Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services
December 9, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Welcome, Introduction of Tribal Leaders, and Review of Agenda

René Mollow, Deputy Director
Health Care Benefits & Eligibility

DHCS

Welcome and Webinar Logistics

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 the New IHP Coordinator Consuelo Gambino

Andrea Zubiate

Chief, Office of Tribal Affairs

DHCS

DHCS Director's Update

Michelle Baass

DHCS Director

DHCS

Quality and Population Health Management Update

Palav Barbaria

Deputy Director and Chief Quality and Medical Officer

DHCS

Objectives

Understand:

- Goals of DHCS' Medi-Cal Connect, the Population Health Management (PHM) Service
- Functions of Medi-Cal Connect via Tribal User Story
- Current Data Dashboard
- Medi-Cal Connect Tribal Engagement Plan

Participants Can:

- Ask Questions about Medi-Cal Connect *(please put questions in the chat)*
- Provide feedback via an upcoming survey

Agenda

- Vision | Goals | Objectives of Medi-Cal Connect
- Tribal Engagement Plan
- Medi-Cal Connect Conditions Prevalence Dashboard
- Prior Feedback Review
- Comments and Questions

Medi-Cal Connect

Vision | Goals | Objectives

Vision for Medi-Cal Connect

- To provide a data-driven business solution that supports whole-person care by integrating information from trusted partners to support population health functions and allow for multi-party data access and sharing.

Goals of Medi-Cal Connect

» The PHM Service has four primary goals supported by 10 core objectives.

- **Member Experience**
  1. Streamline access
  2. Navigate benefits
  3. Reduce service gaps
  4. Enable self-service updates
- **Whole-Person Care**
  5. View member risks and unmet needs
  6. Utilize risk stratification
- **Population Level Insights**
  7. Facilitate data aggregation and integration
  8. Act on population-level health trends and disparities
- **Informed Policymaking**
  9. Strengthen Medi-Cal oversight and monitoring
  10. Leverage analytics and insights

Medi-Cal Connect Supports Whole-Person Care

- Whole-person care combines physical health, behavioral health, and social services to improve member health and well-being.
- Medi-Cal Members
  - Food
  - Corrections
  - Housing
  - Enhanced Care Management
  - Social Supports
  - Health

Medi-Cal Connect will prioritize member whole-person care by creating an **easy-to-access platform,** empowering members to:

- Navigate benefits
- Close gaps in services
- Update contact information

PHM Service: Thomas' Story

- **Thomas, a 32-year-old Yurok male**, is struggling with opioid addiction, depression, and a digestive issue. He requires **Medication-Assisted Treatment (MAT), traditional healing services**, and specialty care for his digestive health.
- Thomas logs in to MyMedi-Cal Connect and **updates his contact and demographic information**, which directs him to the **Indian Health Provider Locator.** This tool helps him quickly access information and make an appointment with a local Indian health care provider.
- At his initial primary care appointment, Thomas is diagnosed with pre-diabetes and referred to a nutritionist. The nutritionist **sees in Medi-Cal Connect that Thomas is eligible for CalFresh** and encourages him to apply. His primary care provider also refers Thomas to behavioral health, traditional healing services, and a specialist for his chronic abdominal pain.
- Thomas begins treatment for opioid addiction and is scheduled for monthly check-ups to monitor his pre-diabetes. **His behavioral health provider and specialty clinic access his medications and health history via Medi-Cal Connect,** ensuring tailored and coordinated care, including support from both modern and traditional practices.

Medi-Cal Connect

Tribal Engagement Plan

Medi-Cal Connect Engagement Plan

» Current Engagement Activities

Engagement Forum	State Partners & Agencies	Health Care Delivery Partners	Tribes & Tribal Partners	Members
Webinars/Listening Sessions	X	X	X	X
Small Group Discussions	X	X	X	X
Lobby Tours				X
Focus Groups			X	X
Surveys (e.g., Enrollment Navigators)			X	X

Release 4 Tribal Engagement Schedule

Completed Engagement

Meeting Date	Stakeholder	Meeting Description
3/11/2024	PHMS Tribal Partners	Medi-Cal Connect Tribes and Tribal Partners Webinar 1
5/29/2024	All Early Adopters	Medi-Cal Connect Early Adopter Webinar 1
10/03/2024	All Early Adopters	Medi-Cal Connect Early Adopter Webinar 2
12/9/2024	Tribal Quarterly Webinar	Medi-Cal Connect Tribal Quarterly Webinar

Small Group Discussions

Meeting Date	Stakeholder	Meeting Description	Status
Q1-Q3 2025 (Tentative)	Tribal Health Program and Tribal Area Board	Medi-Cal Connect Early Adopter Intro & User Questions	TBD
Q1-Q3 2025 (Tentative)	Tribal Health Program and Tribal Area Board	Medi-Cal Connect Early Adopter User Questions	TBD
Q1-Q3 2025 (Tentative)	Urban Indian Health Program and Urban Indian Consortium	Medi-Cal Connect Early Adopter Intro & User Questions	TBD
Q1-Q3 2025 (Tentative)	Urban Indian Health Program and Urban Indian Consortium	Medi-Cal Connect Early Adopter User Questions	TBD

Release 4 Tribal Engagement Schedule (cont.)

AI/AN Medi-Cal Member Engagement

Meeting Date	Stakeholder	Meeting Description
Q3-Q4 2025	AIAN Medi-Cal Members	AIAN Medi-Cal Member Focus Group

Medi-Cal Connect Tentative Calendar

Looking Ahead

- Individual **stakeholder groups** may have **additional touchpoints** outside of this timeline.
- These dates are **tentative** and **subject to change** (invites will be sent 30 days in advance).
- Engagement will focus on **feedback**, **status updates**, **configuration**, and identifying **distinct needs.**

May 2024 Webinar 1

Q3 2024 Release 1 (DHCS)

Q4 2024 *Tribal Quarterly* (We are Here)

Q1 2025 Release 2 (DHCS)

Q1 2025 Webinar 3

Q3 2025 Release 3

Q4 2025 Release 4 (Managed Care Plans, County Mental Health Plans, State Partners and Agencies)

Q1 2026 Release 5 (Medi-Cal Members)

Medi-Cal Connect Dashboards

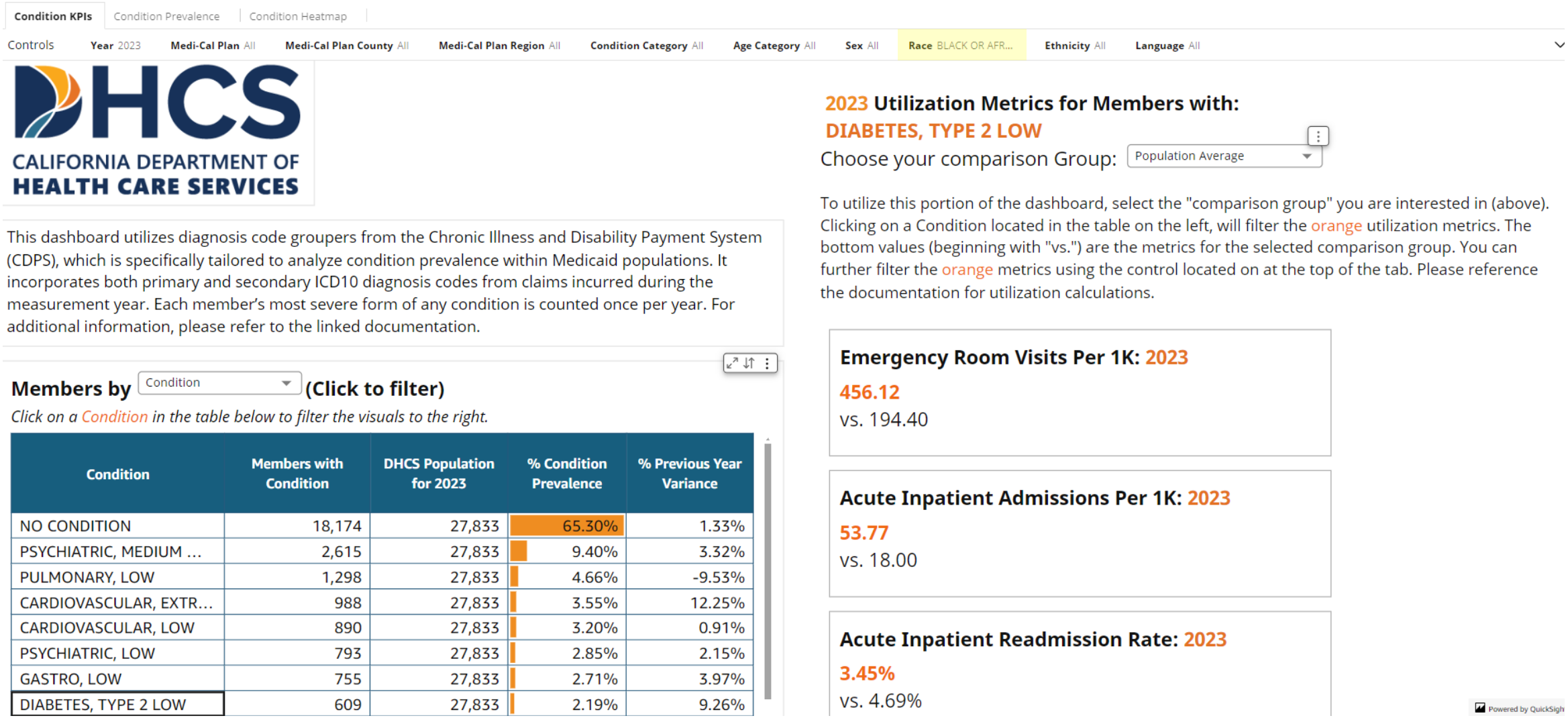
- Dashboards will give users valuable insights into the health of Medi-Cal members across California.

- These tools will allow DHCS and Tribal communities to understand the health of Tribal communities, which will help inform policy and programs in the future.

- Dashboards and data analytics will be used to identify “hotspots” where care and resources are most needed.

PHM Condition Prevalence Dashboard

» *Diabetes, Type 2 (Low) Prevalence Compared to Population Average* ***by Race***



We heard about these opportunities from this group at the last webinar.

And we heard these concerns.

We want to understand more.

- **Health Enrollment Navigator Survey**: More than 30 percent of respondents were from Indian health delivery partners.

- A **Medi-Cal Connect Tribes and Tribal Partners Survey** is being developed and will soon be sent from the Office of Tribal Affairs. Please watch for this survey. We look forward to your input.

Birthing Care Pathway Public Report Briefing

DHCS' Vision for Maternity Care in Medi-Cal

The Birthing Care Pathway is a care model that will cover the journey of all Medi-Cal members from conception through 12 months postpartum. DHCS's goal is to **reduce maternal morbidity and mortality** and **address the significant racial and ethnic disparities** in maternal health outcomes among American Indian/Alaska Native, Black, and Pacific Islander individuals in California.

With the launch of the Birthing Care Pathway, DHCS envisions a future in which:

- Pregnant and postpartum Medi-Cal members have access to a comprehensive menu of maternity care providers and services regardless of where they live.
- Pregnant and postpartum members can access risk-appropriate care and are empowered to choose the provider team and birthing location that align with their needs and preferences.
- All Medi-Cal members feel respected and heard throughout their pregnancy and postpartum journeys
- Pregnant and postpartum members are educated on the services available to them and receive the navigational support they need for all aspects of their care.
- Behavioral health services and social supports are accessible to all pregnant and postpartum members, their newborns, and their families.
- Data collection and sharing are improved to strengthen care for pregnant and postpartum members.

Pre-Decisional Discussion Draft

Public Report Overview

DHCS plans to publish a **public report on the Birthing Care Pathway in December 2024.**

The Public Report will:

- Summarize the current state of maternal health in Medi-Cal and outline DHCS' vision for the Birthing Care Pathway
- Provide an overview of the partner engagement conducted to date
- Share findings from Birthing Care Pathway Medi-Cal member engagement
- Discuss the policies DHCS has implemented/is implementing for the Birthing Care Pathway and share progress to date
- Identify opportunities for further exploration for the Birthing Care Pathway

DHCS is still finalizing the contents of the Birthing Care Pathway public report. The information included in these slides is subject to change.

Public Report Development

To develop the Birthing Care Pathway DHCS:

- **Conducted a landscape assessment** to review California's existing maternal health policies and initiatives, and identify evidence-based programs, policies, and interventions
- **Interviewed** over 25 state leaders, providers, community-based organizations, associations, health plans, and advocates to inform the design of the Birthing Care Pathway
- **Launched** the **Clinical Care Workgroup, Social Drivers of Health Workgroup,** and **Postpartum Sub-Workgroup** to identify challenges and opportunities in perinatal care and develop and validate policy options for the Birthing Care Pathway
- **Engaged Medi-Cal members** through a Member Voice Workgroup, interviews, and member journaling to ensure their lived experiences shaped the design of the Birthing Care Pathway

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

Birthing Care Pathway Community Engagement

Pre-Decisional Discussion Draft

American Indian/Alaska Native & Tribal Partners

DHCS prioritized highlighting American Indian/Alaska Native and Tribal perspectives in the Birthing Care Pathway partner engagement process, including as Workgroup members and interviewees.

- **Workgroup Members:**
  - **Ninoska (Nina) Ayala** (Social Drivers of Health Workgroup)
    - Women, Infants, & Children (WIC) Director, Native American Health Center
  - **Virginia Hedrick** (Clinical Care Workgroup)
    - Executive Director, California Consortium for Urban Indian Health; Board of Directors Member, The California Wellness Foundation; Member of the Yurok Tribe of California
  - **Antoinette Martinez, MD** (Clinical Care Workgroup; Postpartum Sub-Workgroup)
    - Provider, United Indian Health Services (Humboldt and Del Norte Counties); Co-Director, Program in Medical Education – Transforming Indigenous Doctor Education (PRIME-TIDE), University of California Davis School of Medicine; Member of the Chumash Tribe
- **Interviewees**
  - **Barbara Hart**
    - Nurse Consultant, Office of Tribal Affairs, DHCS
  - **Antoinette Martinez, MD**
    - *See affiliations in Workgroup Members section.*
  - **Andrea Zubiate**
    - Chief, Office of Tribal Affairs, DHCS

Birthing Care Pathway Workgroups

Workgroups & Sub-Workgroup	Workgroup Participant Charges	Workgroup Composition
Clinical Care Workgroup	Identifying what needs to happen in the hospital, birthing center, provider office, and other community settings from a Medi-Cal Member's perspective	Obstetrician-gynecologists (OB/GYNs), certified nurse midwives (CNMs), lactation consultants, doulas, Tribal health providers, pediatricians, freestanding birth centers (FBCs), behavioral health providers, federally qualified health centers (FQHCs), family medicine providers, managed care plans (MCPs), and Comprehensive Perinatal Services Program (CPSP) and other local public health program representation
Social Drivers of Health Workgroup	Identifying best practices and needs from programs and providers that currently work to address perinatal health-related social needs	Community health workers (CHWs), doulas, and other providers representing organizations addressing the social needs of birthing people including violence prevention organizations, local Maternal Child & Adolescent Health (MCAH) programs including CPSP and Black Infant Health programs, Women, Infants, and Children Program (WIC), and food and diaper banks, organizations addressing housing and financial insecurity, home visiting providers, and providers with Black birthing expertise

Birthing Care Pathway Workgroups cont.

Workgroups & Sub Workgroup	Workgroup Participant Charges	Workgroup Composition
Postpartum Sub-Workgroup	Designing a clinical pathway for what providers can do during the postpartum period to achieve positive health outcomes	Cross-representation from the Clinical Care Workgroup and Social Drivers of Health Workgroup, as well as additional pediatricians, family physicians, and FQHC providers

Medi-Cal Member Engagement Activities

A foundational priority for DHCS has been to ensure the Birthing Care Pathway design is shaped by Medi-Cal members with lived experience. DHCS partnered with Everyday Impact Consulting (EIC) — a California-based organization focused on community engagement that is also supporting the Medi-Cal Member Advisory Committee — to conduct the member engagement activities for the Birthing Care Pathway. All members were compensated for their participation.

Member Engagement Activity	Description
Member Interviews	Conducted **1:1 interviews** with **6** members who were pregnant or postpartum in March and April.
Member Journaling	Invited **6** members who were pregnant or postpartum to submit five biweekly **journal entries** about their perinatal experience from late March through mid-May.
Member Voice Workgroup	Launched a **Member Voice Workgroup** composed of **20** members who were pregnant or postpartum. Three meetings were held between March and April.

Four Medi-Cal members who participated in the Birthing Care Pathway member engagement activities identified as American Indian or Alaska Native, including one from a Tribal nation and indigenous community.

Birthing Care Pathway Medi-Cal Member Engagement Key Findings

- Feeling respected and heard by health care providers is critical to a member's perinatal experience in Medi-Cal; members often feel that their birth plans and breastfeeding choices are not respected; however, members feel like midwives and doulas listen to their needs and preferences.
- Some members **experienced discrimination in their health care encounters** during all three perinatal phases; members felt connected to their health care providers and better supported when they received **racially and culturally concordant care**.
- **Key moments for trust building with members are often missed,** particularly around mindful discussions on behavioral health screening results and referrals to services, trauma-informed approaches to intimate partner violence (IPV) screenings, smooth hospital discharges after birth, and timely access to high-quality breast pumps.
- Medi-Cal members often felt like the **onus was on them to independently navigate and coordinate many aspects of their perinatal care** – ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.
- **Finding mental health providers that accept Medi-Cal, are taking new patients, and have perinatal experience is difficult;** Medi-Cal members want more frequent and intensive mental health supports.
- Medi-Cal members often **do not understand what Medi-Cal benefits and public benefits/social services are available** to them in pregnancy or during the postpartum period (e.g., doula services, Enhanced Care Management (ECM); WIC/CalFresh; and transportation services).

Additional Input for the Birthing Care Pathway

DHCS solicited additional input on the Birthing Care Pathway through meetings with clinical and non-clinical maternity care providers, social services providers, state leaders, MCP representatives, Tribal health providers, local public health, and birth equity advocates.

Birthing Care Pathway Focus Areas

Pre-Decisional Discussion Draft

Overview of Birthing Care Pathway Focus Areas

The landscape assessment and partner and member engagement led to the crystallization of problem statements and the identification of an array of policies within DHCS' purview to support pregnant and postpartum Medi-Cal members through the Birthing Care Pathway.

» **Today's Discussion**

- Policies DHCS Has Implemented/Is Implementing for the Birthing Care Pathway
  - Many of these policies align with DHCS' CalAIM program areas currently being operationalized (e.g., Population Health Management (PHM), ECM, Community Supports, Justice-Involved Reentry Initiative).
  - These policies do not need additional budgetary or legislative authority.

Through extensive community engagement, DHCS has identified opportunities for future exploration for the Birthing Care Pathway. These opportunities, subject to additional assessment and planning, can inform future discussion and help to lay the foundation for the "next generation" of policy solutions.

Overview of Policies DHCS Has Implemented/Is Implementing

- Through the landscape assessment and partner and member engagement, DHCS identified policies that it will implement for the Birthing Care Pathway. DHCS has already implemented some of these policies while others are in progress. Partners and Medi-Cal members provided recommendations for how DHCS can implement these policies most effectively.
- The policies DHCS has implemented/is implementing are in the following eight focus areas:
  - Provider Access and MCP Oversight and Monitoring
  - Behavioral Health and Trauma-Informed Care
  - Risk Stratification and Assessment
  - Medi-Cal Maternity Care Payment Redesign
  - Care Management and Social Drivers of Health
  - Perinatal Care for Justice-Involved Individuals
  - Data and Quality
  - State Agency Partnerships

Provider Access and MCP Oversight and Monitoring

Problem Statements:

- There is **limited racial and ethnic diversity of maternity care providers** in Medi-Cal today**, with low representation of American Indian/Alaska Native providers**. Partners shared that racism in health care and a **lack of culturally, linguistically concordant care** results in biased care across races and ethnicities and can **exacerbate health disparities** amongst Black, **American Indian/Alaska Native**, and Pacific Islander pregnant and postpartum individuals.
- Some members shared positive feedback on midwives and doulas, noting that they listened to their **needs and preferences** and made them feel **supported** during **labor and delivery**, but partners reported **confusion among MCPs and providers** on Medi-Cal coverage and reimbursement for midwifery care, home births, and lactation and doula services.
- Partners – including Medi-Cal members – expressed a need for improved and timely access to a range of **high-quality breast pumps** that meet their needs.
- Members and providers are often **unaware of the full array of available maternity care services**.
- Members also expressed a need for **smoother hospital discharges after birth** to ease transitions into the postpartum period.

Behavioral Health and Trauma-Informed Care

Problem Statements:

- Black and American Indian/Alaska Native postpartum individuals report higher rates of anxiety and depression compared to other races/ethnicities.
- Pregnant and postpartum Medi-Cal members face challenges accessing timely behavioral health care with limited mental health providers who accept Medi-Cal, are taking new patients, and have perinatal experience.
- Substance Use Disorders (SUDs) are prevalent and have been identified as precipitating factors in maternal suicides in California. Medi-Cal providers have reported confusion around how long a pregnant or postpartum member can receive residential SUD treatment.
- Statewide, 1.5 percent of pregnant Californians had an SUD at delivery in 2022. This rate is highest among American Indian / Alaska Native (7%) and Black (5%) individuals.
- Trauma – which may include adverse childhood experiences (ACEs), IPV, community violence, racism, and discrimination – can negatively impact a member's physical and mental health outcomes, relationships with health care providers, engagement with the health care system, and adherence to treatment.

Risk Stratification and Assessment

Problem Statements:

- There is a lack of standardization with regard to how MCPs use risk stratification algorithms, employ risk tiers, and connect members to services, including for pregnant and postpartum members.
- American Indian/Alaska Native pregnant and postpartum individuals in California report IPV rates that are nearly twice as high as those reported by other races/ethnicities.
- Partners shared that IPV screening was inconsistent with limited follow-up care or support. This is troubling because the risk of IPV increases during the prenatal period, and IPV may be a contributing factor in homelessness, other behavioral health conditions, and pregnancy-associated suicides and homicides in California.

Medi-Cal Maternity Care Payment Redesign

Problem Statements:

- Partners explained that Medi-Cal's reimbursement rates for licensed and non-licensed maternity care providers are not high enough to incentivize participation in Medi-Cal.
- The existing Medi-Cal maternity payment model is hospital-oriented, causing challenges for FBCs and midwives providing home births to be recognized and reimbursed for their birthing approaches. This model does not incentivize providers to appropriately transfer a patient to a higher level of care based on their needs.
- Lastly, partners report that the existing FQHC and rural health clinic (RHC) reimbursement methodology does not incentivize clinics to provide dyadic services because they do not get reimbursed for the dyadic services separately from and in addition to the Prospective Payment System (PPS) reimbursement rate for dyadic services provided during or on the same day as an eligible FQHC/RHC visit.

Care Management and Social Drivers of Health

Problem Statements:

- Partners expressed a **need for** education on **which Community Supports can best support** pregnant and postpartum Medi-Cal members as well as **more provider technical assistance (TA), support, and educational materials around the ECM Birth Equity Population of Focus** to better leverage the benefit and ensure that eligible Black, **American Indian/Alaska Native**, and Pacific Islander pregnant and postpartum individuals access the **benefit.**
- Some Medi-Cal **members reported being unaware of ECM and Community Supports, what they include,** and how they can find out if they are eligible or which Community Supports are offered by their MCP.
- Partners stressed the **need for ECM and Community Supports providers** serving pregnant and postpartum members **to have perinatal expertise**.
- Partners also identified a need to prevent and address the adverse maternal and infant outcomes that result from **homelessness and housing insecurity**.

Perinatal Care for Justice-Involved Individuals

Problem Statements:

- Today, there are an estimated 58,000 admissions of pregnant individuals into prisons and jails every year across the country; 8,000 of those admissions are pregnant individuals with opioid use disorder (OUD). Up to 4% of women entering a correctional facility are pregnant.
- While California prisons and some jails provide medications for OUD (MOUD) during pregnancy, there are few policies in place to ensure those medications are continued after delivery, meaning many individuals are abruptly discontinued from these medications postpartum.

Data and Quality

Problem Statements:

- Like every other state in the nation, Medi-Cal currently lacks a statewide technology platform for maternity care providers, programs, and MCPs to easily and safely share patient data and help members manage their medical, behavioral, and social needs.
- Eligibility and enrollment data sharing across public benefits and programs are inconsistent in California causing gaps in care and service delivery.
- Maternity care quality metrics that are used for MCP quality improvement and accountability processes are limited, and additional metrics are needed to fully understand the scope and quality of Medi-Cal maternity care..

State Agency Partnerships

There are multiple programs and systems serving pregnant and postpartum Medi-Cal members that are under different state agencies' purviews. In developing the Birthing Care Pathway, DHCS did not limit its scope to areas solely within its purview but looked for opportunities to partner with other state agencies.

Problem Statements:

- California state agencies have identified multiple challenges and gaps in maternal health, including inadequate culturally appropriate care delivery; a lack of access and links to risk-appropriate care; no universal standards for risk assessment and inconsistent follow-up; limited maternal health data access and transparency; and siloed services, programs, and interventions.
- California has multiple home visiting programs, including the DHCS American Indian Maternal Support Services (AIMSS) program, for pregnant and postpartum members, but they are not coordinated across state agencies, causing a lack of member awareness and underutilization of these programs.

Questions

- What Birthing Care Pathway focus areas are you most excited about?
- What else should DHCS consider for the Birthing Care Pathway to better address the needs of American Indian/Alaska Native Medi-Cal members?
- How can DHCS continue to engage American Indian/Alaska Native Medi-Cal members and partners in the Birthing Care Pathway?

Comments and Questions?

Managed Care Update

Bambi Cisneros

Assistant Deputy Director

DHCS

Tribal Liaison Monitoring Update

MCP Tribal Liaison

- Tribal Liaison requirement
  - Effective January 1, 2024, MCPs are required to have an identified tribal liaison dedicated to working with each contracted and non-contracted Indian Health Care Provider (IHCP) in its service area. The tribal liaison is responsible for coordinating referrals and payment for services provided to American Indian MCP Members who are qualified to IHCP.
- Survey scope aims to:
  - Obtain information from IHCPs regarding the effectiveness of the MCP Tribal Liaisons
  - Gather any promising practices that can be lifted up across MCPs
  - Identify the general categories of assistance that MCP Tribal Liaisons are offering
  - Inform of any needed improvements
- Monitoring objectives:
  - Identify additional needs for policy guidance/TAs
  - Understand the successes, challenges, and concerns of working with Tribal Liaisons
- DHCS issued the survey on December 3, 2024. DHCS will review the responses, share with MCPs as needed, and provide a summary report at the next Tribal meeting (tentatively March 11, 2025)

Providing Access and Transforming Health (PATH) Updates

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

CITED Round 3

- On August 30, 2024, DHCS awarded $146.6 million to 133 organizations for CITED Round 3, in addition to $37 million in awards to 49 clinics on July 22.
- A total of 470 applications were received with approximately $711M in requests.
- 7 Round 3 applicants self-identified as a tribe, Indian health program, or urban Indian organization.
- 6 applicants that self-identified as a tribe, Indian health program, or urban Indian organization were awarded in Round 3 or CITED-Clinics.
  - Applications not awarded did not meet minimum eligibility criteria

Round 3 Priorities were focused on closing existing gaps for ECM and Community Supports implementation, including:

- Meets **County ECM POF Gap** from Exception or Corrective Action Plan
- Meets ECM Plan- **County low penetration rate**
- ECM/Community Supports in **Rural Counties**
- ECM providers for **Children/Youth** Populations of Focus
- **Tribal Partners and Tribal Providers**
- County-specific **Gaps in ECM** by Population of Focus

CITED Round 4

- The CITED Round 4 Application window will open on January 6, 2025, and close at 11:59 pm PST on March 7, 2025. Application Preview and Funding Request workbook are available at https://ca-path.com/cited

Register for Upcoming Informational Office Hours

- CITED Round 4 Information Session on January 7, 11:30 AM PT
  - Register Here
- How to Make Your Grant Application Stronger Webinar Part 1 on January 16, 10 AM PT
  - Register Here
- How to Make Your Grant Application Stronger Webinar Part 2 on February 3rd, 10 AM PT
  - Register Here
- Weekly Office Hours
  - PATH CITED website for dates and registration links

Collaborative Planning and Implementation (CPI)

Indian Health Collaborative

- The Indian Health PATH Collaborative is a statewide collaborative, in addition to county and regional PATH Collaboratives held throughout the state, and is intended to build a connected community of care and share best practices among California tribal communities.
- The Indian Health Collaborative is facilitated by HC2 Strategies, Inc. and launched in October 2023
  - There are currently over 90 entities participating in this collaborative, including Tribal organizations, MCPs, county and local agencies, CBOs, and other ECM and Community Supports providers.
  - Contact Information: IndianHealthCPI@hc2strategies.com
- If you have not yet registered to join a Collaborative, please **register here** before signing up for a collaborative event.
- Additional information, including access to reference materials, can be found on the CPI webpage.

Indian Health Collaborative Events

- The next Indian Health monthly collaborative meeting is scheduled for December 20, 2024, at 2pm-3pm PT
- Other upcoming Indian Health Collaborative Events:
  - Office Hours: December 5, 2024, at 1pm-2pm PT; January 9, 2025, 1pm-2pm PT
  - Provider Forum: January 15, 2025, 2pm-3pm PT
- Register here to become a CPI Participant!

Comments and Questions?

Behavioral Health (BH) Update

Paula Willhelm

Deputy Director

DHCS

Today's Agenda

- **Traditional Health Care Practices Status and Next Steps**
- **Claiming and Payment Proposal**
- **Traditional Health Care Practices Opt-in Process**

Traditional Health Care Practices: Status and Next Steps

Defining Terms

- **"Traditional health care practices"** is the term used by the Centers for Medicare & Medicaid services in the approval of services that are delivered by or through IHS facilities, Tribal facilities, or UIO facilities (collectively referred to as Indian Health Care Providers, or IHCPs).
- In California, traditional health care practices is the umbrella term for **Traditional Healer** and **Natural Helper** services, provided by Traditional Healers and Natural Helpers.

Timeline

- **Beginning Summer 2024**
  - Policy development and consultation
- **October 16, 2024**
  - CMS approves DHCS's Traditional Healer and Natural Helper request
- **December 2024**
  - Anticipated release of the draft BHIN for Tribes, Tribal partners, and the public to share comments
- **January 2025**
  - Anticipated release of the BHIN and FAQ document
- **Q1 2025**
  - Ongoing technical assistance for IHCPs

Policy Guidance

DHCS is currently developing policy guidance to support counties and providers with the implementation of this benefit.

- The forthcoming **Behavioral Health Information Notice (BHIN)** will include information about services, eligibility, billing, clinical documentation, provider requirements, oversight, and other topics.
- The guidance is based on CMS requirements as outlined in waiver special terms and conditions; discussions with Tribes, Tribal partners, and other implementation partners; and existing DMC-ODS policies.
- **For discussion:** Tribes, Tribal partners, and the public will have opportunities to provide comment on the draft BHIN. DHCS proposes to allow for at least 10 business days for public comment and may be able to release the BHIN in the last week of December. Additional time for comment, or a January release to avoid holidays, may delay publication into Feb/March. **What are your recommendations related to the public comment period?**

Technical Assistance

- DHCS will provide technical assistance to assist IHCPs. Based on TA needs discussed in previous meetings, TA will include assistance with navigating:
  - Requirements for participating IHCPs, including any reporting requirements.
  - DMC-ODS policies and operations (e.g., member eligibility, contracting with counties, billing requirements and procedures).
  - Documentation requirements (e.g., medical necessity, progress notes, etc.) to satisfy potential audit requirements.
  - Practitioner requirements.
  - Ensuring quality and appropriateness of service delivery.
  - Templates and examples as appropriate
  - Other questions or barriers that arise during implementation.
- TA will be available at no additional costs to interested IHCP's seeking to provide services by Traditional Healers and Natural Helpers.

What technical assistance topics may be most useful? Are there specific materials, forums, or strategies that you would recommend DHCS utilize?

Future Consultations

DHCS continues to engage with Tribes and Tribal partners to solicit feedback to inform the design

- DHCS will consult with Tribes, Tribal partners, IHCPs, counties, and other partners to solicit their feedback to prepare to operationalize this benefit.
- Today's meeting will focus on claiming and payment for Traditional Healers and Natural Helpers as well as a proposed process for IHCPs to opt-in to providing traditional health care practices.

Claiming and Payment Proposal

County Reimbursement Obligations for IHCPs

DMC-ODS counties must observe differing reimbursement obligations for care provided to American Indian and Alaska Native (AI/AN) and non-AI/AN individuals, per 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.
- Consistent with existing policy, IHCPs serving Medi-Cal members from varying counties need to seek reimbursement from the member's Medi-Cal "county of responsibility." Coverage of traditional healing and natural helper services is available when the member is from a DMC-ODS county.

Additional Context

CMS's national framework of Medicaid requirements for Traditional Healer and Natural Helper 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 will develop an alternative payment approach for practitioner types ineligible to bill at the AIR for Traditional Healer and Natural Helper services, including all practitioners working with Urban Indian Organizations.

Rates and Payment

DHCS developed an alternative payment proposal **for practitioner types ineligible to bill at the AIR** for Traditional Healer and Natural Helper services, including all practitioners working with Urban Indian Organizations.

- DMC-ODS counties shall reimburse IHCPs at the rate they claim **when Traditional Health Care Practices are provided outside of a contract** (to AI/AN members). **This policy applies to both services billed at the AIR, and services billed using the alternative payment rates below.*
  - When counties and IHCPs contract, the rates the IHCP receives will be subject to negotiation.
- **Traditional Healer** services ineligible for the AIR will be paid at an AIR equivalent rate.
  - AIR for SFY 2024-25: $719.00
- **Natural Helper** services ineligible for the AIR will be paid using an encounter rate (billed once per member per day), based on statewide average rate for DMC-ODS Peer Support Specialist Services.
  - Natural Helper encounter rate: $335.37
- **For Discussion: What questions or feedback do you have about this proposed payment policy?**

DMC-ODS Claiming and Payment Guidance

- IHCPs shall **submit claims** for payment to the relevant DMC-ODS county.
  - Traditional health care practices shall be paid consistent with BHIN 24-008 and BHIN 22-053.
    - BHIN 24-008 updates and clarifies county Mental Health Plan, DMC, and DMC-ODS county responsibilities to pay for SUD and/or SMHS provided to members who move to another county.
    - BHIN 22-053 clarifies DMC-ODS counties' responsibilities and requirements for reimbursement of IHCPs, stating that they must reimburse providers, even those who are not contracted with the county, and are obligated to contract with sufficient IHCPs for their county.

Opt-in Process for IHCPs that Provide Traditional Health Care Practices

For Discussion: IHCP Opt-in Process to Provide Traditional Health Care Practices

The following steps outline DHCS' proposed process for IHCPs to opt-in to providing traditional health care practices.

- **IHCPs shall submit an Opt-In Package to DHCS for approval,** using a DHCS template/detailed guidance, that shall include, but is not limited to:
  - **A letter of intent** (LOI) including:
    - Services provided (TH/NH/DMC-ODS)
    - Whether/how the IHCP is enrolled in Medi-Cal
  - **Attestations to:**
    - Only provide TH and/or NH services (if not seeking DMC certification)
  - **Policies and Procedures**:
    - Practitioner Qualifications
    - Required Evidence-Based Practices
    - Referring members for comprehensive substance use disorder assessment and access to DMC-ODS services
    - Medications for Addiction Treatment (MAT) Access
- **For discussion:**
  - What feedback or questions do you have about the opt-in package materials?
  - At minimum, DHCS will recommend that the opt-in package be shared with the relevant DMC-ODS counties for informational purposes and to support coordination. This could also be required. What are your thoughts about how IHCPs should be communicating with counties?

Comments and Questions?

Appendix

Service Descriptions

DHCS partnered with Tribes to develop draft service descriptions of traditional healer and natural helper services. These services are now coverable under the CalAIM 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.

Practitioner Descriptions

DHCS partnered with Tribes to develop draft practitioner descriptions of traditional healer and natural helper services. These services are now coverable under the CalAIM demonstration.

Practitioner Descriptions:

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

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.
- **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.

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Current DMC-ODS Reimbursement Policies:
IHS Facilities and IHS-MOA Clinics

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) *(Negotiated Rate with the DMC-ODS County)*
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 FFS = rates that are available for counties to claim for DMC-ODS services

Sources: California's Medicaid State Plan; BHIN 22-053

Current DMC-ODS Reimbursement Policies:
Tribal FQHCs

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)** ***(Negotiated Rate with the DMC-ODS County)***
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) CMS has also stated that practitioner types billable by a Tribal FQHC must be the same as those of a non-Tribal FQHC.	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 FFS = rates that are available for counties to claim for DMC-ODS services

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

Current DMC-ODS Reimbursement Policies:
Urban Indian Organizations

There are different reimbursement approaches for IHCPs depending on the facility type. The negotiated rate with the DMC-ODS county only applies to UIOs so long as they meet both practitioner AND service requirements.

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

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar