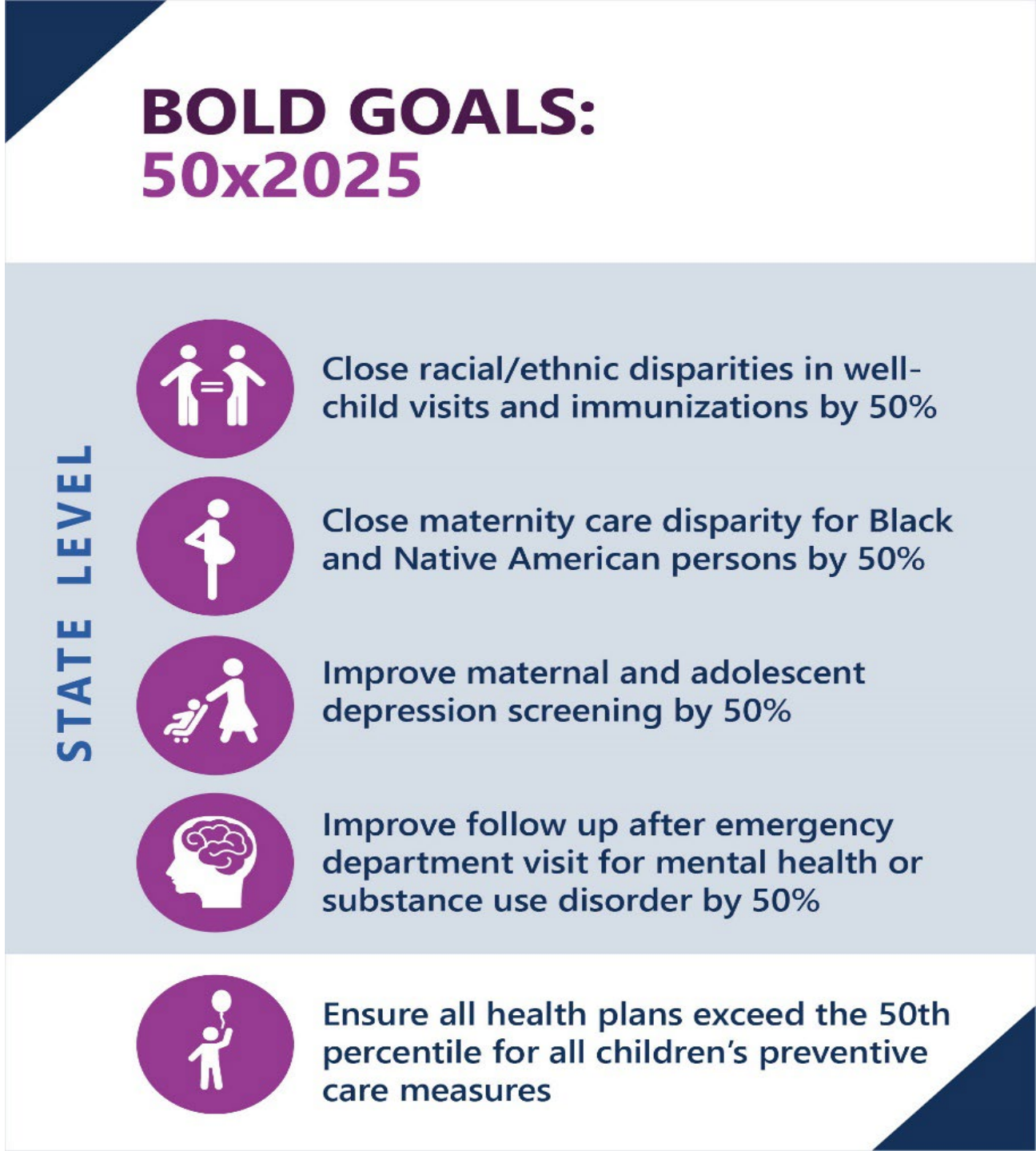
Revised auto-assignment algorithm

Where are we going?

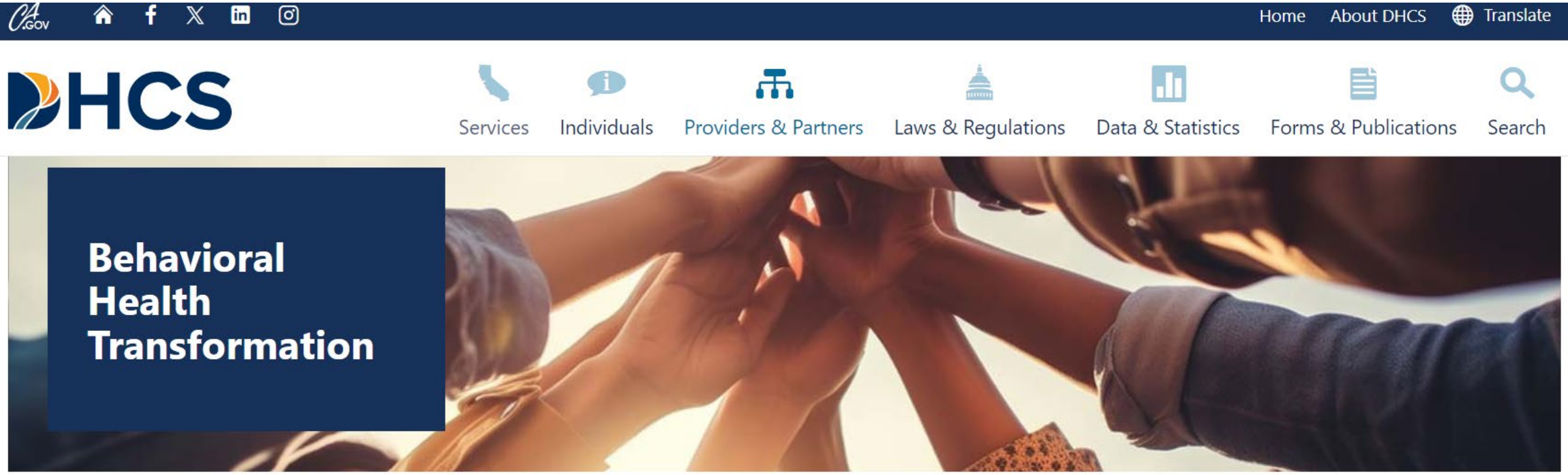
Maintaining our priority populations



Achieving the Bold Goals



Developing a Population Health Approach to Behavioral Health Quality & Equity



DHCS Birthing Care Pathway

- DHCS is developing 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.

Transforming Maternal Health Model

On June 26, the Centers for Medicare & Medicaid Services (CMS) released the Notice of Funding Opportunity (NOFO) for the Transforming Maternal Health (TMaH) Model, which is a 10-year Medicaid and Children's Health Insurance Program (CHIP) delivery and payment model designed to test whether effective implementation of evidence-informed interventions, sustained by a value-based payment (VBP) model, can improve maternal outcomes and reduce Medicaid and CHIP program expenditures.

Overview of TMaH Model

- CMS will issue cooperative agreements to **up to 15 state Medicaid agencies (SMAs).**
- Each SMA selected to participate will be eligible to receive **up to $17M** over the course of the Model.
  - **Up to $8M in the three-year Pre-implementation Period** (2025-2027). States will receive technical assistance and infrastructure funding to help achieve required milestones.
  - **Up to $9M in the seven-year Implementation Period** (2028-2035). States will execute the Model, including implementing a VBP model.

TMaH Goals

Reduced rates of low-risk c-sections

↓

Reduced incidence of severe maternal morbidity

↓

Reduced rates of low-birthweight infants

↓

Improved experience of perinatal care

↓

Reduced Medicaid and CHIP program expenditures for maternity and infant care

TMaH Test Region Selection

SMAs must propose either to implement TMaH statewide or in a sub-state region specified by counties or zip codes. CMS strongly prefers sub-state implementation for evaluation purposes. DHCS is proposing to implement TMaH in a sub-state region that includes **Fresno, Kern, Kings, Madera, and Tulare counties.**
DHCS submitted a Letter of Intent on 8/8 to CMS outlining its intent to apply for TMaH and the proposed test sub-state region.

Sub-State Implementation

- Counties for TMaH implementation is based on several factors, such as: **maternal mortality and morbidity, the average number of Medicaid- and CHIP-covered births per year, racial and ethnic diversity, geographic diversity, MCP rating regions, and tribal nations and FQHCs/public hospitals representation**.

- For CMS evaluation, DHCS is **proposing a comparison region (Sacramento and San Joaquin counties)** that is similar in demographic composition, resource availability, and population size and density to the proposed sub-state region and has little to no service overlap with the sub-state region

Health Equity Roadmap

Pamela Riley, MD, MPH

Assistant Deputy Director & Chief Health Equity Officer

Quality and Population Health Management

DHCS

DHCS Comprehensive Quality Strategy Outlines DHCS Bold Goals to Improve Quality and Advance Health Equity

Specific Measures
Infant, child, and adolescent well-child visits Childhood and adolescent vaccinations
Prenatal and postpartum visits C-section rates
Prenatal and postpartum depression screening Adolescent depression screening and follow up
Follow up after ED visit for SUD within 30 days Depression screening and follow up for adults Initiation and engagement of alcohol and SUD treatment
Infant, child, and adolescent well-child visits Childhood and adolescent vaccinations Blood lead and developmental screening Chlamydia screening for adolescents

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 health plans exceed the 50th percentile for all children's preventive care measures

DHCS Comprehensive Quality Strategy – Health Equity Framework

- **Data collection and stratification:** Complete, accurate data on race, ethnicity, disability, and language and SOGI (Sexual Orientation and Gender Identity) information for Medi-Cal members will be utilized to illuminate and address healthcare inequities
- **Workforce diversity and cultural responsiveness:** Medi-Cal workforce should reflect the diversity of the Medi-Cal population and provide culturally and linguistically appropriate care.
- **Eliminating healthcare disparities:** Eliminate racial, ethnic, and other disparities within the Medi-Cal population and support policy efforts to eliminate disparities between Medi-Cal members and other populations.

DHCS Health Equity Roadmap – A Co-Design Process with Medi-Cal Members

» **Goals:**

- Understand **barriers/solutions** to supporting members in engaging in care that meets their needs
- Primary focus on groups experiencing **racial/ethnic disparities**
- **Member & community engagement** at the center

» **Phases:**

- Visioning & design phase – Fall 2023
- Statewide listening tour (member feedback sessions) – Winter 2024
- Co-design phase – Beginning Fall 2024
- Roadmap final report drafting/publication – 2025

Health Equity Roadmap Listening Tour

- With support from California Health Care Foundation DHCS partnered with **FutureGood** to design an inclusive member engagement strategy and Roadmap co-design approach.
  - **12 member feedback sessions** (in person & virtual) – conducted in partnership with CBOs
  - Priority focus on **racial/ethnic groups experiencing disparities**
  - Ensure representation of the following groups:
    - Tribal/Rural populations
    - LGBTQ individuals/communities
    - People with BH conditions
    - People with disabilities

Health Equity Roadmap In-Person Member Feedback Sessions

- **Bakersfield American Indian Health Project** – Bakersfield (November 2023)
- **Choice in Aging** – Antioch (January 2024)
- **The Cambodian Family Community Center** – Santa Ana (January 2024)
- **Latino Health Access** – Santa Ana (January 2024)
- **Greater Mount Sinai MBC of Compton** – Compton (February 2024)
- **Cultiva la Salud** – Fresno (March 2024)

Member Feedback Session Themes

- **Feeling seen, heard and respected**
- Facing racism, homophobia, and judgement
- Language barriers
- Patient-centered care matters
- Shared racial/ethnic identity with provider
- Quality of care
- Accessing care
- Waiting for appointments
- Delayed testing and treatments
- Medi-Cal stigma
- Challenges interacting with Medi-Cal program
- Risk of losing Medi-Cal coverage
- Access to Medi-Cal benefits (dental)
- Cost of medical care

DHCS Launched Health Equity Roadmap Landing Page with Information from Member Feedback Sessions

Co-Designing the Roadmap

- DHCS will bring together a diverse group of Medi-Cal members, community based organizations, tribal partners and other implementation stakeholders to co-design a roadmap for achieving the equitable future envisioned for the Medi-Cal program.
- The insights and ideas gathered during the listening tour sessions and data from previous member surveys will be the driving force behind the roadmap design.

The Final Report

- The roadmap is a final report that will make recommendations for improvements to Medi-Cal services for specific segments of members. Ideally, the focus will align with and/or inform DHCS' work on one or more of its five 50X2025 bold goals.

Questions?

DHCS

Transforming Care with Cultural Language and Access Standards (CLAS)

DHCS CLAS Assessment Tool

Sarah Lahidji-Sales

Division Chief

DHCS

Introduction to the Transitioning Care with CLAS Initiative

National Culturally and Linguistically Appropriate Services (CLAS) Standards

- **Principal Standard**: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication need.

https://thinkculturalhealth.hhs.gov/clas

Key Drivers

- OBJECTIVE: Reduce healthcare disparities and improve the quality of care provided to Medi-Cal Members
- NEEDS:
  - Align Medi-Cal with national CLAS standards
  - Drive delivery system transformation
  - Reduce variation and complexity across delivery systems

Goal

- Landscape assessment of DHCS current policies across delivery systems to the national CLAS standards
- Create a uniform Cultural and Linguistic Appropriate Services (CLAS) Standards assessment tool for all delivery systems
- Develop a Strategic Plan to monitor and advance CLAS Standards in future years

Current Landscape
Standards 1 - 6

CLAS Standard	In Alignment	Approaching Alignment	Not Included
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.		X	
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	X		
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.		X	
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.		X	
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	X		
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	X		

* Dental FFS

Current Landscape
Standards 7 - 11

CLAS Standard	In Alignment	Approaching Alignment	Not Included
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.		X	
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	X		
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.		X	
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.		X	
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.		X	

* Dental FFS

Current Landscape Standards 12 - 15

CLAS Standard	In Alignment	Approaching Alignment	Not Included
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.		X	
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.		X	
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.		X	
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.			X

Next Steps

- CLAS assessment tool will be shared for public comment
  - Partnership with Office of Tribal Affairs to distribute
  - Provide a follow-up summary of all public comment
  - Share the finalized tool with Tribal partners
- Develop a Strategic Plan to advance CLAS Standards

Questions?

DHCS

Behavioral Health Transformation Overview

Paula Wilhelm

Deputy Director

DHCS

Introduction to BHT

Behavioral Health Transformation

In March 2024, California voters passed Proposition 1, a two-bill package, to modernize the state's behavioral health care system, improve accountability, increase transparency, and expand the capacity of behavioral health care facilities for Californians. It includes a substantial investment in housing for people with behavioral health care needs.

Behavioral Health Services Act (BHSA)

- Reforms behavioral health care funding to provide services to Californians with the most significant behavioral health needs
- Expands the behavioral health workforce to reflect and connect with California's diverse population
- Focuses on outcomes, accountability, and equity

Behavioral Health Infrastructure Bond Act of 2024 (BHIBA)

- Funds behavioral health treatment beds, supportive housing, and community sites
- Directs funding for housing to veterans with behavioral health needs

Information referenced can be found on the May 2024 BH-SAC Meeting Slides

Behavioral Health Transformation (BHT)

By enacting changes resulting from Prop 1, BHT builds upon ongoing efforts to **support vulnerable populations** living with the **most significant** mental health conditions and substance use disorders.

BHT at a Glance:

1. Evolves the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA)
2. Includes bonds to increase infrastructure

High-level **aims of BHT** include, but are not limited to:

Improving Accountability

Increasing Transparency

Expanding Capacity of BH Facilities

Behavioral Health Transformation Milestones

Below are high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Started Spring 2024

Partner Engagement

Stakeholder and tribal partner engagement including, **public listening sessions,** will be utilized through all milestones to inform policy creation.

Started Summer 2024

Bond BHCIP: Round 1 Launch Ready

Requests for Applications (RFA) for up to $3.3 billion in funding will leverage the BHCIP model.

Beginning Early 2025

Integrated Plan Guidance and Policy

Policy and guidance will be **released in phases** beginning with policy and guidance for integrated plans.

Summer 2026

Integrated Plan

New integrated plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

Behavioral Health Services Act (BHSA)

The BHSA enacts the following:

- **Updates allocations** for local services and state-directed funding categories
- Broadens the target population to **include individuals with substance use disorder**
- Focuses on the **most vulnerable and at-risk**, including amongst children and youth
- Advances community-defined practices as a key strategy of **reducing health disparities** and **increasing community representation** with the addition of **newly engaged tribal partners**
- Revises county processes and improves **transparency and accountability** into how the counties use their behavioral health funding and involve tribal partners and others in the community planning process

BHSA Funding Overview
90% County Allocation
10% State Directed

Behavioral Health Infrastructure Bond Act of 2024

- **Behavioral Health Infrastructure Bond Act of 2024** is a **$6.38 billion** general obligation bond, with up to **$4.4 billion** for competitive grants for counties, cities, tribal entities, nonprofit entities, and the private sector toward **behavioral health treatment settings**.
- Of the **$4.4 billion** available for treatment sites, $1.5 billion, with **$30 million set aside for tribes**, will be awarded through competitive grants **ONLY** to **counties, cities** and **tribal entities**.
- Funds will be distributed through the current **Behavioral Health Continuum Infrastructure Program (BHCIP)**

Information referenced can be found on the May 2024 BH-SAC Meeting Slides

Behavioral Health Infrastructure Bond Act

$6.38B [Behavioral Health Bond]

$4.4B | Up to $4.4 billion for **competitive grants to build, enhance, and expand behavioral health treatment settings**.

$1.065B | Up to $1.065 billion for **housing investments for veterans** experiencing or at risk of homelessness who have behavioral health conditions

$922M | Up to $922 million for housing investments for **persons at risk of homelessness** who have behavioral health conditions

Community Planning Process

Effective Date

*The stakeholder and tribal partner engagement requirements for the integrated plan become **effective January 1, 2025**, with the acknowledgement that some counties may begin (and some have already begun) preparing for the BHSA community planning process (WIC § 5963).

*The first three-year County Integrated Plan for Behavioral Health Services and Outcomes is due to DHCS by June 30, 2026. The County Integrated Plan must be approved by DHCS to take effect on July 1, 2026

Key Changes

- Counties already engage in extensive community program planning and engagement with their communities under MHSA
- BHSA builds upon the MHSA requirements to meaningfully engage with stakeholders and tribal partners with a few key changes

Key changes to community planning process in WIC § 5963.03:

✓ Stakeholder list expanded to include Substance Use Disorder

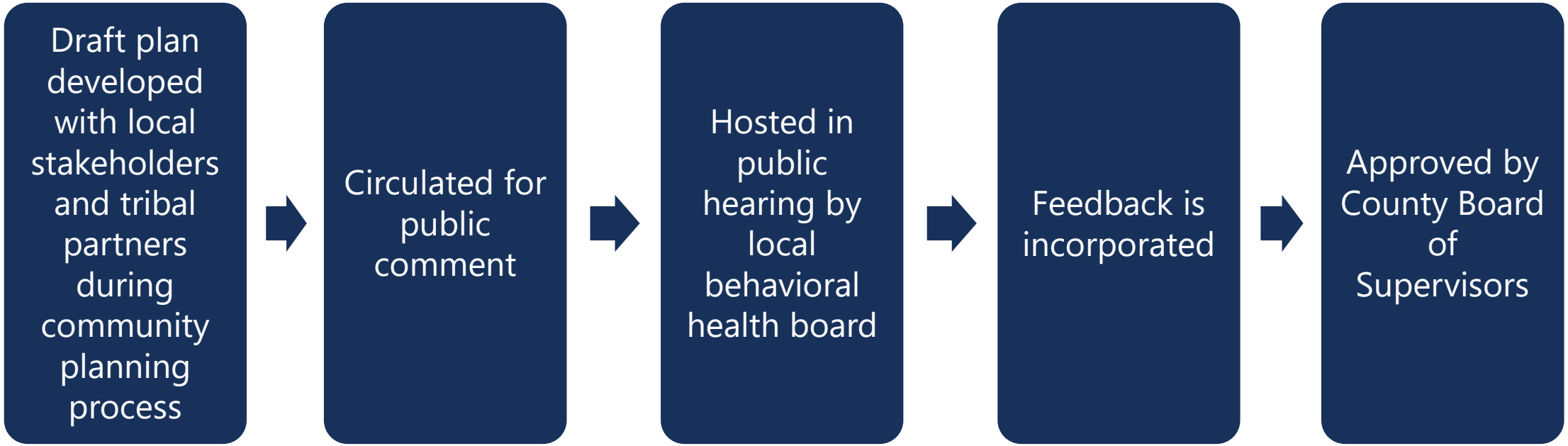
✓ Key stakeholder and tribal partner groups updated to include:

- Historically marginalized communities
- **Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes.**
- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse
- People with lived experience of homelessness

Several Additional Groups have been added – Consult **WIC § 5963.03** for details

Integrated Plan Local Review Process

The local review process for integrated plans remains in place under BHSA:



Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1: Launch Ready

Bond BHCIP Round 1: Launch Ready

1

Up to $3.3 billion in competitive grants to construct, acquire, and rehabilitate facilities that will expand service capacity for behavioral health facility infrastructure.

2

Eligible entities: counties, cities, **tribal entities (including urban Indian clinics)**, nonprofit organizations, for-profit organizations

3

Funding Focus

- Regional models or collaborative partnerships, including public-private partnership
- Campus-type models that collocate multiple levels of care on the continuum, with a focus on residential treatment facilities.

Bond BHCIP: "Tribal Entity" Definition

In accordance with Section 5960.35 of the Welfare and Institutions Code, a "Tribal entity shall mean a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code."

Eligible Facility Types – Outpatient (RFA Section 2.4)

- Behavioral Health Urgent Care (BHUC)/Mental Health Urgent Care (MHUC)
- Community Mental Health Clinic
- **Community Wellness/Prevention Center (Tribal entities only)**
- Crisis Stabilization Unit (CSU)
- Hospital-based Outpatient Treatment (outpatient detoxification/ withdrawal management)
- Narcotic Treatment Program (NTP)
- NTP Medication Unit
- Office-based Opioid Treatment (OBOT)
- Outpatient Treatment for SUD
- Partial Hospitalization Program (PHP)
- Sobering Center (funded under the Drug Medi-Cal Organized Delivery System and/or Community Supports

Funding Regions (RFA Section 3.1)

1. Regions for All Eligible Entity Funds	Subtotal Available to Regions for All Eligible Entities: $1.8 billion
Los Angeles County	$479,190,226
Bay Area: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma	$278,108,183
Southern California: Imperial, Orange, Riverside, San Bernadino, San Diego, Ventura	$263,680,311
San Joaquin Valley: Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare	$154,666,275
Sacramento Area: El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba	$81,768,565
Central Coast: Monterey, San Benito, San Louis Obispo, Santa Barbara, Santa Cruz	$51,771,065
Balance of State: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne	$58,815,375
Tribal	$90,000,000
Discretionary: The discretionary set-aside may also be used to fund high-scoring projects in regions that have met their funding reserve.	$342,000,000

Funding Regions (RFA Section 3.1) cont.

2. No Regional Caps for County, City, and Tribal (only) Funds	Subtotal Available Statewide for County, City, and Tribal*: $1.5 billion
Total for Bond BHCIP Round 1: Launch Ready	Up to $3.3 billion

Of the $1.5B, a minimum of **$30M shall be designated for tribal entities, as required by statute.*
Minimum Tribal Funding =$120 million ($90 million all regions portion) + $30 million (Tribal designation)

License, Certification, and Accreditation (RFA Section 2.1)

- Tribal entities that are exempt from state license and/or certification requirements, depending on proposed facility type, must describe the basis for their exemption and their plan for meeting programmatic requirements.
- Technical assistance (TA) will be made available during PACs, including additional information and guidance about the licensure and certification process, for proposed facility types requiring a license/certification.

Resources

Behavioral Health Transformation Website and Monthly Newsletter

Explore the Behavioral Health Transformation website to discover additional information and access resources.

Please sign up on the DHCS website to receive monthly Behavioral Health Transformation updates.

Public Listening Sessions

Attend public listening sessions to provide feedback on Behavioral Health Transformation-related topics. Registration links will be posted on the Behavioral Health Transformation website, along with recordings, once available.

Bond BHCIP Round 1: Launch Ready

Visit the BHCIP website to access the application and learn more.
Please send any other questions to bondbhciproundl@ahpnet.com

Questions and Feedback

Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov.

Traditional Healers and Natural Helpers

Background

DHCS

Context

CMS aims to approve DHCS' Traditional Healers and Natural Helpers demonstration amendment (originally proposed in 2017) by late Summer or early Fall of 2024. DHCS requests feedback from Tribes and tribal partners on the design and implementation of Traditional Healer and Natural Helper services.

- Since 2017, DHCS has requested to cover Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery System (DMC-ODS).
  - In 2020, DHCS submitted a second request to CMS
  - In 2021, DHCS submitted a third request to CMS
- In April 2024, CMS hosted an All-Tribes Consultation Webinar on Medicaid coverage of traditional health care practices where it shared its initial national framework that it will use to approve Traditional Healer and Natural Helper requests across four states (California, New Mexico, Arizona, Oregon). *(See appendix)*
- **Given these recent developments, DHCS is seeking feedback from tribes and tribal partners on the design and implementation of traditional health care practices and aims to identify any updates needed to the waiver request language, or other policy recommendations, developed together to-date.**

Summary from July 22 Consultation *(1 of 2)*

During the July 22 consultation, DHCS solicited feedback on CMS' monitoring and evaluation expectations and provided an update on Medi-Cal reimbursement for Traditional Healer and Natural Helper services.

- CMS shared its initial vision for monitoring and evaluating the delivery of traditional health care practices (THCPs) to Medicaid-enrolled members.
  - **Monitoring.** States must develop methods and timelines for collecting and analyzing administrative data. Acknowledging that tribes use varying terminology for identical or similar practices, states will be required to group similar practices together for monitoring purposes. CMS will not prescribe the categories.
  - **Evaluation.** CMS indicated the goal of the evaluation is to assess whether the THCP benefit increases access to culturally appropriate care. CMS will require states to engage with tribal providers and beneficiaries in the development of the evaluation design.

Summary from July 22 Consultation *(2 of 2)*

During the July 22 consultation, DHCS solicited feedback on CMS' monitoring and evaluation expectations and provided an update on Medi-Cal reimbursement for Traditional Healer and Natural Helper services.

- DHCS sought initial feedback on the types of categories that would be appropriate to classify and report on Traditional Healer and Natural Helper services. Tribes and tribal partners primarily had questions around how CMS intends to use the data that will be provided as part of monitoring and evaluation. The tribes indicated this will need to be discussed further internally.
- DHCS has relayed this information to CMS and is committed to continue working with tribes and tribal partners to develop categories of identical or similar services for reporting and evaluation purposes.

Have the tribes had an opportunity to discuss further internally? If so, do you have any suggestions for categories of Traditional Healer and Natural Helper services?

Traditional Healer and Natural Helper Services: Reimbursement Policy and Rates

DHCS

Background

CMS released its national framework of Medicaid requirements for Traditional Healer and Natural Helper services to guide coverage of different tribal practices. The framework includes detail around reimbursement for providers of these services.

- Consistent with CMS' national Traditional Healing framework, DHCS will pay the All-Inclusive Rate (AIR) for program and practitioner types able to claim at the AIR as defined in California's Medicaid State Plan and described in Behavioral Health Information Notice 22-053.
- DHCS must identify an alternative reimbursement approach for practitioner types ineligible to bill at the AIR for Traditional Healer and Natural Helper services.

County Reimbursement Obligations for IHCPs

DMC-ODS counties are subject to differing reimbursement obligations for care provided to American Indian and Alaska Native (AI/AN) and non-AI/AN individuals consistent with federal requirements outlined in 42 CFR 438.14.

- **AI/AN Individuals:** DMC-ODS counties must reimburse an IHCP that meets DMC-ODS participation requirements for covered DMC-ODS services provided to AI/AN individuals in accordance with reimbursement requirements outlined in BHIN 22-053, whether or not they have a current contract with the IHCP.
- **Non-AI/AN Individuals:** DMC-ODS counties are not obligated to reimburse IHCPs for services provided to non-AI/AN individuals they do not have contracts with. DMC-ODS counties may choose to contract with IHCPs for the care of non-AI/AN individuals. If so, IHCP reimbursement obligations outlined in BHIN 22-053 apply.

Current DHCS Reimbursement Policies: IHS Facilities and IHS-MOA Clinics *(1 of 3)*

There are different reimbursement approaches for IHCPs depending on the facility type. The AIR only applies to IHS facilities and IHS-MOA clinics so long as they meet both practitioner AND service requirements.

	All-Inclusive Rate	**Fee-for-Service (FFS)** FFS = rates that are available for counties to claim for DMC-ODS services
Facility	• IHS facilities • IHS-MOA clinics	• IHS facilities • IHS-MOA clinics
Practitioner	Practitioner types listed in Section A of the Medicaid State Plan (e.g., physician, nurse practitioner, clinical psychologists)	Practitioners that **do not** fall under one of the practitioner types listed in Section A of the Medicaid State Plan
Services ***Clinical encounter limits apply.***	• Ambulatory • Medical • Mental health	Services that **do not** fall under the service categories listed in the "AIR" column

Current DHCS Reimbursement Policies: Tribal FQHCs *(2 of 3)*

There are different reimbursement approaches for IHCPs depending on the facility type. The APM (set at the AIR) only applies to Tribal FQHCs so long as they meet both practitioner AND service requirements.

	Alternative Payment Methodology (APM) ***(set at the AIR)***	**Fee-for-Service (FFS)** FFS = rates that are available for counties to claim for DMC-ODS services
Facility	Tribal FQHCs	Tribal FQHCs
Practitioner	Practitioner types listed on pages 3-4 of the Tribal FQHC Provider Manual (e.g., physician, licensed clinical social worker, nurse midwife)	Practitioners that **do not** fall under one of the practitioner types listed on pages 3-4 of the Tribal FQHC Provider Manual
Services ***Clinical encounter limits apply.***	• Ambulatory • Dental • Medical • Mental health (e.g., clinical psychologist services, licensed clinical social worker services)	Services that **do not** fall under the service categories listed in the "APM" column

Sources: California's Medicaid State Plan; BHIN 22-053; Tribal FQHC Provider Manual

Current DHCS Reimbursement Policies: UIOs *(3 of 3)*

There are different reimbursement approaches for IHCPs depending on the facility type. Practitioners at UIOs are not eligible to receive the AIR and receive negotiated rates. The payment amount depends on whether the facility has a contract with the DMC-ODS county.

Reimbursement at UIOs that are FQHCs

	Negotiated Rate with DMC-ODS County	Negotiated Rate Paid to Contracted FQHCs that are Not IHCPs
Practitioner	Practitioners employed or contracted by an FQHC that is **contracted** with the DMC-ODS county	Practitioners employed or contracted by an FQHC that is **not contracted** with the DMC-ODS county
Services	• DMC-ODS covered services	• DMC-ODS covered services

Reimbursement at UIOs that are not FQHCs

	Negotiated Rate with DMC-ODS County
Practitioner	Practitioners employed or contracted by a UIO that is not an FQHC
Services	• DMC-ODS covered services

Sources: BHIN 22-053; FQHC and RHC Manual

Proposed Reimbursement Approach for Traditional Healers and Natural Helpers

DHCS intends to develop rates that DMC-ODS counties may use to claim Medi-Cal reimbursement for Traditional Healer and Natural Helper services that are not eligible for payment at the AIR.

- **Traditional Healers:** DHCS is developing a rate that considers ~~r~~ates for psychologists as a reference.
- **Natural Helpers:** DHCS is developing a rate that considers rates for community health workers as a reference.

Are psychologists and community health workers appropriate proxies to use to determine the reimbursement rates for the provision of Traditional Healer and Natural Helper services by provider types ineligible to bill the AIR? What other questions or recommendations do you have related to reimbursement policy?

Documentation Policies

Recap of Provider Qualification Policies

On June 24, DHCS and Tribes and tribal partners discussed several proposed provider qualifications for those offering Traditional Healer and Natural Helper services.

- Indian Health Care Providers (IHCPs) offering Traditional Healer and Natural Helper services will be required to:
  1. Provide or facilitate/refer for a clinical assessment consistent with the American Society of Addiction Medicine Criteria (ASAM Criteria).
  2. Provide or facilitate access to the SUD Level(s) of Care recommended by the completed ASAM Criteria assessment.
  3. Provide or facilitate referrals for medications for addiction treatment (MAT), including assessment for MAT needs.
  4. Provide (within the IHCP) at least two of the following evidence-based practices (EBPs): motivational interviewing, cognitive-behavioral therapy, relapse prevention, trauma-informed treatment.
- DHCS will expect IHCPs to demonstrate or document that they can meet these requirements. Additional detail is forthcoming.

NOTE: DHCS will not require each individual practitioner of Traditional Healing to provide these services. However, at the organizational level, IHCPs will need to provide these services, or facilitate referrals to these services.

DMC-ODS Documentation Requirements *(1 of 2)*

Currently, providers participating in the DMC-ODS program are subject to the documentation requirements outlined in Behavioral Health Information Notice 23-068.

Problem List

- Providers must create and maintain a problem list.
- The list must include, at a minimum, the following: diagnosis (if any); current ICD CM codes; problem(s) identified by the provider and member; and name/title of and date that the provider that identified, added, or resolved the problem.
- A problem that is identified and addressed by the provider during a service encounter must be subsequently added to the problem list.
- The problem list must be maintained on an ongoing basis to reflect the current presentation of the member.

DMC-ODS Documentation Requirements *(2 of 2)*

Currently, providers participating in the DMC-ODS program are subject to the documentation requirements outlined in Behavioral Health Information Notice 23-068.

Progress Notes

- Providers shall create progress notes for the provision of all DMC-ODS services. Each progress note shall provide sufficient detail to support the service code(s) and diagnostic code(s) included with the claim.
- Progress notes for individual services must include: type, date, duration, and location of service; name and signature of the provider; brief description of how the service addressed the member's needs; summary of next steps.
- Progress notes for group services must be included in the clinical record of each participant, and must include: type, date, duration, and location of service; name and signature of the provider; and a brief description of the member's response to the service. Providers must also maintain a list of participants.
- Progress notes generally must be completed within three business days of providing the service.

For Discussion: Documentation Requirements

- Problem Lists are a tool to support team-based care and information exchange between providers.
  - Does your program maintain problem lists today? If not, what are your thoughts about implementing this?
- Progress Notes support clinical practice and communication, but also serve an essential program integrity function (i.e., they demonstrate that a covered service did in fact take place). This requirement cannot be waived.
  - What is your current capacity or capability to meet the Progress Note requirements today? What questions do you have about these requirements?
- How might documentation look different for Traditional Healer and Natural Helper services, compared to other DMC-ODS services? What additional recommendations should DHCS consider in this area?

Some Next Steps

- DHCS is awaiting CMS approval of Traditional Healer/Natural Helper Services in DMC-ODS.
- DHCS anticipates holding additional consultation on policy decisions including:
  - Rates and reimbursement
  - Categorization of services
- Implementation to occur no sooner than January 1, 2025.

Questions?

DHCS

Appendix

Level Setting *(1 of 2)*

In 2021, DHCS requested to amend the CalAIM Section 1115 demonstration to receive federal funding to provide Traditional Healer and Natural Helper services to DMC-ODS beneficiaries.

Key Points from the CalAIM 1115 Application Submitted in June 2021:

- Section 1115 expenditure authority for Traditional Healer and Natural Helper services, which allows federal Medicaid matching funds for these services
- Provided by Indian Health Care Providers (IHCPs)
- To DMC-ODS beneficiaries
- From January 1, 2022, through December 31, 2026

Level Setting *(2 of 2)*

In 2021, DHCS requested to amend the CalAIM Section 1115 demonstration to receive federal funding to provide Traditional Healer and Natural Helper services to DMC-ODS beneficiaries.

Key Points from the CalAIM 1115 Application Submitted in June 2021:

- As part of CalAIM's focus on advancing health equity, DHCS is seeking expenditure authority to allow federal reimbursement for all DMC-ODS services that are provided by traditional healers and natural helpers.
- The purpose of this request is to provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives receiving SUD treatment services through IHCPs.
- For American Indians and Alaska Natives, traditional healing practices are a fundamental element of Indian health care that helps patients achieve wellness and healing and restores emotional balance and one's relationship with the environment.
- Medi-Cal recognizes that reimbursement for these services to address SUD in a manner that retains the sanctity of these ancient practices is critical.

CMS' Framework on Traditional Healers and Natural Helpers *(1 of 2)*

CMS released its national framework of Medicaid requirements for Traditional Healer and Natural Helper services in April to guide coverage of different tribal practices. Additional detail is forthcoming.

- **Eligible beneficiaries:** Eligible beneficiaries would include any Medicaid beneficiary eligible to receive services by or through Indian Health Service (IHS) or tribal facilities. Non-American Indian/Alaska Native (AI/AN) individuals can also receive these services, like all other services, by or through IHS or tribal facilities.
- **Traditional Health Care Practices:** Covered services (in alignment with the Indian Health Care Improvement Act) would need to be delivered by or through IHS or tribal facilities, and includes practices provided in the community. Practices would be reimbursed at 100% federal match for AI/AN individuals who receive services through IHS or tribal facilities.[1]

[1] As defined in federal state, UIOs will not be eligible to receive 100% federal matching funds for the provision of THCPs. The American Rescue Plan Act included an allowance for states to claim 100% federal match for services provided through UIOs that expired in March 2023.

CMS' Framework on Traditional Healers and Natural Helpers *(2 of 2)*

CMS released its national framework of Medicaid requirements for Traditional Healer and Natural Helper services in April to guide coverage of different tribal practices. Additional detail is forthcoming.

- **Providers/Practitioners:** Providers of services would need to be employed or contracted by IHS or tribal facilities, and would not have to undergo additional state licensing or credentialing requirements beyond what is already in place.[1]
- **Reimbursement and Infrastructure:** CMS will consider infrastructure funding to states, which can facilitate system updates, staff training, and development of processes to ensure compliance.
- **Evaluation:** Post approval evaluations are expected to assess beneficiary awareness and understanding of traditional health care practices; reasons for receiving these services; access to, cost of, and utilization of services; quality and experience of care and beneficiary physical and behavioral health outcomes.

[1] CMS indicated UIOs will be included in CMS' framework. Providers and practitioners employed or contracted by UIOs would be eligible to provide Traditional Health Care Practices. Additional detail from CMS is forthcoming.

California's Proposed Approach

DHCS intends to request several changes to CMS' national framework to better meet the needs of Medi-Cal members receiving Traditional Healer and Natural Helper services.

- **Eligible beneficiaries:** Medi-Cal members receiving care through DMC-ODS to promote treatment of substance use disorders (SUDs).
- **Counties:** All DMC-ODS counties will be required to offer the Traditional Healer and Natural Helper services benefit. As of July 2024, there are 38 DMC-ODS counties.
- **Providers/Practitioners:** Inclusion of UIOs as eligible providers.
- **Reimbursement:** Requesting Traditional Healer and Natural Helper services be reimbursed consistent with DHCS' existing policy for DMC-ODS services; see BHIN 22-053.

Service Descriptions

DHCS partnered with Tribes to develop draft service descriptions of Traditional Healer and Natural Helper services and will work to ensure that these descriptions are coverable under the Demonstration.

Service Descriptions

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

Individual Provider Qualifications *(1 of 2)*

In partnership with tribes, DHCS also developed preliminary qualification requirements for individuals who will offer Traditional Healer and Natural Helper services through IHCPs and will work to ensure they are retained under the Demonstration.

Individual Provider Qualifications

- A **Traditional Healer** would be a person currently recognized as a spiritual leader and in good standing with his/her Native American tribe, Nation, Band or Rancheria, and with two years of experience as a recognized Native American spiritual leader practicing in a setting recognized by his/her Native American tribe, Nation, Band or Rancheria who is contracted or employed by the IHCP. A Traditional Healer would be a person with knowledge, skills and practices based on the theories, beliefs, and experiences which are accepted by that Indian community as handed down through the generations and which can be established through the collective knowledge of the elders of that Indian community.

Individual Provider Qualifications *(2 of 2)*

In partnership with Tribes, DHCS also developed preliminary qualification requirements for individuals who will offer Traditional Healer and Natural Helper services through IHCPs and will work to ensure they are retained under the Demonstration.

Individual Provider Qualifications

- **Natural Helpers** would be health advisors contracted or employed by the IHCP who seek to deliver health, recovery, and social supports in the context of Tribal cultures. Natural Helpers could be spiritual leaders, elected officials, paraprofessionals and others who are trusted members of his/her Native American tribe, Nation, Band or Rancheria.
- IHCPs seeking reimbursement for Natural Helpers and/or Traditional Healers would **develop and document credentialing (e.g., recognition and endorsement) policies consistent with the minimum requirements above.**

Payment Assurances

Federal statute includes payment assurances for IHCPs to ensure they are sufficiently reimbursed for the provision of care.

- **42 CFR 438.14(b)(2):** Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:
  - I. At a rate negotiated between the MCO, PIHP, PAHP, or PCCM entity, and the IHCP, or
  - II. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO, PIHP, PAHP, or PCCM entity would make for the services to a participating provider which is not an IHCP; and
  - III. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.
- **42 CFR 438.14(c)(1):** When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the MCO, PIHP, PAHP or PCCM entity, it must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.

Payment Assurances cont.

Federal statute includes payment assurances for IHCPs to ensure they are sufficiently reimbursed for the provision of care.

- **42 CFR 438.14(c)(2):** When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

Background on THCP Rates

DHCS intends to develop rates that DMC-ODS counties may use to claim Medi-Cal reimbursement for Traditional Healers and Natural Helpers based on an existing methodology that CMS has previously approved for outpatient DMC-ODS services and on providers' experiences in the field.

- DHCS needs to develop DMC-ODS payment rates for Traditional Healers and Natural Helper Services that cannot be claimed at the AIR.
- DHCS acknowledges funding to date for IHCPs has been not sustained through reimbursement and has been based on available grants.
- DHCS solicited feedback from IHCPs to understand current utilization, costs and reimbursement arrangements for IHCPs offering Traditional Healer and Natural Helper services. DHCS understands the IHCP responses reflects a data point within a broader context rather than a total baseline.

Key Themes

Based on feedback received to date, DHCS has learned that:

- Most Traditional Healers are contractors, rather than staff members
- Rates vary across providers
- Approaches to reimbursement differ (e.g., daily rate v. per visit)
- Many IHCPs do not offer these services today due to the lack of reimbursement

Medi-Cal Redeterminations

Yingjia Huang

Assistant Deputy Director

Health Care Benefits and Eligibility

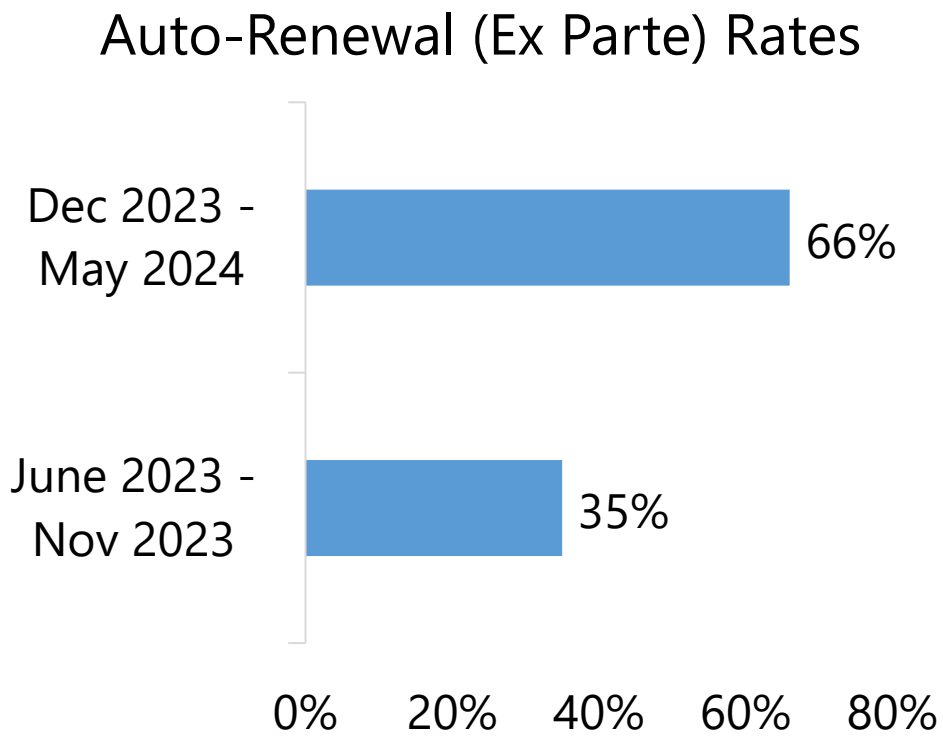
DHCS

Where We Are

- Continuous Coverage Unwinding officially ended on May 31, 2024
- California had over 13 million renewals (excludes Medi-Cal members in Presumptive Eligibility, state-only, and federal SSI programs) and is the largest Medicaid caseload in the nation.
- As of August 2024, 90% of the Unwinding renewals have been completed.

A Year in Reflection

- **Policy Flexibilities and Automation:** Significantly increased auto-renewal rates for California Seniors and Persons with Disabilities (Non-MAGI) after policy flexibilities. Auto-renewal rate increased from 3.9% to 47% in April 2024.
- **Coverage Retention:** As of August 2024, successfully maintained coverage for approximately 8.7 million Californians through redetermination, ranking among the highest retention rates nationally.
- **Disenrollment Reduction:** Policy automation lowered monthly disenrollment rates from 18-22% (June – Nov 2023) to 8-10% (Dec to May 2024). Approximately 2 million individuals were disenrolled during the Continuous Coverage Unwinding.

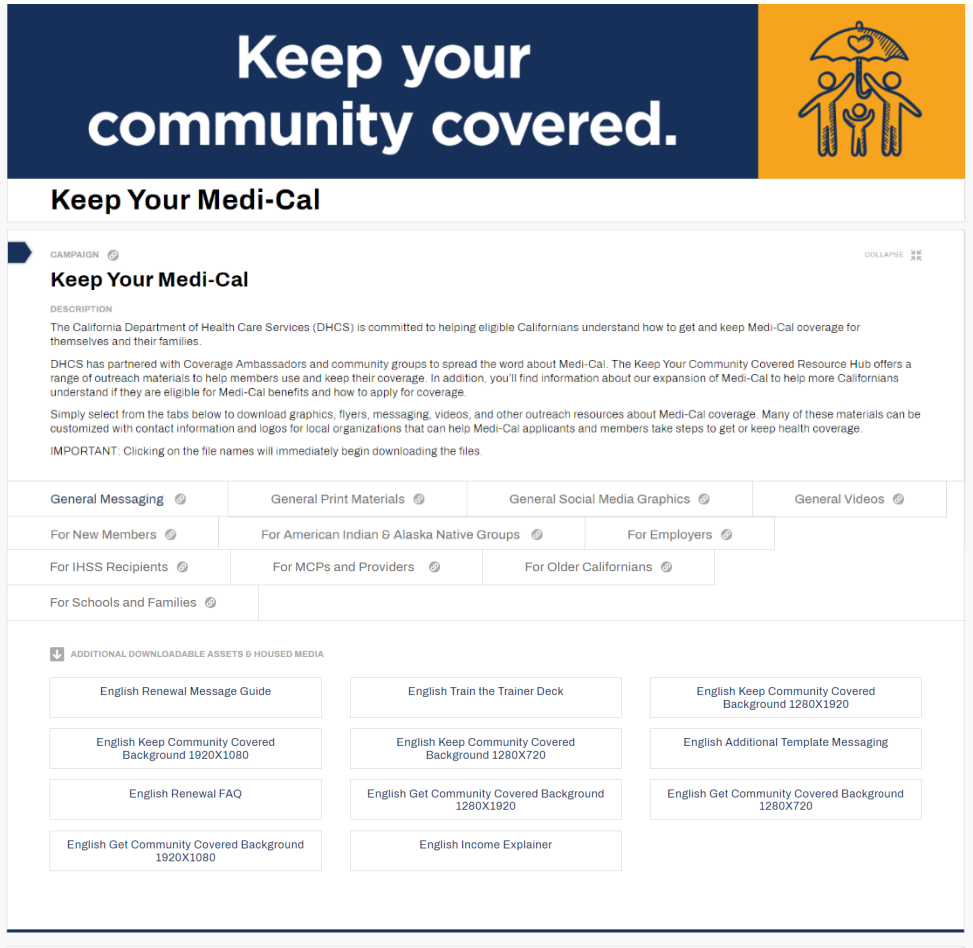


Summary Redetermination Statistics for AI/AN Medi-Cal Members

Redetermination Statistics for AI/AN Members by Region			
Region	**# Due**	**# Discontinued**	**% of Completed that were Discontinued**
Bay Area	4223	552	18%
Central Coast	755	87	16%
Central Valley	6798	879	17%
Far North	5055	692	18%
Los Angeles	314	53	20%
North Coast	10314	1581	20%
Sacramento Valley	7162	969	18%
Sierra Range/Foothills	4927	803	20%
Southern California	6135	765	17%
Unknown*	94	12	24%
Statewide	45777	6393	18%

*June 2023 CalSAWS Data did not include county information. A MIS/DSS match was performed to find counties based on CIN. Some matches were not found.

Member Outreach



Campaign Overview

- DHCS created one landing page for application and renewal information: Get Medi-Cal or Keep Your Medi-Cal, which provides information for Medi-Cal members at different places in their journey.
  - More than 3.1 million unique visitors to the landing page throughout the campaign.
- Development of a resource hub, Keep Your Community Covered, that offers informational materials about using and keeping coverage.
- Community partnership: As of June 2024, there were close to 8,000 DHCS Coverage Ambassadors.

Tailored Audience Resources

» Tailored resources for specific audiences and outreach partners, including American Indian/Alaska Natives

Thank you CRIHB for supporting this effort with artwork.

Targeted Messaging

17,000 downloads of 6,750 total outreach assets by Ambassadors and Stakeholders via the Social Press Kit.

Targeted digital ads reached over 1.69 billion people based on zip code and income, driving 3.4 million clicks.

Partnerships with ethnic media (~70 media outlets) resulting in a total of 183 pieces of news coverage.

Text Messaging: Most successful communication modality.

COMING SOON!
Interactive Map of Medi-Cal Enrolled Indian Health Care Providers (IHCPs)

- The map will be posted to the DHCS Indian Health Program website in the next few weeks and will:
  - Provide detailed site information including contact details, website links, and available services
  - Be viewable by county, region, and provider type
  - Feature a “near me” function to assist current American Indian/Alaska Native Medi-Cal members and those that are newly enrolling to locate their nearest IHCPs
  - Be updated on a quarterly basis by DHCS

Questions?

DHCS

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Meeting