Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services
March 11, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Overview

- Welcome and Introductions
- Agenda Review
- Items for Next Meeting

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"

Office of Tribal Affairs Update

Andrea Zubiate

Chief

DHCS

Update on Indian Health Program and Medi-Cal Utilization Data

What is Medi-Cal

- Medi-Cal is free or low-cost health coverage for children and adults with limited income and resources.
- Medi-Cal is California's Medicaid program.
- Medi-Cal is authorized and funded through a federal-state partnership.
- The federal Centers for Medicare and Medicaid Services approves changes to the Medi-Cal program.

Medi-Cal Delivery System

- **Fee-For-Service (FFS):** Providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
- **Medi-Cal Managed Care:** DHCS contracts with health plans for services through established provider networks. Most Medi-Cal beneficiaries are enrolled in Medi-Cal managed care.
- **County Behavioral Health:** DHCS contracts with counties for Medi-Cal Specialty Mental Health Services and substance use disorder treatment services. Authorized through a county-federal-state partnership.
- **Dental:** Dental services under Medi-Cal are primarily provided through the Dental Fee-for-Service system; there is also Dental Managed Care in Sacramento and Los Angeles counties.
- **California Children's Services:** State program to provide specialty care for children with complex/serious health conditions.

Medi-Cal Covered Benefits

Medi-Cal covers the following Essential Health Benefits:

- Outpatient (Ambulatory) Services
- Emergency Services
- Hospitalization
- Prescription Drugs
- Rehabilitative Services and Devices
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Children's (Pediatric) Services, including oral and vision care
- Maternity and Newborn Care
- Specialty and Non-Specialty Mental Health Services
- Substance Use Disorder Services
- Plus: Dental, Vision, and Long-Term Care

Note: Some benefits are optional under the Medicaid State Plan

Medicaid State Plan Overview

- State Plan: The official contract between the state and federal government by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding.
- The State Plan describes the nature and scope of Medicaid and gives assurance that it will be administered in accordance with the specific requirements of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and State law/regulations.
- California's State Plan can be accessed online at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

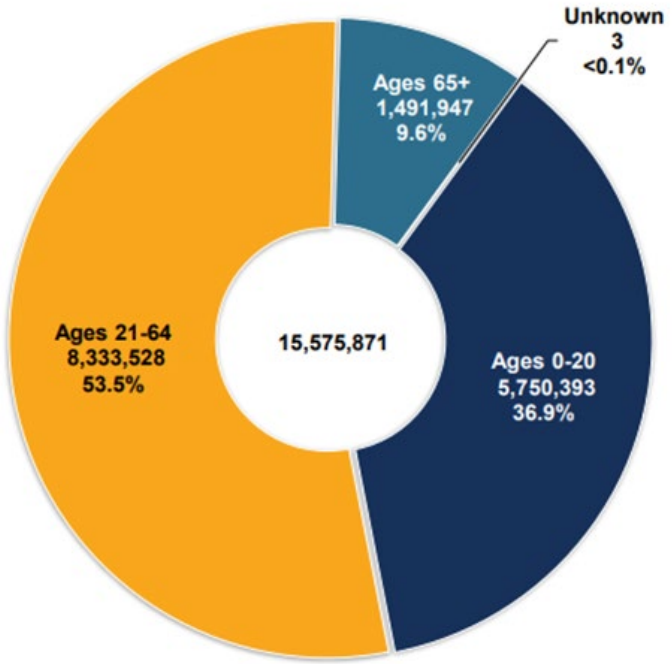
State Plan Amendment (SPA) Overview

- SPA: Any formal change to the State Plan.
- Approved State Plans and SPAs ensure the availability of federal funding for the state's program (Medi-Cal).
- The CMS reviews all State Plans and SPAs for compliance with:
  - Federal Medicaid statutes and regulations
  - State Medicaid manual
  - Most current State Medicaid Directors' Letters, which serve as policy guidance.

Who Medi-Cal Serves

- 15.58 million Californians
  - 5.75 million children up to age 20
  - 8.33 million adults ages 21-64
  - 1.49 million adults age 65+

MEDI-CAL ENROLLEES IN CALIFORNIA BY AGE GROUP, JULY 2023

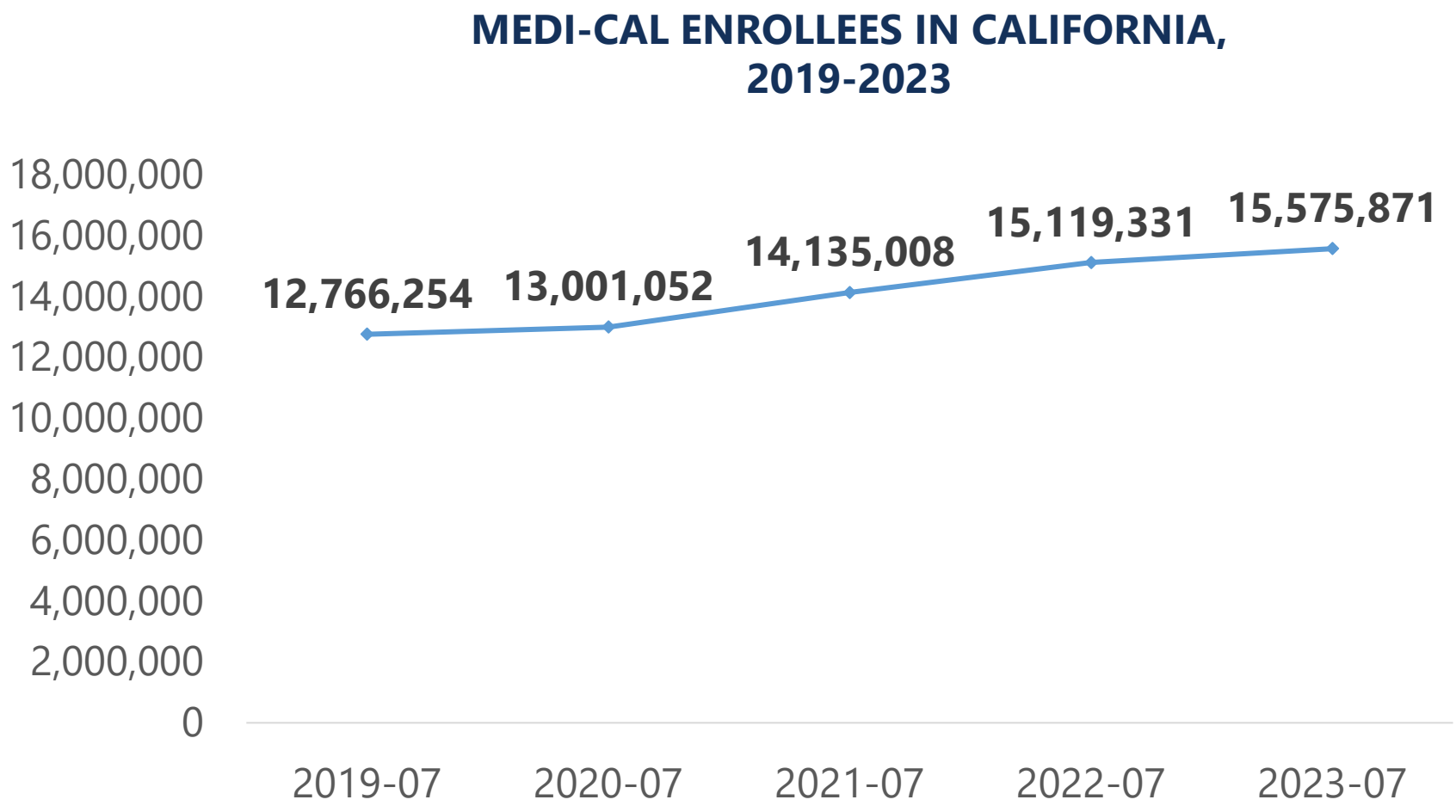


Source: https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf

Total Medi-Cal Certified Enrollees 2019 - 2023

- Medi-Cal reached its highest enrollment numbers in May 2023. The Public Health Emergency ended in May and redetermination of members, which had been put on hold since 2020, resumed shortly thereafter.

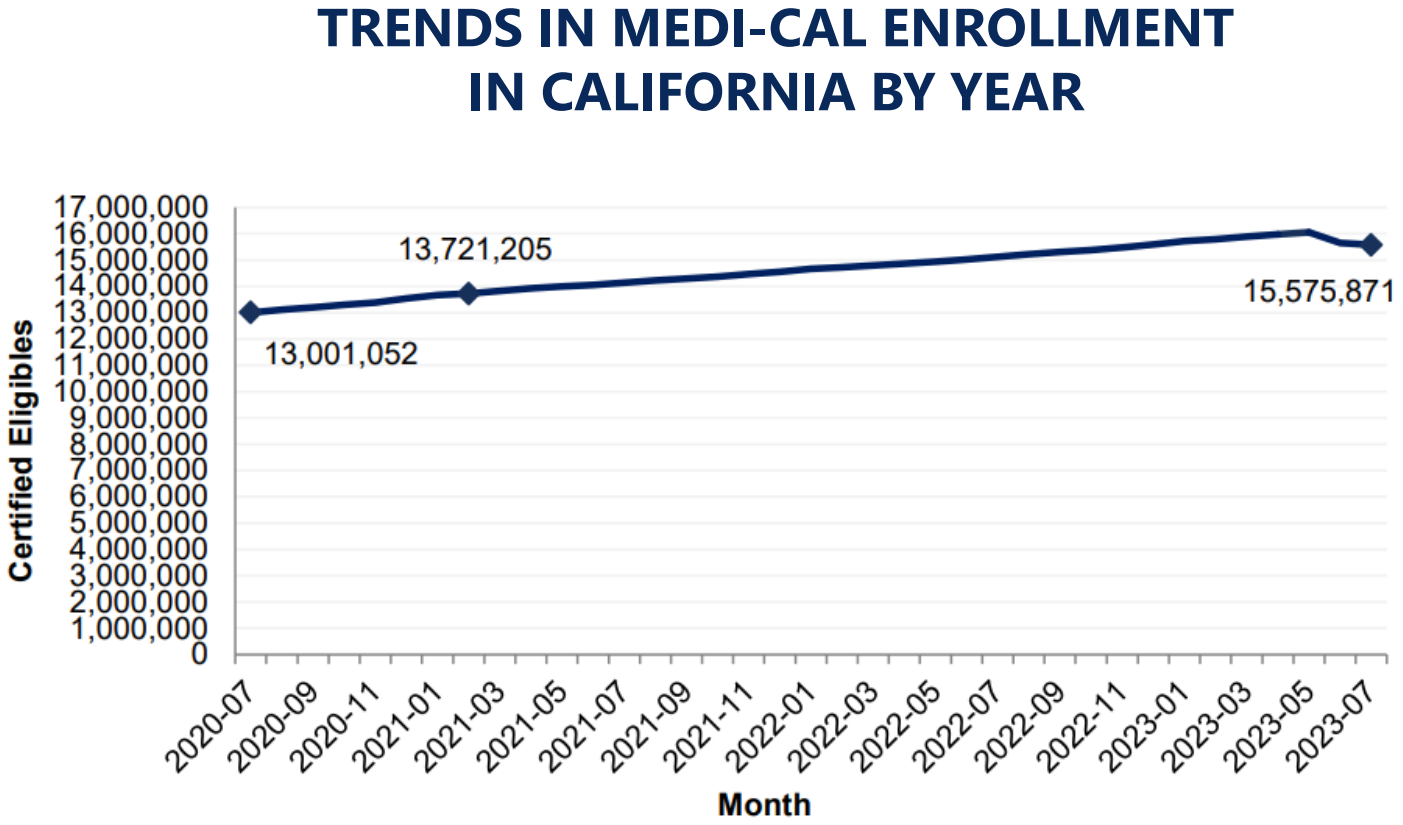
- As of July 2023, there are almost 15.6 million Medi-Cal members.



Source: https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf

Total Medi-Cal Certified Enrollees July 2020 – July 2023 (Pandemic Era)

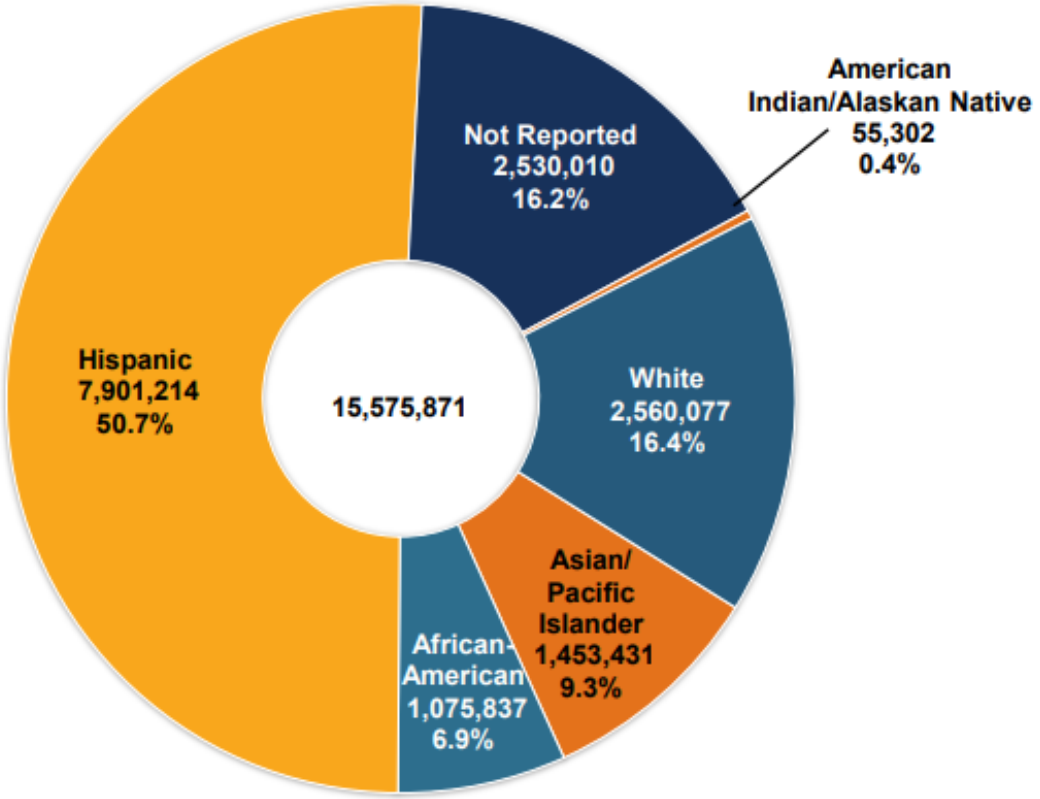
- Medi-Cal enrollment continued to decline, reaching about 12.5 million by early 2020.
- However, the enrollment numbers started to increase due to the COVID-19 Public Health Emergency (PHE), outpacing the high seen after the institution of the ACA, reaching 16.1 million by May 2023.
- Redeterminations followed shortly thereafter resulting in the first decrease since the PHE began.



Source: https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Fast_Facts.aspx

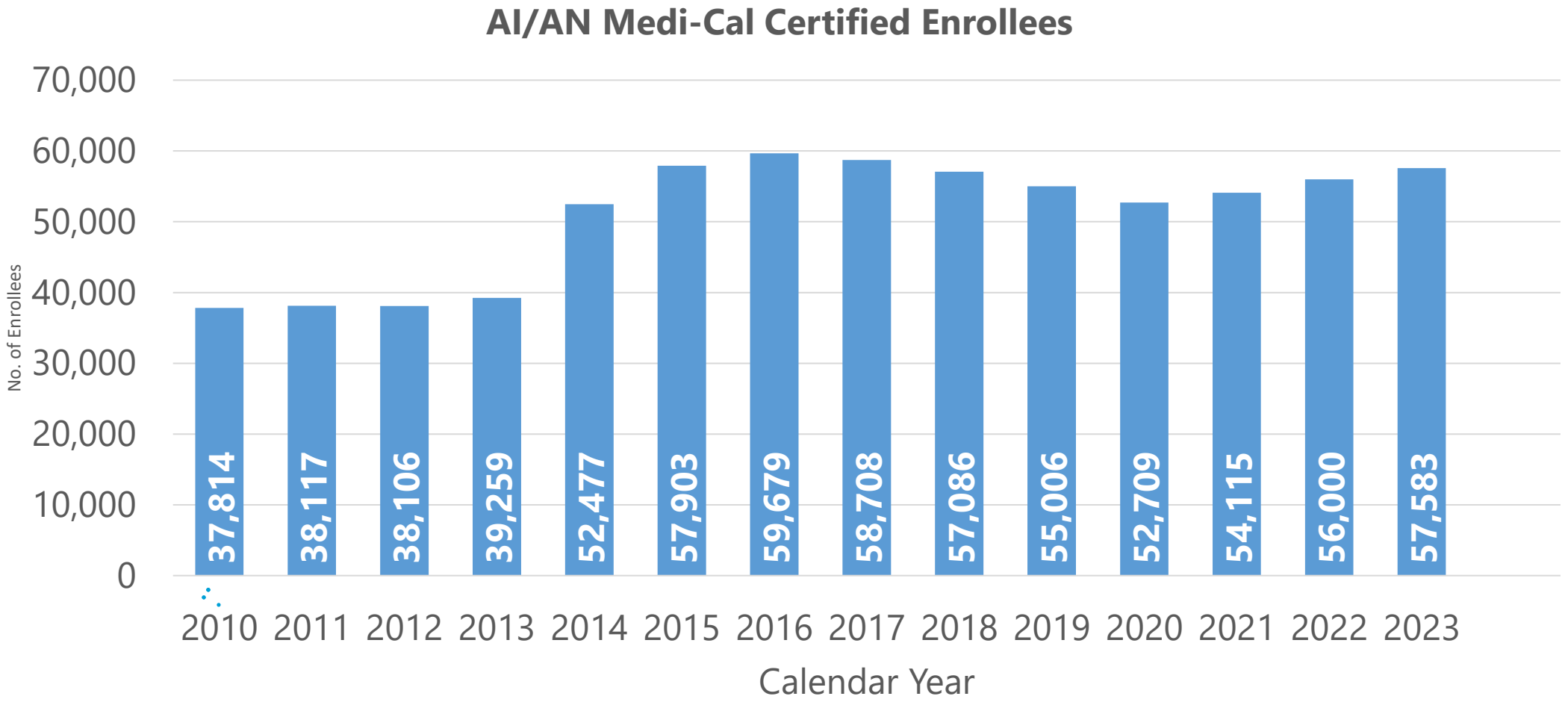
Medi-Cal Enrollees by Ethnicity/Race July 2023

- Medi-Cal enrollees with self identified ethnicity categorized as Alaskan Native/American Indian (AI/AN) was 55,302, which accounted for 0.4% of the Medi-Cal enrollees in July 2023



Source: https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf

AI/AN Medi-Cal Certified Enrollees, Calendar Year 2010 - 2023*



*Enrollment numbers reported here are larger than what is reported in Fast Facts due to longer reporting lag
Source: MIS/DSS Data Warehouse pulled on 3/7/2024

Indian Health Clinic Medi-Cal Providers

- There are a total of 143 American Indian primary care clinic sites in California serving American Indians including:
  - 71 Indian Health Service Memorandum of Agreement - PT 75
  - 55 Tribal Federally Qualified Health Centers – PT 96
  - 17 Urban Indian Federally Qualified Health Center Clinic sites - PT 35
- Additionally, there are 7 Youth Regional Treatment Centers (YRTCs) enrolled in Medi-Cal

Source: DHCS-OTA

Indian Health Clinic Corporation Fee for Service (FFS) Medi-Cal Payments for Date of Service (CY)2018 to 2023

	2018	2019	2020	2021	2022	2023
Urban Indian Federally Qualified Health Center Clinic sites – PT 35	$49,779,968	$50,170,012	$42,601,970	$49,381,765	$50,900,781	$61,704,663
Tribal Health Clinics (IHS-MOA) – PT 75	$100,292,216	$109,833,235	$84,558,507	$92,458,788	$63,412,411	$66,836,442
Tribal Federally Qualified Health Centers – PT 96				$20,650,772	$83,855,915	$92,703,233

*Memorandum of Agreement (MOA) & Federally Qualified Health Center (FQHC)

Between Calendar Year 2020 and 2023:

- Payments to Tribal Federally Qualified Health Centers increased by $72,052,461
- Payments to Tribal Indian Health Clinics (IHS-MOA) decreased by $25,622,347
- Payments to Urban Indian Health Clinics increased by $12,322,898

In 2020, DHCS established provider type 96 that designates some tribal health programs as Tribal Federally Qualified Health Centers.

Source: MIS/DSS data warehouse.

Number of Tribal Health Clinic (IHS-MOA) Visits per User in CY 2018 - 2023

- Between **CY 2018 and 2020,** Tribal Health Clinic (IHS-MOA) users decreased by 10,604
- Between **CY 2021 and 2023**, Tribal Health Clinic (IHS-MOA) users decreased by 29,061
- Between **CY 2018 and 2020**, Tribal Health Clinic (IHS-MOA) visits decreased by 55,224
- Between **CY 2021 and 2023**, Tribal Health Clinic (IHS-MOA) visits decreased by 102,327. This can be attributed to the increase in tribal health programs that converted to a Tribal FQHC and the transfer of user counts to the enrolled Tribal FQHC as illustrated on next slide.

	Tribal Health Clinic (IHS-MOA)		
	Users	Visits	# of Average Visits per Year
CY 2018	70,669	242,575	3.4
CY 2019	72,018	251,303	3.5
CY 2020	60,065	187,351	3.1
CY 2021	62,392	204,952	3.3
CY 2022	32,748	105,545	3.2
CY 2023	33,331	102,625	3.1

Note: Users were counted using aka_cin. User counts are not unduplicated. A user may be represented in more than one clinic type..
Source: MIS/DSS data warehouse.

Number of Tribal Federally Qualified Health Center Visits per User in CY 2021 – 2023*

- Between **CY 2018 and 2020**, Tribal Federally Qualified Health Center visits increased by 20,509
- Between **CY 2021 and 2023**, Tribal Federally Qualified Health Center visits increased by 98,580

	Tribal Federally Qualified Health Center		
	Users	**Visits**	**# of Average Visits per Year**
CY 2021	19,116	41,944	2.2
CY 2022	37,888	133,052	3.5
CY 2023	39,625	140,524	3.5

*These clinics were created in 2021
Note: Users were counted using aka_cin. User counts are not unduplicated. A user may be represented in more than one clinic type..

Source: MIS/DSS data warehouse.

Number of Urban Indian Health Clinic Visits per User in CY 2018 - 2023

- Between **CY 2018 and 2020,** Urban Indian Health Clinic users decreased by 6,160
- Between **CY 2021 and 2023**, Urban Indian Health Clinic users increased by 3,659
- Between **CY 2018 and 2020**, Urban Indian Health Clinic visits decreased by 26,072
- Between **CY 2021 and 2023**, Urban Indian Health Clinic visits increased by 36,568

	Urban Indian Health Clinics		
	Users	**Visits**	**# of Average Visits per Year**
CY 2018	48,835	214,244	4.4
CY 2019	49,457	215,616	4.4
CY 2020	42,675	188,172	4.4
CY 2021	46,141	207,489	4.5
CY 2022	47,823	212,385	4.4
CY 2023	49,799	244,057	4.9

Note: Users were counted using aka_cin. User counts are not unduplicated. A user may be represented in more than one clinic type..

Source: MIS/DSS data warehouse.

Top Ten Clinical Classifications by Payments for Medi-Cal Users of IHS/MOAs Services CY 2023 (1/2)

Indian Health Services Clinics (PT 75)				
Rank	CCS Description	Users	Claims Count	Claims Amount
1	Any dental condition including traumatic injury	40,429	67,956	$43,352,224
2	Nontraumatic dental conditions	40,287	67,783	$43,239,398
3	Caries, periodontitis, and other preventable dental conditions	38,072	63,832	$40,674,728
4	Medical examination/evaluation	17,972	35,067	$21,794,892
5	Disorders of teeth and gingiva	23,719	34,423	$22,389,056

Source: DHMIS/DSS data warehouse.
Data notes:

- Users were counted using AKA_CIN. User counts are not unduplicated. A user may be represented in more than one clinic type and CCS category.
- Visits were counted using a unique combination of provider number, date of service, and AKA_CIN.
- Dollars do not include year-end reconciliation performed by Audits & Investigations, DHCS for Medi-Medi Services

Top Ten Clinical Classifications by Payments for Medi-Cal Users of IHS/MOAs Services CY 2023 (2/2)

Indian Health Services Clinics (PT 75)				
Rank	CCS Description	Users	Claims Count	Claims Amount
6	Encounters for observation and examination for conditions ruled out (excludes infectious disease, neoplasm, mental disorders)	9,598	16,998	$11,048,525
7	Other specified status	1,699	2,107	$1,311,137
8	Implant, device or graft related encounter	1,233	2,023	$1,311,137
9	Disorders of jaw	370	1,668	$1,084,779
10	Encounter for prophylactic measures (excludes immunization)	945	1,142	$744,924

Source: DHMIS/DSS data warehouse.
Data notes:

- Users were counted using AKA_CIN. User counts are not unduplicated. A user may be represented in more than one clinic type and CCS category.
- Visits were counted using a unique combination of provider number, date of service, and AKA_CIN.
- Dollars do not include year-end reconciliation performed by Audits & Investigations, DHCS for Medi-Medi Services

Top Ten Clinical Classifications by Payments for Medi-Cal Users of Tribal FQHCs CY 2023 (1/2)

Tribal Federally Qualified Health Centers (PT 96)				
Rank	CCS Description	Users	Claims Count	Claims Amount
1	Any dental condition including traumatic injury	56,254	110,666	$70,600,140
2	Nontraumatic dental conditions	55,928	110,307	$70,367,349
3	Caries, periodontitis, and other preventable dental conditions	54,421	108,265	$69,043,433
4	Medical examination/evaluation	31,939	70,833	$44,157,469
5	Disorders of teeth and gingiva	25,478	40,737	$26,562,871

Source: MIS/DSS data warehouse.
Data notes:

- Users were counted using AKA_CIN. User counts are not unduplicated. A user may be represented in more than one clinic type and CCS category.
- Visits were counted using a unique combination of provider number, date of service, and AKA_CIN.
- Dollars do not include year-end reconciliation performed by Audits & Investigations, DHCS for Medi-Medi Services

Top Ten Clinical Classifications by Payments for Medi-Cal Users of Tribal FQHCs CY 2023 (2/2)

Tribal Federally Qualified Health Centers (PT 96)				
Rank	CCS Description	Users	Claims Count	Claims Amount
6	Encounters for observation and examination for conditions ruled out (excludes infectious disease, neoplasm, mental disorders)	4,127	5,234	$3,394,008
7	Depressive disorders	572	2,545	$1,189,548
8	Implant, device or graft related encounter	1,009	2,253	$1,464,466
9	Trauma- and stressor- related disorders	463	2,218	$1,047,339
10	Anxiety and fear-related disorders	594	2,176	$1,008,024

Source: MIS/DSS data warehouse.
Data notes:

- Users were counted using AKA_CIN. User counts are not unduplicated. A user may be represented in more than one clinic type and CCS category.
- Visits were counted using a unique combination of provider number, date of service, and AKA_CIN.
- Dollars do not include year-end reconciliation performed by Audits & Investigations, DHCS for Medi-Medi Services

Top Ten Clinical Classifications by Payments for Medi-Cal Users of Urban FQHCs CY 2023

Urban Federally Qualified Health Centers (PT 35)				
Rank	CCS Description	Users	Claims Count	Claims Amount
1	Any dental condition including traumatic injury	49,725	68,688	$19,742,060
2	Nontraumatic dental conditions	49,585	68,529	$19,706,349
3	Caries, periodontitis, and other preventable dental conditions	46,435	64,078	$18,451,524
4	Disorders of teeth and gingiva	35,958	51,009	$15,559,337
5	Medical examination/evaluation	28,435	35,468	$7,258,645
6	Diabetes mellitus, Type 2	3,453	7,159	$1,495,100
7	Essential hypertension	3,480	7,007	$1,446,359
8	Depressive disorders	2,072	6,472	$1,387,224
9	Contraceptive and procreative management	3806	5,053	$1,398,508
10	Musculoskeletal pain, not low back pain	3309	4,285	$910,029

Source: MIS/DSS data warehouse.

Data notes:

- Users were counted using AKA_CIN. User counts are not unduplicated. A user may be represented in more than one clinic type and CCS category.
- Visits were counted using a unique combination of provider number, date of service, and AKA_CIN.
- Dollars do not include year-end reconciliation performed by Audits & Investigations, DHCS

Number of Visits per Day in Tribal Health Programs, 2023

Tribal Health Clinics (IHS-MOA) – PT 75

- The majority of members (66%) have one visit per day
- 34% of members have 3 visits a day
- Preliminary data reveals that there may be some providers submitting claims for 4 or more visits per day. DHCS is researching these claims further to see why this may have occurred and may pursue recoupment of funds for visits in excess of the existing visit per day policy.

Tribal Federally Qualified Health Centers – PT 96

- The majority of members (65%) have one visit per day
- 32% of members have 3 visits a day
- Preliminary data reveals that there may be some providers submitting claims for 4 or more visits per day. DHCS is researching these claims further to see why this may have occurred and may pursue recoupment of funds for visits in excess of the existing visit per day policy.

Currently, DHCS is examining the number of visits per day by service type (medical, mental health, ambulatory/dental)

- Results are not yet available

Source: MIS/DSS data warehouse.
Data notes:

- A contact is defined as at least one visit per provider type per AKA_CIN per Date of Service
- Visits were determined by counting distinct Record_IDs.
- A user may be represented in more than one clinic type and CCS category.

IHP Update

Future Funding Release

- Available funds for cycle 3 total $20,926,000
- Cycle 3 award amounts released in March 2024
- OTA will work with existing awardees to amend grants as necessary for new award amounts and will be releasing an additional RFA for unfunded programs on March 15th
- Initial IHP funding is multi-year and available until June 30, 2025
- Funds available for FY 2024-2025 onward are only available for one state fiscal year
- IHP was awarded $22.6 million ongoing funding each year beginning in FY 2024-2025, subject to appropriation by the legislature
- OTA is working with the American Indian Health Policy Panel (AIHPP) for funding recommendations and use of ongoing funds

American Indian Health Policy Panel (AIHPP) Update

- OTA currently does not have a quorum due to lack of membership.
- We anticipate the submission of needed appointees this month from California Consortium for Urban Indian Health (CCUIH).
- The AIHPP will be supported by the Indian Health Program (IHP) staff including orientation of new members, organization of virtual and in-person meetings, providing regular updates, and briefing documents such as budget summaries calling out areas of interest for Tribes and Indian health programs.

Quarterly Submission of FMAP Data

- OTA needs data for all registered American Indians (AI) seen by each clinic corporation
- This quarterly data submission process allows DHCS to determine which AI patients are Medi-Cal members, thereby allowing the department to claim the 100% FMAP reimbursement for any services provided to them
- More clinics are now reporting their data, consequently, there has been an increase in the amount of FMAP coming to California
- OTA sends out multiple reminders to help notify clinics when it is time to submit the data
- IHS reports for some clinics, however each non-RPMS program would need to pull the data from their systems and send it to DHCS
- Please contact TribalAffairs@dhcs.ca.gov if you need technical assistance or have any questions

How to Contact DHCS' OTA

- Contact Information:

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

- Requests for Assistance:

  TribalAffairs@dhcs.ca.gov

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

THANK YOU!

Questions?

DHCS

Updates on Population Health Management

Palav Babaria

Deputy Director & Chief Quality and Medical Officer

Hope Neighbor

Division Chief

DHCS

PHM Service Tribes & Tribal Partners Update

Objectives

- Sharing the goals & functions of DHCS' Population Health Management (PHM) Service Project
- Understanding Tribal Perspectives on the project

PHM service vision

Vision

The PHM Service will improve the health of Medi-Cal members and reduce disparities by providing a data-driven solution that supports whole-person care and population health functions

The Service will integrate information from diverse sources, enabling multi-party data access and sharing to inform policy and to provide members a resource that enhances their experience with the Medi-Cal program

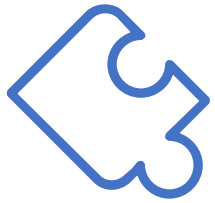
PHM Service goals and objectives

Member Experience

1. Streamline access
2. Navigate programming
3. Reduce service gaps
4. Enable self-service updates

Whole Person Care

5. View member's risks & unmet needs
6. Utilize Risk Stratification



Population Level Insights

7. Facilitate Data Aggregation & Integration
8. Act on population-level health trends & disparities

Informed Policymaking

9. Strengthen Medi-Cal Oversight & Monitoring
10. Leverage analytics & insights

Guidelines for tribal engagement

Guiding Principles

Recognize Tribes in California administer their own health programs

Adhere to Tribal data sovereignty

Recognize that each Tribe is unique

Uphold confidentiality of Tribal consultation materials

Ensure frequent requests for input to capture valuable perspectives

DHCS is committed to following these guiding principles throughout the PHM Service engagement to strengthen and sustain effective relationships with Tribes and Tribal Partners

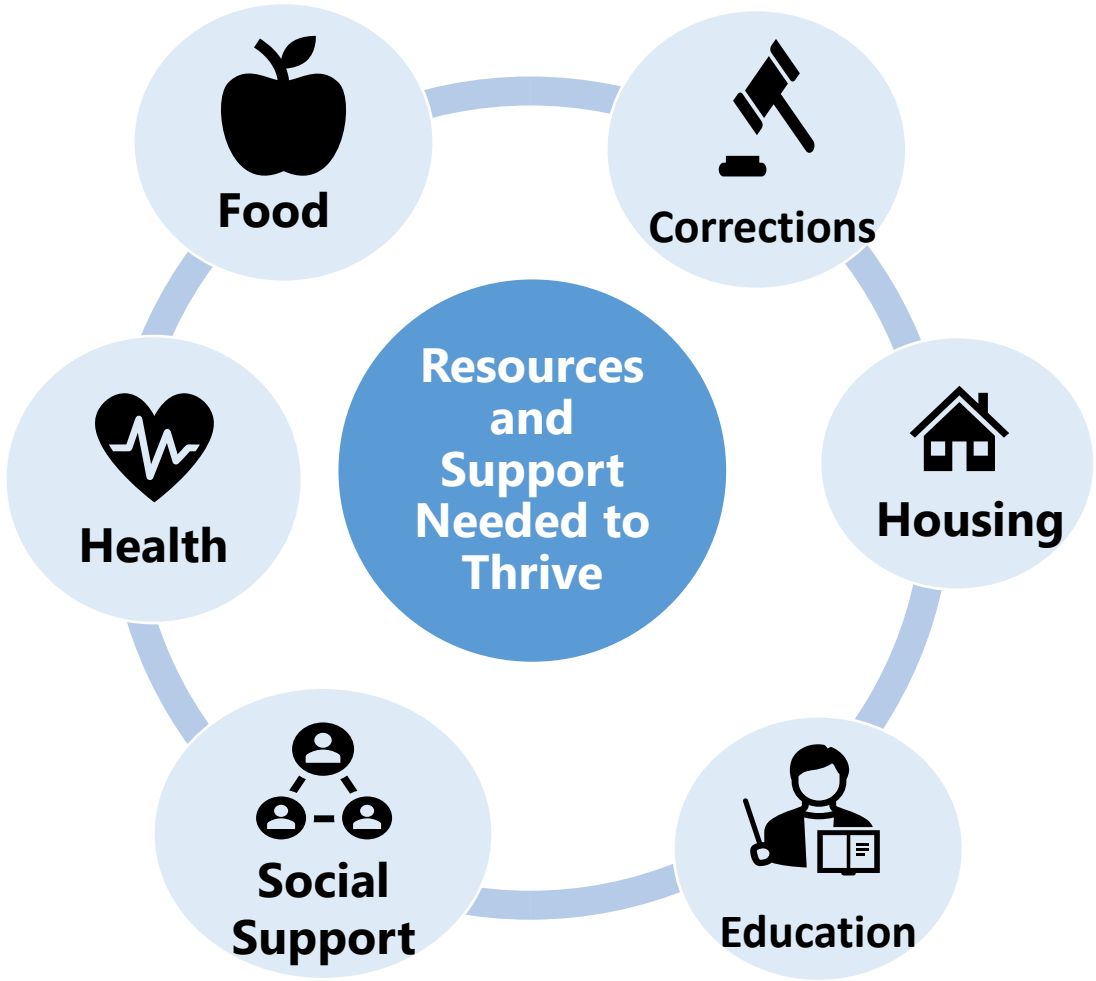
A member focused service

The PHM Service will provide members a resource that enhances their experience with the Medi-Cal program.

- Support navigating Medi-Cal Program
- Reduce Gaps in services
- Streamline access to health education and benefits information
- Easily update demographic and contact information

Supporting whole person care

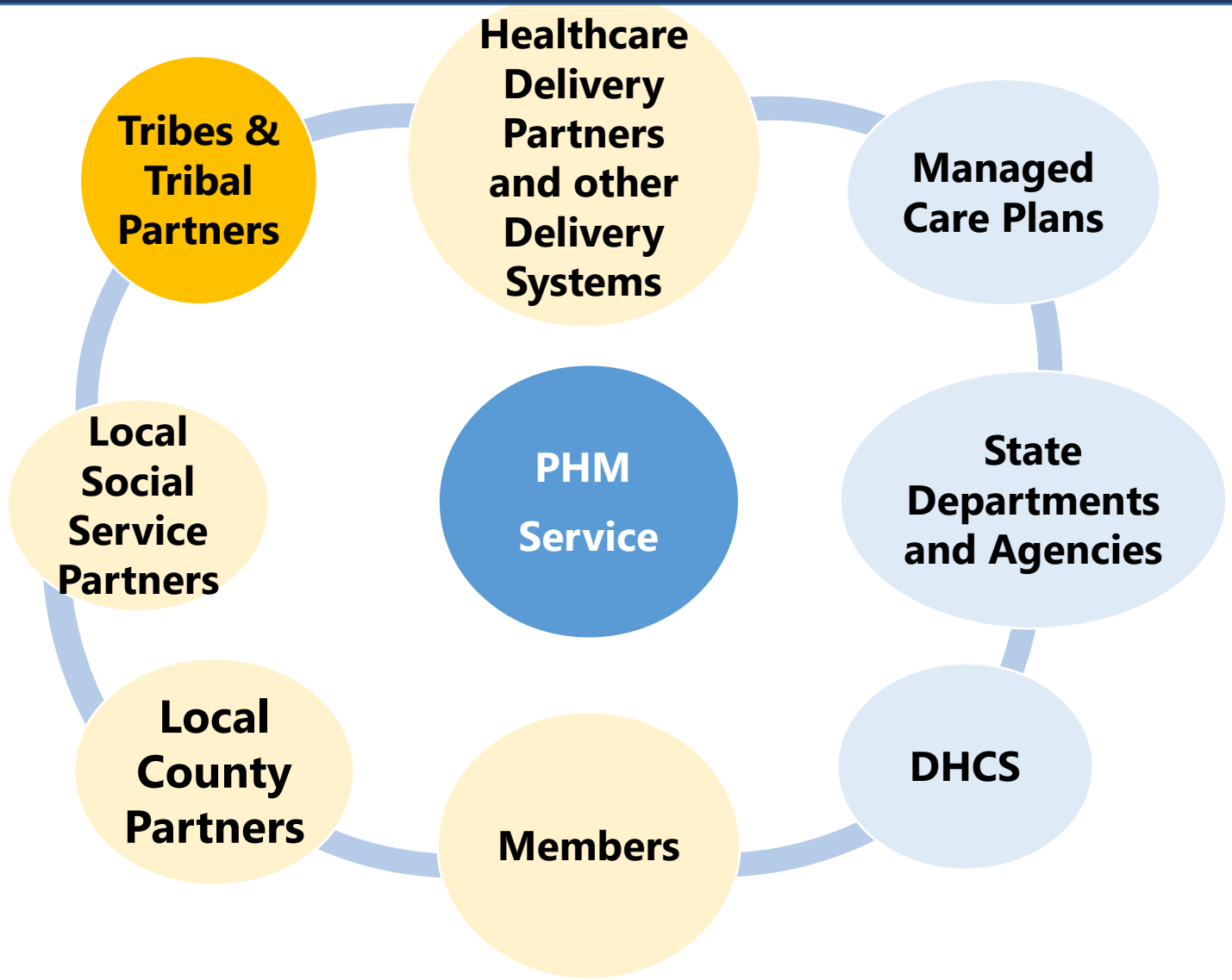
Whole Person Care is the combination of physical health, behavioral health, and social services to improve member wellbeing



The PHM Service will support Whole Person Care by creating an easy-to-access platform where a member can navigate social, behavioral, and physical health services.

Supporting multiple stakeholder's needs

The PHM Service will enable multi-party data access and sharing



Data driven solution from diverse sources

The Service will integrate health and social information from many sources to support people and communities.

Example Sources

Housing Agencies

Department of Social Services

Medi-Cal Health Plans

California Department of Public Health

PHM Service

Outputs

1. Data to support care of people
2. Data to improve policy and programs for communities

As well as Department of Corrections and Rehabilitation, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), etc.

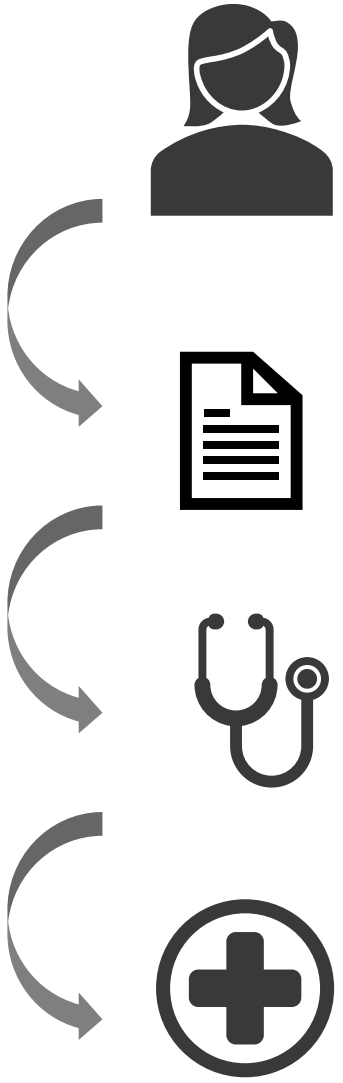
PHM service: Tina’s story

Tina, an American Indian/Alaska Native, is a new member of Medi-Cal who has recently relocated.

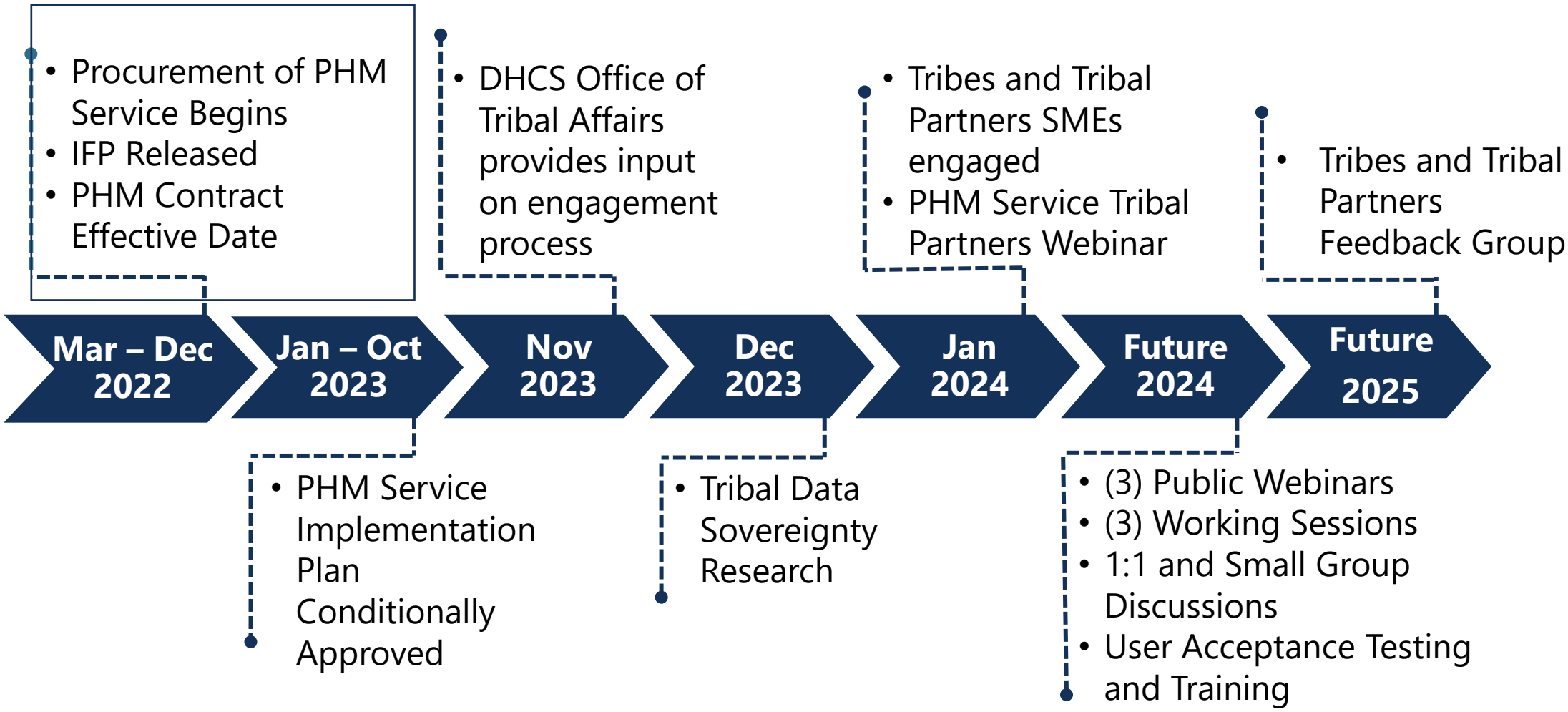
She wants to establish care in the new city

Tina can use the PHM Service to update her contact and demographic information, ensuring she receives relevant state services and identifies providers to meet her needs

To ensure Tina has continuity of healthcare coverage, supporting whole person care



PHM service timeline



Design considerations

Tribal Healthcare in California	▸ Care is primarily provided by tribal health programs, allowing tribes to assume control of healthcare services from the federal government, ensuring community values are represented in care ▸ We acknowledge that California is home to the largest populations of American Indians of both federally and non-federally recognized tribes, and members of tribes from other states.
Tribal Data Sovereignty	▸ The data passed to the government and returned to tribes is often inaccurate or may have data suppression issues ▸ Racial misclassification is a significant issue, with 40% of native descendants classified as white in their death certificates
Roadblocks to Population Health Service	▸ Data Stewardship – Having safeguards around what the data collected will be used for an who can access it is vital to success

These lessons mark the start of our collaboration with Tribes & Tribal Partners. Recognizing the diverse experiences of American Indians and Alaska Natives, we're committed to continuous learning and growth.

Questions?

If time runs short, kindly enter any remaining questions via this link, and we'll ensure they're addressed promptly

https://www.surveymonkey.com/r/9SNSG6P

Tribes & Tribal Partners Pre-Engagement Preparation

1	DHCS Office of Tribal Affairs Input	**DHCS Office of Tribal Affairs has been highly involved in guiding engagement with Tribes & Tribal Partners, input on materials, and informing the service on DHCS work with Tribes & Tribal Partners**
2	DHCS Tribes & Tribal Partners Work Group	**DHCS has selected individuals from throughout the organization to discuss the service and impact for Tribes & Tribal Partners from their departments for regular engagement.**
3	Subject Matter Expertise Input	**As recommended by the DHCS Office of Tribal Affairs, DHCS has scheduled meetings with subject matter experts in the fields of Population Health and Data Sovereignty as it relates to Tribes & Tribal Partners**
4	Tribes & Tribal Partners Training	**Ongoing research, consultation, and training has been done to prepare to properly and responsibly engage with Tribes & Tribal Partners.**

Update on Medi-Cal Eligibility Redeterminations

Yingjia Huang

Assistant Deputy Director

DHCS

Medi-Cal Continuous Coverage Unwinding

Background

March 2020 – March 2023
Continuous Coverage Requirement

April 1, 2023
Renewals resume for June 2023 renewal month

Continuous Coverage Unwinding Period

2023

Jun	Jul	Aug	Sept
Oct	Nov	Dec	

2024	Jan

Feb	Mar	Apr	May

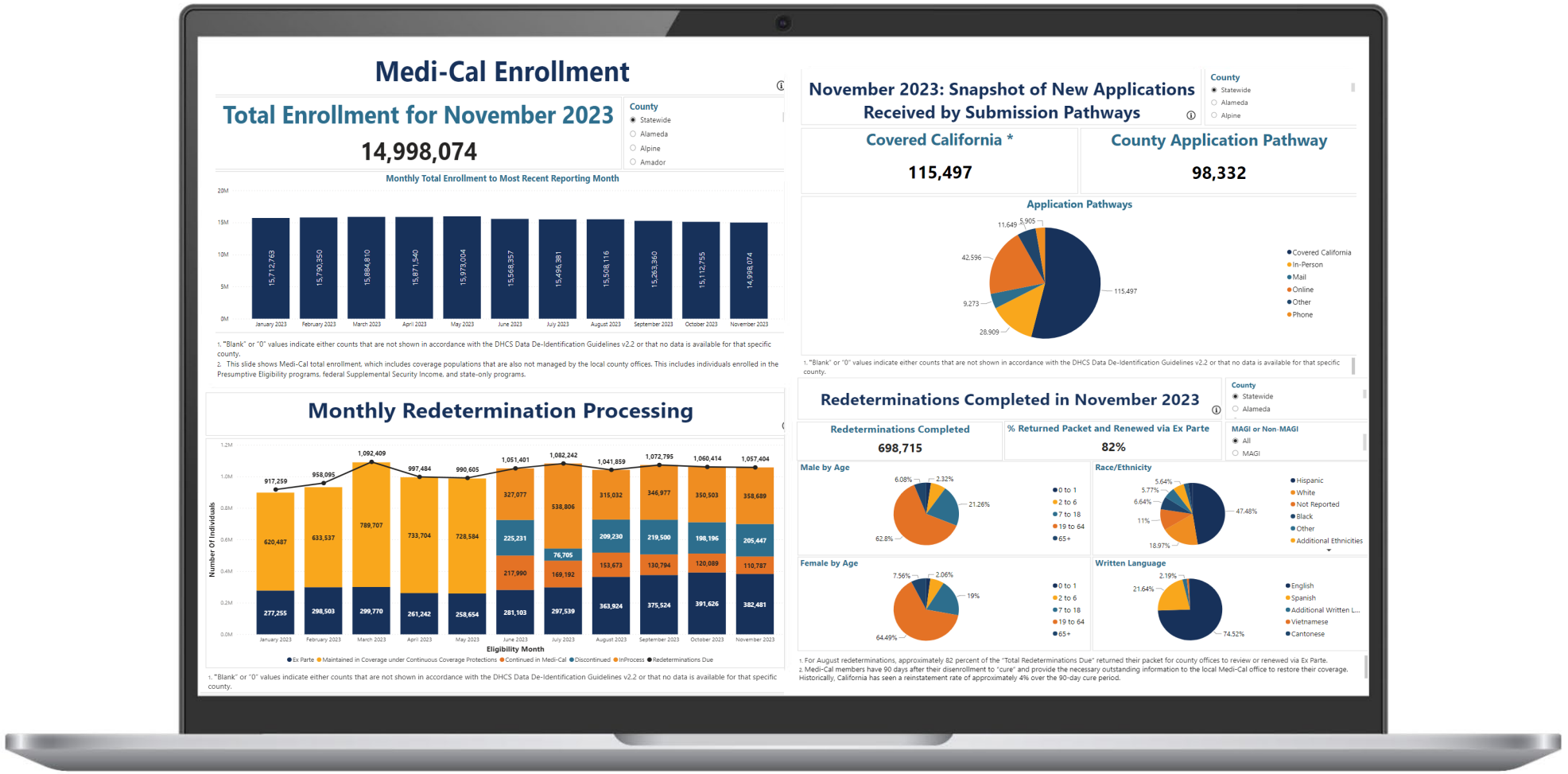
Continuous Coverage Unwinding Updates

- Federal guidance received provides an extension of continuous coverage unwinding waivers through December 31, 2024.
- DHCS posted 90-day data refreshes for June, July, and August 2023 on our DHCS unwinding webpage.
- DHCS, in partnership with the California Health Care Foundation, is conducting a survey with individuals procedurally disenrolled from Medi-Cal to gather insights on renewal barriers and reasons for disenrollments. Month 1 Survey results are now posted on the DHCS unwinding webpage.

Redetermination Outcomes

	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Enrollment							
Monthly Enrollment	15.6 million	15.5 million	15.5 million	15.3 million	15.1 million	14.9 million	14.9 million
Number of New Applications Received	143,069	142,052	171,798	160,682	181,721	213,829	204,313
Newly Enrolled in Medi-Cal for the First Time	53,836	63,443	72,569	62,576	57,772	68,453	77,505

Medi-Cal Continuous Coverage Unwinding Dashboard



Continued Redetermination Outcomes

	June 2023	uly 2023	ug 2023	ept 2023	ct 2023	ov 2023	Dec 2023
Redeterminations							
Number redeterminations due	1.05 million	1.08 million	1.04 million	1.07 million	1.06 million	1.05 million	25 million
Percentage returned renewal packets for review or complete through ex parte	81%	80%	82%	81%	83%	82%	
Number of disenrollment as a result of renewals	225,231	76,705[1]	209,320	219,500	198,196	205,447	350
Percentage disenrolled (of total redeterminations due)	21%	7%	20%	20%	19%	19%	7%
Ex parte percentage	30%	27%	35%	35%	37%	36%	1%

Tailored Audience Resources

- Tailored resources for specific audiences and outreach partners, including American Indian & Alaska Native Groups

Summary Redetermination Statistics for AI/AN Medi-Cal beneficiaries, November 2023

For those American Indian/Alaska Native Medi-Cal beneficiaries who were due for redetermination in November 2023, 29% were discontinued from coverage compared to 19% for all race/ethnicities combined.

Regions	Number Renewals Completed	Number Discontinued	% of Completed that were Discontinued
Bay Area	875	235	27%
Central Coast	230	55	24%
Central Valley	1,089	237	22%
Far North	452	137	30%
Los Angeles	973	317	33%
North Coast	1,314	412	31%
Sacramento Valley	923	195	21%
Sierra Range/Foothills	610	210	34%
Southern California	1,454	496	34%
Statewide	**7,920**	**2,294**	**29%**

Questions?

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Assistant Deputy Director, Health Care Benefits and Eligibility
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DHCS Director's Update

Michelle Baass

DHCS Director

DHCS

Governor's Proposed Budget

- The Governor's proposed fiscal year 2024-25 budget includes $253.4 billion total funds for all health and human services programs.
- The Governor's proposed budget includes **$161.1 billion total funds for DHCS** and 4,649.5 positions to support DHCS programs and services. Of this amount, $1.3 billion funds state operations (DHCS operations), while $159.8 billion supports local assistance (funding for program costs, partners, and administration).
- DHCS budget proposals continue to build on the Administration's previous investments and enables DHCS to continue to transform Medi-Cal and behavioral health services.

DHCS Budget Proposals

- Full scope coverage to Californians ages 26-49
- Asset Test Elimination
- Managed Care Organization (MCO) Tax
- Targeted Provider Rate Increases
- Children and Youth Behavioral Health Initiative – Wellness Coach Benefit (CYBHI)
- Assisted Living Waiver (ALW) slot increase
- Home and Community Based Alternatives (HCBA) Waiver slot increase
- Respiratory Syncytial Virus vaccines and injectable drugs

DHCS Budget Proposals (Continued)

Considering the state's overall General Fund condition, several budget solutions were included in the DHCS budget.

- New MCO Tax revenue
- Increased use of the Medi-Cal Provider Payment Reserve Fund
- Delay Round 6 of the Behavioral Health Continuum Infrastructure Program
- Delay Behavioral Health Bridge Housing Program

Introduction to Sarah Brooks, Chief Deputy Director

DHCS

BREAK

Return at 1:00 PM

Office of Strategic Partnerships Update

Autumn Boylan

Deputy Director

DHCS

Update on Justice-Involved Waiver

National Context for California's 1115 Demonstration Request

Until now, due to a provision of federal Medicaid law known as the "inmate exclusion," inpatient hospital care was the only service that could be covered by Medicaid for individuals considered an "inmate of a public institution."

- In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) which requires HHS to provide guidance to states on how to seek 1115 demonstration authority to waive the inmate exclusion in order to improve care transitions to the community for incarcerated individuals.
- Prior to HHS' release of guidance, California, along with 14 other states, submitted 1115 demonstration requests to provide pre-release services to justice-involved populations.
- Through its CalAIM 1115 Demonstration, California received federal approval to provide a targeted set of Medi-Cal services to youth and adults in state prisons, county jails and youth correctional facilities for up to 90 days prior to release.

California was the first state in the nation to get federal approval to provide pre-release services.

Rationale for Providing Pre-Release Services

California has received approval to authorize federal Medicaid matching funds for select Medicaid services for eligible justice-involved individuals in the 90-day period prior to release from incarceration in prisons, county jails and youth correctional facilities.

The intent of the demonstration is to **build a bridge to community-based care for justice-involved Medi-Cal members**, offering them services to stabilize their condition(s) and establishing a re-entry plan for their community-based care prior to release.

For example: Connecting American Indians to Indian health providers, offering them services up to 90 days prior to their release to stabilize their health conditions and establish a plan for their community-based care (collectively referred to as “pre-release services”).

This demonstration is **part of California’s comprehensive initiative to improve physical and behavioral health care for the justice-involved population** and builds on the State’s substantial experience and investments on ensuring continuity of Medi-Cal coverage and access to care for JI populations.

Rationale for Providing Pre-Release Services Continued

California has received approval to authorize federal Medicaid matching funds for select Medicaid services for eligible justice-involved individuals in the 90-day period prior to release from incarceration in prisons, county jails and youth correctional facilities.

- With its 1115 demonstration, California will directly test and evaluate its expectation that **providing targeted pre-release services to Medi-Cal-eligible individuals will avert the unnecessary use** of inpatient hospitals, psychiatric hospitals, nursing homes, emergency departments and other forms of costly and inefficient care that otherwise would be paid for by Medi-Cal.

- Through a federal Medicaid 1115 demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) will partner with state agencies, counties, tribal health providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities.

- The initiative will help California address the unique and considerable health care needs of tribal justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

Justice-Involved Reentry Initiative Goals

The demonstration approval represents a first-of-its-kind section initiative, focused on improving care transitions for incarcerated individuals.

With the implementation of this demonstration, DHCS hopes to achieve the following:

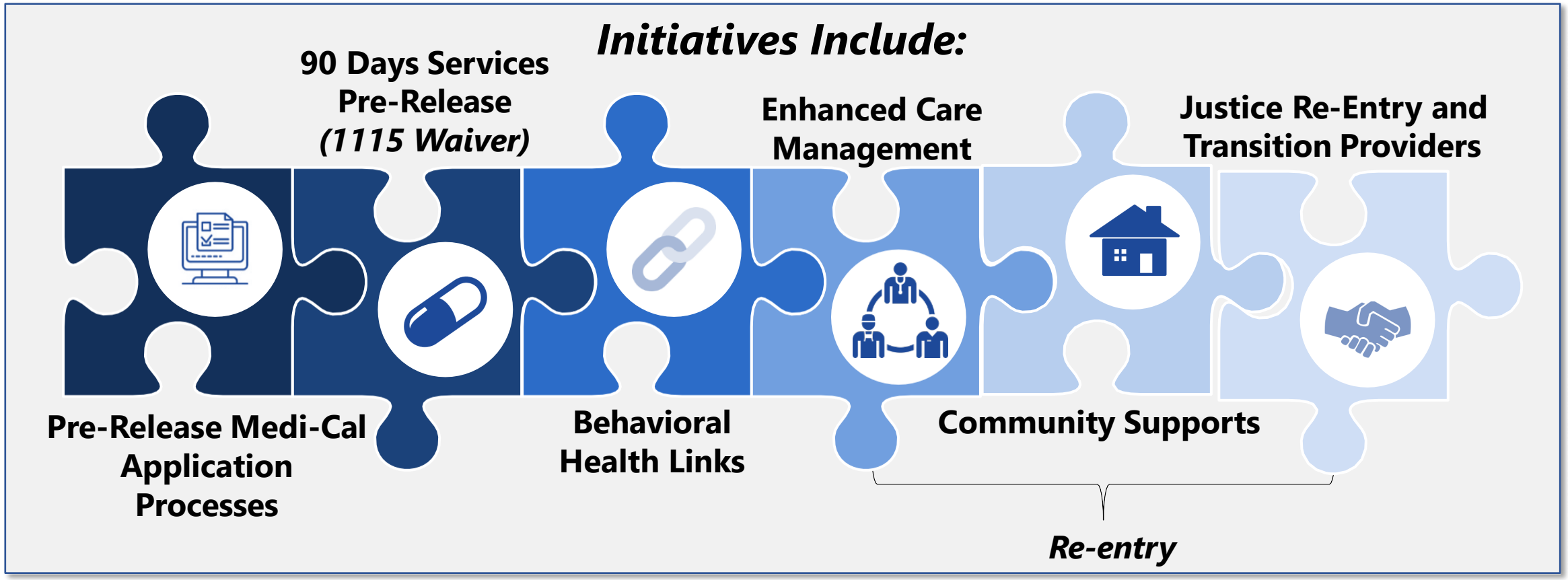
Advance health equity: The issue of poor health, health outcomes, and death for incarcerated people is a health equity issue because Californians of color, including American Indians, are disproportionately incarcerated—including for mental health and SUD-related offenses. These individuals have considerable health care needs but are often without care and medications upon release.

Improve health outcomes: By implementing this initiative, California aims to provide a targeted set of services in the pre-release period to establish a supportive community reentry process, help individuals connect to physical and behavioral health services upon release, and ultimately improve physical and behavioral health outcomes. This includes establishing a supportive community reentry process that helps connect JI individuals to Indian health programs and services.

Serve as a model for the rest of the nation: California is the first state to receive approval for this initiative. We hope our model will serve as a blueprint for the dozen additional states with pending justice-involved 1115 waivers.

The Justice-Involved Reentry Initiative is One Component of the CalAIM Justice-Involved Initiative

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their re-entry.



California Actively Works With Implementation Partners

Over the past 24 months, DHCS has actively met with its Justice-Involved Advisory Group and one-on-one with implementation partners, to inform the 1115 Demonstration and provide input into development of operational policies.

Justice-Involved Advisory Group members include:

- CDCR/California Correctional Health Care Services (CCHCS) which delivers health care services in State prisons
- County Jails, including correctional officers and correctional health staff
- Chief Probation Officers of California (CPOC)/County Youth Correctional Facilities
- Board of State and Community Corrections (BSCC)
- County Welfare Directors Association (CWDA)
- County Social Service Departments (SSDs)
- County Behavioral Health Department (including working group of county behavioral health directors)
- Council on Criminal Justice and Behavioral Health (CCJBH)
- Office of Youth and Community Restoration (OYCR)
- Reentry Providers (including TCN, STOP, Healthright360, WestCare, and Amity Foundation)
- Medicaid managed care plans
- Individuals with lived experience
- Community based organization

Listen to this Medicaid Leadership Exchange podcast episode to hear more about the importance of collaboration with implementing partners

Eligibility Criteria, Covered Services and Capacity Funding

Eligibility Criteria for Pre-Release Services

Medi-Cal-eligible individuals who meet the pre-release access screening criteria may receive targeted Medi-Cal pre-release services in the 90-day period prior to release from correctional facilities.

Incarcerated individuals must meet the following criteria to receive in-reach services:

- ✓ Be part of a **Medicaid or CHIP Eligibility Group**, and
- ✓ Meet **one** of the following health care need criteria:
  - Mental Illness
  - Substance Use Disorder (SUD)
  - Chronic Condition/Significant Clinical Condition
  - Intellectual or Developmental Disability (I/DD)
  - Traumatic Brain Injury
  - HIV/AIDS
  - Pregnant or Postpartum

Note: *All Medi-Cal/CHIP eligible youth that are:*

- *Incarcerated at a youth correctional facility;*
- *Under 21 and incarcerated at an adult jail; or*
- *Former foster youth under 26 and incarcerated at an adult jail*

Are eligible to receive pre-release services and do not need to demonstrate a health care need.

Medi-Cal Eligible: Adults, Parents, Youth under 19, Pregnant or postpartum, Aged, Blind, Disabled, Current children and youth in foster care, Former foster care youth up to age 26

CHIP Eligible: Youth under 19, Pregnant or postpartum

Note:
Eligibility criteria for pre-release services are the same as eligibility criteria for the Justice Involved Enhanced Care Management (ECM) Population of Focus, so all individuals who are eligible to receive pre-release services is also eligible and is presumptively authorized to receive post-release ECM.

Covered Pre-Release Services

- Reentry case management services;
- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medication assisted treatment/medications for addiction treatment (MAT), for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Services provided by community health workers with lived experience.

In addition to the pre-release services specified above, qualifying individuals will also receive **covered outpatient prescribed medications and over-the-counter drugs** (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and **durable medical equipment (DME)** upon release, consistent with approved state plan coverage authority and policy.

Care Management in the Pre-Release Period

To maximize continuity of care management and access to services in the pre- and post-release period, care management may be provided by an in-reach or embedded care manager. If the pre- and post-release care managers are different, they must participate in a warm handoff.

Care Management Models:

In-Reach Model: Some correctional facilities will rely on community-based care management providers to deliver pre-release care management services to individuals in correctional facilities (in person or via telehealth). This community-based provider will become the ECM provider after release and enrollment into managed care.

Embedded Model: Some correctional facilities will use care managers that they directly employ or contract with to deliver pre-release care management services to individuals in correctional facilities (in person). Embedded care managers must facilitate a warm handoff to the post-release ECM Provider.

Mixed Model: Some correctional facilities will assign a mix of in-reach and embedded pre-release care managers to provide flexibility in the face of staff/network shortages and ensure assignment of a pre-release care manager who is best able to meet the needs of an incarcerated individual.

Eligibility criteria for the JI ECM POF are the same as pre-release service eligibility criteria, so everyone who is eligible to receive pre-release services is also eligible to receive post-release ECM.

Care Management in the Pre-Release Period

If the pre- and post-release care managers are different individuals, the pre- and post-release care managers must conduct a warm handoff meeting with the individual 14+ days prior to release.

Warm Handoff Requirements:

Minimum requirements for the warm handoff between the pre-release care manager and post-release ECM provider include:

- **Share the reentry care plan** with the post-release ECM provider and MCP.
- **Schedule and conduct a pre-release care management meeting** (in-person or via telehealth) with the individual present and pre- and post-release care managers (if different) to:
  - Establish a trusted relationship.
  - Develop and review care plan with individual.
  - Identify outstanding service needs.
- **Obtain necessary consents** for information sharing.
- **Review the reentry care plan** and reentry services with the member.
- **Identify any outstanding service needs** or other supports required for successful community reentry (e.g., transportation or housing) with input from the member and the post-release ECM provider.
- **Modify the reentry care plan** based on any new knowledge.
- **Ensure the member has received their Benefits Identification Card (BIC).**

Behavioral Health (BH) Links

To promote continuity of treatment for individuals who receive behavioral health services while incarcerated, DHCS will require correctional facilities to facilitate referrals/links to post-release behavioral health providers and share information with the individual's health plan.

BH Links Requirements:

To operationalize behavioral health links for individuals who will receive services through SMHS/MHPs, DMC, and DMC-ODS, DHCS has laid out the following minimum requirements for CFs, county behavioral health agencies, and pre-release care management providers/post-release ECM providers:

Correctional Facilities (CFs)	Pre-Release Care Manager	County Behavioral Health Agency
• Leverage existing processes to screen and identify individuals who may qualify for a BH link. • County CFs will be expected to screen for this need at intake; CDCR will be expected to leverage existing treatment plans to screen for need.	• Review all available records related to the individual's behavioral health care. • If a screening was not already performed, complete the standardized behavioral health screening to identify behavioral health needs. • Determine if a BH link is needed. • Develop a Reentry Care Plan.	• Enter into agreements or amend current agreements as needed, by mutual consent, with the CFs to provide or support in-reach provision of pre-release services related to reentry behavioral health treatment. • Within 14 days prior to release (if known) from a county CF and within 30 - 60 days prior to release for CDCR, and in coordination with the pre- and/or post-release care manager, ensure processes are in place for a professional-to-professional clinical handoff between the correctional behavioral health provider, a county behavioral health agency provider, and the member (as appropriate).

Enhanced Care Management (ECM)

ECM is a Medi-Cal benefit to support comprehensive care management for Members with complex needs. Individuals who are eligible for pre-release services will be eligible to receive ECM under the Individuals Transitioning from Incarceration Population of Focus.

- ECM is interdisciplinary, high-touch, person-centered, and provided primarily through in-person interactions with Members where they live, seek care, or prefer to access services.
- DHCS' vision for ECM is to coordinate all care for eligible Members, including across the physical, behavioral, and dental health delivery systems.
- Every MCP Member enrolled in ECM will have a dedicated care manager.
  - *Best practice for the JI POF: DHCS encourages leveraging Lead Care Managers and other staff (e.g., CHWs) with lived experience.*
- ECM is available to MCP Members who meet ECM "Population of Focus" definitions; Members may opt out at any time.

Seven ECM Core Services

- **Outreach and Engagement**
- **Member and Family Supports**
- **Comprehensive Assessment and Care Management Plan**
- **Health Promotion**
- **Enhanced Coordination of Care**
- **Comprehensive Transitional Care**
- **Coordination of and Referral to Community and Social Support Services**

ECM for the JI POF went live for all counties on January 1, 2024. MCPs submitted a Model of Care specific to the JI POF in advance of go-live; DHCS is currently working with MCPs to improve and strengthen JI Models of Care.

JI ECM Provider Requirements

To promote continuity of care between pre- and post-release period and quality of care management, DHCS requires that MCPs ensure that all providers with which they contract to provide ECM for the JI POF meet minimum expectations.

Meet ECM Requirements

All contracted JI ECM providers must meet the standard requirements to be considered an ECM provider.

Participate in Pre-Release Care Management Services and Warm Handoffs

If CFs in the county use in-reach care managers: JI ECM providers must offer pre-release care management services as in-reach care management providers billed under fee-for-service. The post-release ECM Lead Care Manager is the same person as the in-reach care manager, to the greatest extent possible.

If CFs in the county use embedded care managers: The post-release ECM Lead Care Manager must conduct a warm handoff with the pre-release embedded care manager.

Bill FFS for All Pre-Release Care Management Services and Warm Handoffs

JI ECM providers must ensure that claims for any pre-release care management services and/or warm handoffs are submitted under FFS by **either:**

1. Enrolling in FFS through PAVE
2. Contracting with correctional facility to provide pre-release services as an embedded care manager and billing under the correctional facility's NPI

Next Steps for Correctional Facilities

Looking Ahead

DHCS will continue to offer TA to implementing partners over the coming months to support JI ECM Provider Network development and preparedness for pre-release service go-live.

Upcoming Milestones

- Correctional facilities will begin **going live with pre-release services** on **October 1, 2024**. All correctional facilities must be approved to go live based upon a **Readiness Assessment** submitted to DHCS.
- County behavioral health agencies will go live with **behavioral health links** on October 1, 2024. CBHAs must also submit a **Readiness Assessment** to DHCS.
- DHCS will continue working with MCPs to build and strengthen their **JI ECM provider networks**.
- DHCS will host **All-Comer Webinars** focused on the Justice Involved Initiative throughout 2024.

CalAIM Justice-Involved Initiative Go-Live Timeline

January 1, 2024
ECM went live for the JI POF

October 1, 2024
Correctional facilities begin to go-live with pre-release services, based on readiness assessment. **MCPs must be prepared to provide ECM services to individuals who receive pre-release services.**

September 30, 2026
Final date for correctional facilities to go-live with pre-release services

MCPs to coordinate with correctional facilities to support reentry for members as they transition from incarceration into the community and managed care.

Correctional Facility Readiness Assessment Requirement

As a condition of the Section 1115 demonstration, all prisons, jails, and youth correctional facilities (CFs) are required to demonstrate readiness to participate in the Justice-involved Initiative and receive DHCS approval prior to going live with pre-release services.

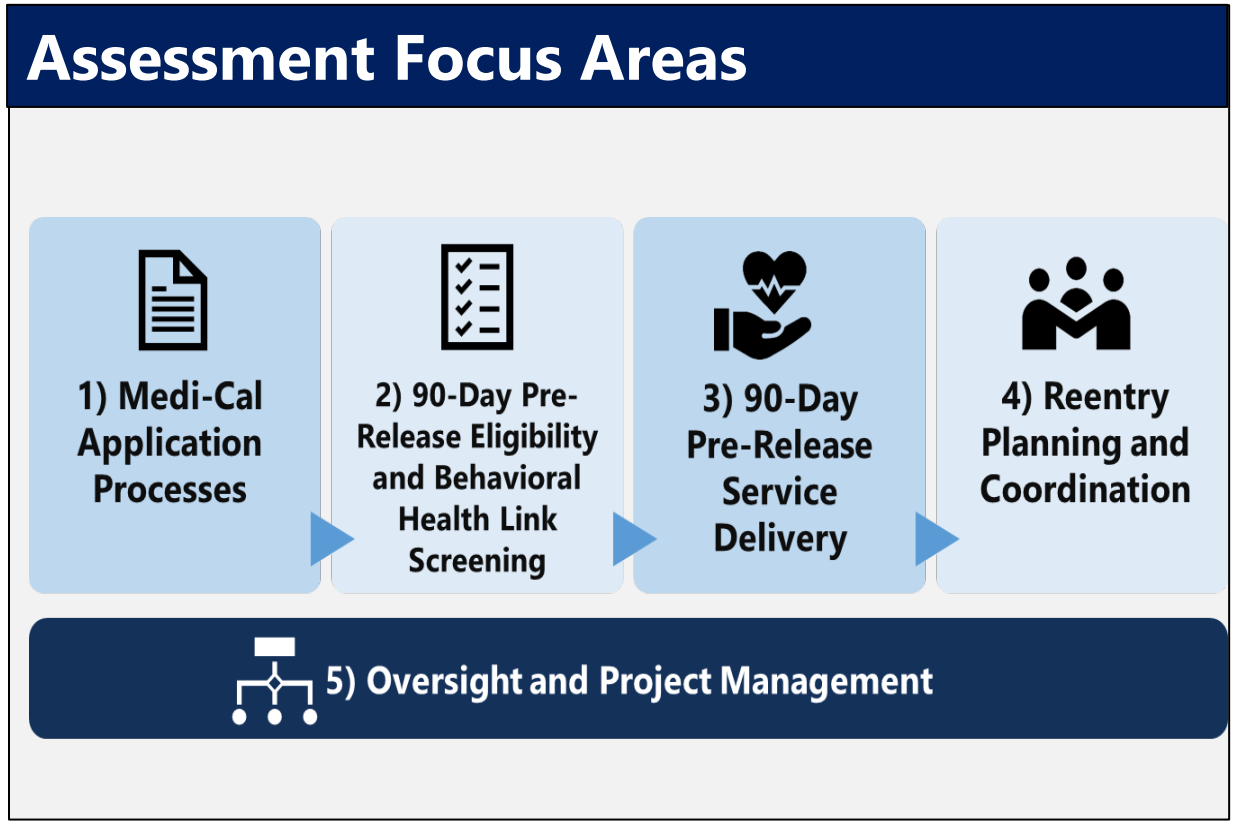
Readiness Assessment Template

DHCS will require each CF to complete and submit a Readiness Assessment Template ("Template") at least six months prior to its go-live date to demonstrate its readiness to provide pre-release services and Behavioral Health Links. The Template includes the following components:

1. Readiness Checklist and Supporting Information
2. Readiness Assessment Attestation Form
3. Go-Live Date Request Form

Readiness assessments will be conducted on a quarterly basis and will focus on five key areas.

Assessment Focus Areas



In a change from previous policy, readiness decisions and approval for go live will be made at the individual facility (rather than county) level.

Eligible Correctional Facilities

- State law requires the following correctional facilities to provide Medi-Cal services in the 90-days prior to release:
  - State Prisons
  - County Jails, Detention Centers, Detention Facilities
  - County Youth Correctional Facilities
- Pre-release services will only be provided to individuals prior to leaving a correctional facility and reentering the community.
- 90-Day Pre-Release Services do **not** include:
  - State forensic mental health hospitals (i.e., Department of State Hospital facilities)
  - City Jails
  - Federal Prisons

CalAIM Justice Involved Initiative Resources

- CalAIM Justice Involved Initiative Webpage
- Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative
- Enhanced Care Management (ECM) Policy Guide

Questions?

CalAIMJusticeAdvisoryGroup@dhcs.ca.gov

DHCS

Behavioral Health (BH) Update

Paula Willhelm

Assistant Deputy Director

Ivan Bhardwaj

Division Chief

DHCS

Traditional Healers and Natural Helpers

Traditional Healers and Natural Helpers: Background

- In 2017, DHCS requested authority from CMS 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
  - CMS neither approved nor disapproved
- In 2021, DHCS submitted a third request to CMS
  - CMS neither approved nor disapproved
  - Request is still pending
- In January 2024, CMS informed DHCS it aims to approve this request in 2024.

Traditional Healers and Natural Helpers: CMS Update

- CMS has been collaborating with the Indian Health Service and other federal partners to develop a national policy approach so that all four states with pending requests to cover Traditional Healers can potentially be approved under the same Section 1115 framework.
  - CMS aims to achieve this in **Calendar Year 2024**.
- DHCS highlighted for CMS that our Tribal and Indian Health Program partners would need to guide and shape any updates to the language that we have developed to-date.
  - CMS indicated that they intend to engage with Tribal partners in **Spring 2024**.
- DHCS will share more information but wanted to convey this positive development.

Traditional Healers and Natural Helpers: Request

- Section 1115 expenditure authority for Traditional Healer and Natural Helper services
- Provided by Indian Health Care Providers
- To DMC-ODS beneficiaries
- From January 1, 2022 through December 31, 2026

Traditional Healers and Natural Helpers: Key Considerations

- DMC-ODS reimbursement
  - Pursuant to DHCS Behavioral Health Information Notice 20-065
- Provider qualifications
- Service descriptions
- Implementation

BH-CONNECT

BH-CONNECT Waiver: Vision and Objectives

- California's goal for the BH-CONNECT demonstration is to establish a robust continuum of community-based behavioral health care services and improve access, equity, and quality for Medi-Cal members living with significant behavioral health needs, in particular populations experiencing disparities in behavioral health care and outcomes.
- BH-CONNECT will expand Medi-Cal service coverage, drive performance improvement, and support fidelity implementation for key interventions proven to improve outcomes for Medi-Cal members experiencing the greatest inequities, including:
  - children and youth involved in child welfare,
  - individuals with lived experience with the criminal justice system, and
  - individuals at risk of or experiencing homelessness.

Why BH-CONNECT?

The BH-CONNECT initiative builds upon unprecedented investments and policy transformations to establish a robust continuum of community-based behavioral health services and improve access, equity, and quality for Medi-Cal members.

- Like the rest of the nation, **California faces a growing mental health crisis**, which has been exacerbated by COVID-19: as of 2019, nearly 1 in 20 adult Californians were living with serious mental illness (SMI), and 1 in 13 California children were living with serious emotional disturbance (SED).
- California has **invested more than $10 billion and is implementing landmark policy reforms** to strengthen the behavioral health care continuum through initiatives that include:
  - The **California Advancing and Innovating Medi-Cal** (CalAIM) demonstration to transform and strengthen Medi-Cal, including policy changes to move Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility.
  - The **Children and Youth Behavioral Health Initiative** (CYBHI), a historic investment to enhance, expand and redesign the systems that support behavioral health for children and youth.
  - Investments in infrastructure and new housing settings through the **Behavioral Health Continuum Infrastructure Program** (BHCIP) and the **Behavioral Health Bridge Housing** (BHBH) Program.
  - Strengthening the behavioral health crisis care continuum, including implementing **mobile crisis services** and the **988 Suicide and Crisis Lifeline**.

Proposed Approach

BH-CONNECT aims to:

- **Expand the continuum of community-based services and evidence-based practices (EBPs)** available through Medi-Cal.
- **Strengthen family-based and supports** for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Connect members living with significant behavioral health needs to **employment, housing, and social services and supports**.
- **Invest in statewide practice transformations** to better enable county behavioral health plans and providers to support Medi-Cal members living with behavioral health conditions.
- **Strengthen the workforce** needed to delivery community-based behavioral health services and EBPs to members living with significant behavioral health needs.
- Reduce the risk of individuals **entering or re-entering the criminal justice system** due to untreated or under-treated mental illness.
- **Incentivize outcome and performance improvements** for children and youth involved in child welfare that receive care from multiple service systems.
- **Reduce use of institutional care** by those individuals most significantly affected by significant behavioral health needs.

Important Updates

- DHCS submitted the draft waiver application to CMS on October 20, 2023:
  - BH-CONNECT Section 1115 Demonstration Application
  - BH-CONNECT Section 1115 Demonstration Budget Neutrality Workbook

- January 2024 - Implemented the county Child Welfare Liaison as a requirement in the Managed Care Plan contract

- On January 31, 2024, DHCS released RFI #23-070 to provide information and solicit input from interested parties to establish one or more Centers of Excellence (COEs) that will offer training and technical assistance on several evidence-based practices (EBPs) to Medi-Cal specialty behavioral health providers and county behavioral health plans.

BH-CONNECT Timeline & Next Steps

- Spring 2024 – Provide draft State Plan Amendments (SPA) on EBPs to CMS. Indian Health Programs and Urban Indian Organizations will have 30 days to provide comment.
- Summer 2024 – Finalize SPA package and submit to CMS.
- Demonstration Go-Live. The BH-CONNECT demonstration will be implemented on a phased timeline to ensure ample time for successful implementation.
- Ongoing Stakeholder and Tribal Partner Engagement. DHCS is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of the proposed BH-CONNECT demonstration.

BH-CONNECT Timeline & Next Steps (continued)

DHCS intends to implement the BH-CONNECT demonstration using a phased approach. Counties may opt in to receive FFP for IMDs and meet other demonstration requirements on a rolling basis.

Proposed Implementation Milestones

January 2025 (*Demonstration Effective*)

- Counties opt-in to participate in BH-CONNECT IMD opportunity (*rolling*)
- Counties opt-in to offer enhanced community-based services, including ACT/FACT, CSC for FEP, IPS Supported Employment, Transitional Rent Services, Community Health Worker Services, and Clubhouse Services (*rolling*)
- Launch workforce initiative
- Statewide & opt-in incentive program go-live
- Release guidance on family therapies
- Centers of Excellence operational

July 2025

- Activity Stipends go-live
- Implement initial child welfare/behavioral health assessment

January 2026:

- Cross-sector incentive program go-live
- Evidence-based tools to connect members to appropriate care
- Tool to track availability of inpatient and crisis stabilization beds

Tribal Engagement for the 988 Suicide and Crisis Lifeline and Medi-Cal Mobile Crisis Response Services

988 Tribal Engagement Plan

- **DHCS is developing a Tribal Engagement Plan in partnership with the California Health and Human Services Agency, as part of its SAMHSA 988 grant.**
- **DHCS aims to:**
  - Coordinate with tribes, tribal partners, state agencies, and associations to ensure effective communication and implementation of 988 within California's tribes and tribal partners
  - Support 988 tribal partner grantees
  - Actively listen to and learn from tribes and tribal partners
  - Participate in tribal partner-led meetings
  - Develop communication material tailored to cultural and language needs of tribes and tribal partners
  - Ensure that implementation of and communication for 988 reflect the input and unique needs and experiences of California tribes and tribal partners

Key Milestones for 988

The goal is to guide engagement between DHCS, the California 988 Network Administrative Entity, California 988 Crisis Centers, tribes, and tribal partners to support successful implementation of the 988 Suicide & Crisis Lifeline within California's tribes and tribal partners.

Completed

Submit Tribal Engagement Plan

- ✓ Submitted to SAMHSA in January 2024

Meet with SAMHSA 988 Tribal Grantees

- ✓ Meetings held in December 2023 and January 2024

Select 988 Network Administrative Entity

- ✓ In January 2024 DHCS selected the Advocates for Human Potential as the California 988 Network Administrative Entity

Near Term

Identify Priorities and Challenges

- ✓ Schedule meetings with tribes and tribal partners
- ✓ Continue meeting with 988 Tribal Grantees
- ✓ Explore subcontract with tribal partner to guide this work

Long Term

Provide Resources to Support Tribal-Specific Messaging

- ✓ Partner with tribes on DHCS' Communications Strategy

Explore tribal-specific 988 line like Washington's Native & Strong 988 Lifeline

- ✓ Initiated meetings with Washington State and CalHHS in February 2024

Medi-Cal Mobile Crisis Services Benefit Tribal Engagement

- Medi-Cal behavioral health delivery systems are required to make a good faith effort to identify:
  - If the individual is a Tribal member
  - If Tribal members have seen an Indian Health Care Provider (IHCP) in the previous 12 months
  - If the Tribal member has a preference to receive follow-up care from an IHCP.
  - The mobile crisis team may check with the Tribal member or their significant support collateral(s), if appropriate; the beneficiary's MCP; or the local IHCP to determine if the Tribal member is a current IHCP patient or prefers to receive follow-up care from an IHCP.
- If the Tribal member is an IHCP patient or prefers to be seen by an IHCP for follow-up care, the mobile crisis team is responsible for making a good faith effort to connect the beneficiary with their IHCP or an IHCP that provides Medi-Cal-covered behavioral health services for follow-up care.
- If the Tribal member sees a non-IHCP for follow-up care, the mobile crisis team must make a good faith effort to share follow-up care information with the member's IHCP, provided the mobile crisis team has the member's consent to make such disclosure.
- Medi-Cal behavioral health delivery systems are required to describe culturally responsive and accessible services within their Implementation Plans, which may include description of services for Tribal members
- For more information, please review Behavioral Health Information Notice 23-025.

Tribal Fentanyl Roundtable

Tribal Fentanyl Roundtable Summary

- A Tribal Fentanyl Roundtable was held on December 4, 2023 in a hybrid format.
  - 109 federally recognized tribes were invited and 28 were represented.
- The purpose was to convene tribal leaders, tribal organizations, DHCS, CDPH, CalHHS, DOJ, the Attorney General's office, and the legislature to hear directly from tribal leaders regarding the impact the fentanyl crisis has had in their communities.
- Provide tribal leaders with information and resources:
  - Funding and technical assistance opportunities for tribes to combat the fentanyl crisis.
  - Ways to access naloxone, naloxone training, and fentanyl testing strips.
  - Culturally-centered educational and community engagement materials.
  - Evidence-based practices available for tribal communities.

Tribal Fentanyl Roundtable Outcomes

- Tribal Leaders expressed an interest in holding a State Opioid Summit, similar to the summit held in the state of Washington last year.
  - See this link for more information regarding the Washington State Tribal Opioid/Fentanyl Summit.
- Discussed the possibility of setting aside monies in the state budget specifically for California tribes to address the opioid crisis.
- Future roundtables and discussions to be held to continue the conversation on the fentanyl crisis in tribal communities.

Naloxone Distribution Project (NDP)

- To apply for naloxone through the NDP:
  - Gather the required supplemental materials.
  - Complete the NDP online application form.
  - Submit the application and supplemental materials via the NDP online application form.
    - Entities applying for the NDP can now request up to 204 units before they are required to submit supporting policy and procedure documents. (Previously, supporting policies and procedures were required for requests over 48 units.)
  - Manufacturer ships naloxone directly to applicants.
  - The NDP is currently developing an online menu option that will include free fentanyl test strips alongside Naloxone.
    - The go-live date for this option is still to be determined.

Tribal Medication Assisted Treatment (TMAT) Project

- *Tribal and Urban Indian Community-Defined Best Practices program*
  - **Grant funding** and **technical assistance** opportunity for Tribal and Urban Indian health programs.
  - Support the implementation and integration of culturally-validated traditional healing and recovery practices for SUD into clinical services serving Tribes and Urban Indian populations.
- *Tribal and Urban Indian MAT and Stimulant Use Disorder Learning Community*
  - **Grant funding** and **technical assistance** opportunity for Tribal and Urban Indian health programs
  - Develop, enhance, and sustain MAT and/or stimulant use disorder services in ways that leverage the local Tribal cultural context and facilitate peer-to-peer learning.

Mobile Narcotic Treatment Programs and Medication Units

- DHCS has opened applications for DHCS-licensed Narcotic Treatment Programs (NTPs) wanting to expand their services via a Medical Unit (MU) and/or a Mobile Narcotic Treatment Program (MNTP) to prioritize rural communities including justice-involved populations, indigenous and Native communities, patients without transportation, and areas that do not have NTPs within close proximity to patients in need of NPT services.
- Eligible applicants may choose to apply for two tracks:
  - Track one: Medication Unit (MU)
  - Track two: Mobile Narcotic Treatment Program (MNTP)
- **Applications were due on February 26 and DHCS is in the process of reviewing submissions.**

Elevate Youth California

- Elevate Youth California (EYC) is a statewide program addressing substance use disorder prevention by investing in youth leadership and activism for youth of color ages 12 to 26 living in communities disproportionately impacted by the war on drugs.
- To date, DHCS has distributed $205.9M through 290 grant awards, with 30 of those awards going to Tribal partners.
- Round 5 Standard Track Grantees are anticipated to be announced in March 2024.

Behavioral Health Bridge Housing (BHBH) Program

- Tribal Entities RFA
  - Primary focus is to help people experiencing homelessness who have serious behavioral health conditions that prevent them from accessing help and moving out of homelessness.
    - Under Round 2A, DHCS awarded $30 million to 9 initial tribal entities which will be used to provide support for planning and implementation of bridge housing.
    - As of February 13, 2024 Round 2B has been posted, making $20 million in funding available for two tracks. The RFA can be accessed here. An informational webinar will be held on March 14, 2024.
    - Track 1 – Planning Grant: Available in award amounts of $150,000 and intended to facilitate planning and engagement activities.
    - Track 2 – Implementation: Applications may be submitted for up to $5 million with the purpose of launching and operating a BHBH program to provide housing to people experiencing homelessness who have a serious behavioral health condition.

Behavioral Health Continuum Infrastructure Program (BHCIP)

- To date, DHCS has awarded a total of $1.7 billion through the five released rounds of BHCIP grant funding. Information on the past and current grants, as well as applicable dashboards can be found on the BHCIP webpage.
  - Round 1: Crisis Care Mobile Units (CCMU)
    - Project runs through June 2025.
    - The purpose of this project is to expand access to crisis and non-crisis behavioral health care to Tribal entities through the provision of infrastructure funding for vehicles and related costs.
    - On June 1, 2023, over $7.4 million was awarded to 24 organizations.
  - Round 2: Planning Grants
    - More than $7 million awarded to 48 county and tribal entities to support activities associated with planning for the construction, acquisition, or rehabilitation of BH facilities. Awards announced: 2A in January 2022 and 2B in April 2022.
    - Under Round 2A, $5.1 million in funding was awarded to 34 grantees, including 9 tribal entities.
    - Under Round 2B, $2 million in funding was awarded to 14 grantees, including 9 tribal entities.

BHCIP Continued

- Infrastructure Specific Funding Opportunities:
  - Round 3: Launch Ready
    - $518.5 million awarded 45 launch ready projects to build/expand 37 new inpatient and residential facility sites that offer 1,292 new BH treatment beds, and 44 outpatient facilities to offer more than 130,000 new annual BH treatment slots. Awards announced in June 2022.
    - Of the 45 awarded projects, 2 were tribal entities.
  - Round 4: Children and Youth
    - $480.5 million awarded 52 children and youth focused projects to support 29 new inpatient and residential facility sites to offer 509 new treatment beds, and 44 outpatient facilities to offer close to 77,000 new annual treatment slots. Awards announced in December 2022.
    - Of the 54 awarded projects, 4 were tribal entities.
  - Round 5: Crisis and BH Continuum
    - $430 million awarded to 33 crisis and/or BH focused projects to support the addition of 29 new inpatient/residential facility sites to offer 800 new treatments beds, and 38 outpatient facilities to offer more than 73,000 new annual treatment slots. Awards announced in June 2023. Of the 33 awarded projects, 2 were tribal entities.
  - Round 6: Unmet Needs (In development)
    - Part I initially identified $240.4M available to award in FY 2024/2025; however, the January 2024 budget, released earlier this month, proposes to retain $100M in FY 2024/2025 and delay the remaining $140.4M until FY 2025/2026. Policy for rolling out the Round 6: Part I funding with the delays identified is under review and DHCS, together with Advocates for Human Potential (AHP), the BHCIP administrative entity, will provide updates as they become available.

Managed Care Update

Bambi Cisneros
Assistant Deputy Director
Dana Durham
Division Chief

DHCS

2024 Managed Care Plan Transitions

2024 MCP Transition Context

Scale and Complexity

- **Scale**: Approximately 1.2 million members were identified to transition to a new MCP on January 1, 2024; in addition, Kaiser became the prime* MCP for approximately 800K members
- **Complexity**: These transitions took place across 21 counties and 14 unique MCPs
  - ~ 250K members received an enrollment packet to choose an MCP because of the county plan model changes in a county where there is more than one plan in the county. (5 counties impacted)
  - ~ 400K members transitioned because of the county plan model change and were enrolled in COHS or Single Plan County (15 counties impacted)
  - ~500K members transitioned from Health Net to Molina in Los Angeles county (1 county impacted)
  - ~800K members transitioned to Kaiser as their Prime MCP* in 27 counties

A **Prime MCP is an MCP that directly contracts with DHCS to provide Covered Services to members within the county or counties specified in their contract.*

Preparation for the 2024 MCP Transition

Operational Readiness Assessment

- DHCS required MCPs to submit approximately 250 Operational Readiness deliverables corresponding to the MCP contract
- For example, Operational Readiness deliverables focused on:
  - Quality Improvement
  - Utilization Management
  - Network Adequacy
  - Delegation Oversight
  - Continuity Of Care
  - Population Health Management
  - Enhanced Care Management
  - Community Supports
- DHCS conducted deep dive assessments for five MCPs identified as high-priority due to the size and complexity of their expansion to additional counties or the number of members they will serve, as well as being new to providing Medi-Cal managed care services

Member Engagement

- **Pre-Transition:** DHCS utilized various strategies for engaging members, raising awareness about the 2024 transition and their rights, and providing contact information
  - Letters
  - Call campaigns
  - Text campaigns
  - Member-focused web resources
  - DHCS' Friday newsletter
- **Post-Transition**: DHCS is analyzing member call data, grievances, appeals, and stakeholder survey feedback to identify and address member challenges
- ***Ongoing:*** DHCS is collaborating with MCP partners and advocates to ensure effective communication and resolution of identified transition issues

MCP Transition Monitoring Approach

Due to the scale and complexity of the 2024 MCP Transition, DHCS is utilizing a multi-pronged approach to enable oversight and ensure compliance with MCP Transition policies.

	Activities	Cadence
MCP Survey Responses	Previous and Receiving MCPs are required to submit Continuity of Care (CoC) performance data via survey across 4 domains: • CoC for all transitioning members and Special Populations members (note: Special Populations members are especially vulnerable members as defined in the MCP Transition Policy Guide) • CoC for Enhanced Care Management (ECM) and Community Supports • Member Issues	***Biweekly*** *November through February;* ***Monthly*** *through March; and* ***quarterly*** *through December 2024*
Stakeholder Survey	DHCS is soliciting and tracking stakeholder feedback through a survey; MCPs are also expected to track stakeholder input and ensure appropriate feedback loops exist with MCP leadership	***Monthly*** *November 2023 through March 2024*
Other Activities	DHCS is also monitoring plan-to-plan data sharing to confirm CoC protections are honored. • **Plan to Plan Data Sharing** (Biweekly): DHCS is reviewing copies of data files shared between Previous and Receiving MCPs for timeliness and completeness.	***Monthly and Biweekly*** *November 2023 through March 2024*

All Plan Letter (APL) 24-002 Overview

Medi-Cal Managed Care Plan (MCP) Responsibilities for Indian Health Care Providers (IHCPs) and American Indian Members

DHCS

APL 24-002 Overview

- APL 24-002 supersedes APL 09-009
- The intent of this APL is to summarize, clarify, and reinforce existing federal and state protections
- DHCS incorporated the contracting components developed by CMS as requested by tribal stakeholders
- The APL also consolidates various MCP requirements pertaining to protections for IHCPs

APL 24-002: American Indian Members Rights and Protections

- American Indian Medi-Cal Members are not required to enroll in an MCP, except in the case of County Organized Health Systems (COHS) or Single Plan Model counties
- American Indians who disenroll from an MCP will receive services under the Fee-for-Service (FFS) delivery system
- IHCPs, whether in or out-of network, can provide referrals directly to Network Providers without a referral from a Network Primary Care Physician (PCP) or Prior Authorization
- When a request to receive services from an IHCP is made and none is available, the MCP must assist the Member in locating and connecting with an out-of network IHCP
- American Indian MCP Members are not subject to enrollment fees, premiums, deductibles, copayments, cost sharing, or other similar charges

APL 24-002: IHCP Rights and Protections

- IHCP Enrollment
  - MCP must ensure that the IHCP is enrolled in the Medi-Cal program if the IHCP is providing Medi-Cal covered services, including transportation, to an American Indian MCP Member through state level or MCP enrollment pathways
- Ordering, Referring, and Prescribing (ORP) Provider Enrollment
  - Licensed practitioners working in the IHCP facility must enroll as an ORP (as long as a state-level enrollment pathway exists)
  - MCP is prohibited from requiring the licensure of a health professional employed by a Tribal Health Program, if the professional is licensed in another state

APL 24-002: IHCP Rights and Protections

- IHCP Contracting
  - MCPs must attempt to contract with each IHCP in its service area.
- IHCP Credentialing/Re-Credentialing and Site Reviews
  - MCPs to ensure that IHCPs contracting as Network Providers are credentialed and re-credentialed, in accordance with the MCP Contract and APL 22-013
  - MCPs must conduct site reviews of their contracted PCP sites, including IHCPs that are PCPs to support the safe and effective provision of appropriate clinical services

APL 24-002: IHCP Rights and Protections

- IHCP Claims Payment
  - MCPs must pay claims from the IHCP in accordance with federal law
  - Tribal Health Programs are to be reimbursed at the federally established AIR as noted in APLs 17-020 and 21-008. Urban Indian Organizations, enrolled in Medi-Cal as a Federally Qualified Health Center, are to be reimbursed through the PPS methodology
  - MCPs must reimburse IHCPs in a timely manner. The federal standard is payment of 90% of all clean claims within 30 calendar days of receipt, and payment of 99% of all clean claims within 90 calendar days of receipt. MCPs should offer and provide training to IHCPs on clean claims protocols

APL 24-002: MCP Tribal Liaison

- Effective January 1, 2024, MCPs are required to have an identified tribal liaison to work with contracted and non-contracted IHCPs in its service area
- The tribal liaison is responsible for coordinating referrals and payment for services provided to American Indian Members who are qualified to receive services from an IHCP
  - The tribal liaison should have experience with tribal health care, American Indian tribes, and managed care to assist IHCPs with the requirements and policies
- MCPs are to fulfill the role with adequate staffing to ensure their ability to serve IHCPs, American Indian MCP Members, and the MCP's service area

APL 24-002: MCP Tribal Liaison Cont.

- The role and responsibilities of the MCP tribal liaison include, but are not limited to:
  - Providing information pertaining to enrollment and disenrollment
  - Coordinating care and ensuring access to in and out-of-network IHCPs
  - Providing assistance with accessing transportation
  - Providing case management
  - Assisting with Provider relations services, claims, payment assistance and resolution, and Member services
  - Providing support in obtaining grievance, appeal, and State Hearing services

APL 24-002: MCP Tribal Liaison Cont.

- Roles and responsibilities of the MCP tribal liaison continued:
  - Providing benefit and service navigation and coordination
  - Providing assistance regarding Medi-Cal program Provider enrollment and MCP contracting, credentialing, and Facility Site Reviews
  - Attesting to the completion of the Cultural Humility training from the California Governor's Office of the Tribal Advisor, the Overview of Trauma-Informed Care and Historical Trauma training from the Indian Health Service (IHS), and other relevant trainings as they are developed and noted by the Department of Health Care Services (DHCS)

PATH Updates

DHCS

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

CITED Round 3

- The CITED Round 3 application window closed on February 15, 2024. Awards are targeted for August 2024.
- 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.
- Tribal Partners and organizations serving Tribal members continue to be a priority for Round 3.
  - DHCS and PCG hosted a CITED informational webinar focused for Tribal partners on January 25, 2024.

DHCS is considering data as it becomes available to help inform funding priorities for Round 3 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

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 March 29, 2024, from 2-3 pm
- Other upcoming Indian Health Collaborative Events:
  - Office Hours: March 7 from 1-2 pm
  - CalAIM 101: March 14 from 1-2 pm
  - Provider Forum: March 20 from 2-3 pm
- Register here to become a CPI Participant!

Questions?

DHCS

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar