# DEPARTMENT OF HEALTH CARE SERVICES

## Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Joint Meeting

## May 27, 2020

## 9 a.m. – 12:30 p.m.

## MEETING SUMMARY

**Stakeholder Advisory Committee Members (SAC) Attending (by phone)**: Maya Altman, Health Plan of San Mateo; Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Doty Cabrera, County Behavioral Health Directors Association; Richard Chinnock, MD, Children's Specialty Care Coalition; Paul Curtis, CA Council of Community Behavioral Health Agencies; Lisa Davies, Chapa-De Indian Health Program; MJ Diaz, SEIU; Anne Donnelly, San Francisco AIDS Foundation; Michelle Gibbons, County Health Executives Association of CA; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Barsam Kasravi, Anthem Blue Cross; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights CA; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Erica Murray, CA Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Andie Patterson, California Primary Care Association; Chris Perrone, California HealthCare Foundation; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Jessica Rubenstein, CA Medical Association; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation; Ryan Witz, California Hospital Association; Anthony Wright, Health Access CA.

**SAC Members Not Attending**: Michael Humphrey, Sonoma County IHSS Public Authority; Gary Passmore, CA Congress of Seniors; Jonathan Sherin, LA Department of Mental Health.

**Behavioral Health Stakeholder Advisory Members (BH SAC) Attending (by phone):** Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Catherine Blakemore, Disability Rights CA; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI California; Steve Fields, Progress Foundation; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Britta Guerrero, Sacramento Native American Health Center; Veronica Kelley, San Bernardino County; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting,

California State Association of Counties; Frank Mecca, County Welfare Directors Association of California; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/ Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Sarah Rock, Rock Health; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation; Jevon Wilkes, California Coalition for Youth.

**BH SAC Members Not Attending:** Sarah Arnquist, Beacon Health Options; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Sherin, Department of Mental Health, County of Los Angeles.

**DHCS Attending**: Bradley Gilbert, MD, Jacey Cooper, Lindy Harrington, Rene Mollow, Kelly Pfeifer, Jim Kooler, Anastasia Dodson, Adam Weintraub, Morgan Clair.

**Public Attending (by phone)**: There were 544 members of the public attending by phone.

**Welcome, Introductions, and Opening Comments**
***Bradley Gilbert, MD, DHCS Director***

Thank you all for attending and for your patience. Due to a power outage and follow-up technical difficulties we are convening the SAC meeting today by conference call rather than the planned webinar. It made sense to combine the SAC and BH-SAC groups for today's meeting to offer you updates and gather your feedback on three big topics: the State Budget May Revision, COVID-19 activity, and the status of the waivers and California Advancing and Innovating Medi-Cal (CalAIM). Before we begin, I want to acknowledge how significantly the world has changed due to the pandemic since our last meeting. It is affecting our lives and is affecting California in a fundamental way.

Update on the Foster Care Model of Care Workgroup: This effort is part of the CalAIM Initiative in partnership with the California Department of Social Services. Foster youth are in a variety of settings and care delivery systems that are Fee-For-Service (FFS) and managed care. DHCS wants to develop a plan for a delivery system that provides consistent, comprehensive, and integrated care for youth in foster care. DHCS is looking for input from stakeholders about how we might think differently to develop, establish, and deliver a high quality, organized system of care for foster youth. The first meeting is set June 26, 2020, and the members have been selected. We are looking forward to that discussion and how we can provide excellent care for this group of children.

The California Health and Human Services Agency convened the Behavioral Health

Task Force to address the urgent mental health and substance use disorder needs across California. The task force includes a diverse set of stakeholders, individuals with lived experience, advocates, providers, and others. They held one meeting to develop the mission: to boldly plan and implement a behavioral health system to meet the diverse needs of all Californians with a focus on children, people at risk or experiencing homelessness, and those with criminal justice involvement. The task force will develop recommendations for the Governor about how California can provide timely access to high-quality behavioral health care for all of its residents. I encourage you to review the objectives and offer feedback to realize the goal of developing a behavioral health plan for California.

**State Budget Update: May Revision**
***Bradley Gilbert, MD, and Jacey Cooper, DHCS***
Slides available: https://www.dhcs.ca.gov/services/Documents/SAC-BH-SAC-Presentation.pdf

Jacey Cooper reviewed information from meeting slides on the May Revision and reported that DHCS has posted highlights of the May Revision on the website. There are modifications to proposals included in the January budget, especially in light of the significant of the General Fund (GF) budget shortfall. Two key drivers for DHCS are the COVID-19 response and projected Medi-Cal caseload increases. We will focus here on caseload and DHCS changes and discuss the COVID-19 response as a separate discussion item. Total DHCS spending is estimated to be $106.6 billion in FY2019-20 and $115.7 billion in FY2020-21.

- There is increased federal funding through the Families First Coronavirus Response Act (H.R. 6201) due to the public health emergency that provides enhanced federal match.
- DHCS estimates an increased caseload peaking at 14.5 million in July 2020. This estimate is drawn from a historical correlation between Medi-Cal caseload and the California unemployment rate. This assumes a one-month lag. We are seeing a longer lag in Medi-Cal enrollment compared to other state programs, such as CalFresh. DHCS also uses actual caseload information from the 2015 economic recovery to estimate the distribution across aid codes.
- There has been extensive work with the Legislative Analyst Office (LAO) and Department of Finance (DOF) on caseload projections. The LAO has a revised proposal that reduces the GF request about $750 million for the current and next fiscal year.
- In order to comply with H.R. 6201, DHCS must suspend renewals and maintain enrollment. This results in an estimate of 104,000 beneficiaries per month continuing who would have lost eligibility.

The state budget deficit, increasing caseload and the requirement to put forward a balanced budget meant difficult budget recommendations. We also have federal and state restrictions that narrow the options we can consider. The reductions include 2019 programs and items in the proposed January budget that are not yet or very recently implemented, optional benefits, repurposing of Proposition 56, and fund transfers.

- $50 million GF reverted funding from various augmentations that were included in the 2019 Budget Act. This includes enrollment navigators, interpretation pilot, and caregiver augmentation and other items.
- $600 million GF in savings related to proposals in the January Governor's Budget that have now been withdrawn. This includes postponing CalAIM, the Behavioral Health Quality Improvement Program, postpartum mental health expansion, Medicare Part B, undocumented older adult coverage, Supplemental Payment Pool for Non-Hospital 340B clinics, and hearing aid grant program.
- $150 million GF related to the elimination of various adult optional Medi-Cal benefits. Adult dental elimination is a reversion back to 2014 benefits. It eliminates the Multi-Purpose Senior Services Program (MSSP) and Community-Based Adult Services Program (CBAS). Optional benefits changes do not apply to children on Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), individuals in long-term care facilities, pregnancy services, or if services are provided in a hospital or and FQHC.
- $1.2 billion GF redirection of Prop 56 revenues to offset GF costs of Medi-Cal caseload growth. This includes elimination of behavioral health integration, developmental screenings for family planning and women's health, supplemental payments for intermediate care facilities for developmentally disabled and CBAS centers, CalHealthCares cohorts 2-5, reduced funding for trauma screening, and no change to home health, freestanding pediatric subacute facilities, and the HIV/AIDs waiver program.
- $390 million GF in various Medi-Cal rate reductions and program efficiencies. This includes reducing managed care capitation rates by 1.5% and implementing a risk corridor for the bridge period.
- $330 million GF to reflect the redirection and transfer of certain special funds and some revenues from the proposed E-Cigarette Tax to fund Medi-Cal.

Two other key factors in the revised budget estimates are a decrease of $1.7 billion GF from the recently approved Managed Care Organization (MCO) tax that offsets General Fund costs in Medi-Cal in 2020- 21 and an increase of $1.4 billion GF to return federal funding where we incorrectly drew down federal dollars for services in state-only programs. The Family Health Local Assistance program caseload is projected to remain relatively stable. The trailer bill language and a list of resources are included in the presentation slides.

**Questions and Comments:**

*Michelle Doty Cabrera, County Behavioral Health Directors Association*: I want to note from the perspective of County Behavioral Health that because we are funded through non-state GF revenues, there is a significant cut to county behavioral health services through this budget. We estimate by next year, we will lose close to $1 billion out of a total of $9 billion funding. We are responsible for Medi-Cal entitlements, including EPSDT to children and have significant concerns about our ability to serve Medi-Cal beneficiaries for specialty mental health and substance use services. Will DHCS consider applying enhanced Federal Medical Assistance Percentages (FMAP) to

behavioral health?

*Lindy Harrington, DHCS*: Yes, the enhanced FMAP will apply to services provided after the start of the emergency period.

*Linda Nguy, Western Center on Law and Poverty*: I agree with the LAO that the Medi-Cal caseload cost is overestimated as we think DHCS has an expensive case mix and early surge peak. The caseload increase is primarily due to layoffs and many are eligible for a 90% federal match rate. How far apart is DHCS from the LAO $750 million revised estimate for the GF?

*Jacey Cooper, DHCS*: We are reviewing this and looking at actual per-member-per-month cost. We don't have a specific delta for you at this time other than the LAO recommendation.

*Linda Nguy, Western Center on Law and Poverty*: I look forward to more information when it is available. On the expanded estate recovery that we believe will exacerbate race and class disparities, how did DHCS calculate the savings? Will you be sending notices to everyone who signed up under the prior limited estate recovery for capitated payment costs even if no health services were used?

*Bradley Gilbert, DHCS*: The estimate is based on the experience prior to 2017 when the rules were similar, but not identical to now. Yes, we will send notices.

*Linda Nguy, Western Center on Law and Poverty*: Related to estate recovery and Medi-Cal cuts, how are DHCS discussions going with CMS related to benefits and estate recovery?

*Jacey Cooper, DHCS*: We are in a continuing discussion with CMS and there is no resolution of optional benefits. I'm happy to talk offline about the recovery piece, as this has not been raised with us. CMS has indicated that the benefits that have not gone live will not violate maintenance of effort, but there are other outstanding questions on the optional benefits. A large number of other states are also engaging in discussions with CMS.

*Linda Nguy, Western Center on Law and Poverty*: I look forward to the response. Many benefits were just restored in January and it will be devastating for the benefits to go away so quickly.

*Anthony Wright, Health Access CA*: There was a discussion about the elimination of CBAS and MSSP in the budget hearing. While savings were scored there also would be an uptick in nursing home utilization, and it is my understanding that the cost for this was not booked. On other optional benefits, was there a calculation for the additional costs like emergency department utilization resulting from not having access to the benefits that tend to be preventive?

*Jacey Cooper, DHCS*: You are correct that we did not score an increase in skilled

nursing facility (SNF) utilization with elimination of CBAS and MSSP. One piece discussed is that for both programs there is a required transition plan for services. It is different for CBAS since many in this population are not medically eligible for skilled nursing. Part of the transition is to require DHCS to work with health plans. Plans do offer services like individual health risk assessments, case management and 24-7 nurse lines that may help. It is not our intent for people to end up in SNF. Also, there are waiver programs that may be used to transition individuals to other Home and Community Based Services. DHCS is exploring with California Department of Public Health (CDPH) and California Health & Human Services Agency (CHHS) how to develop a "long term care at home" benefit to decompress skilled nursing facilities and so there are options to reside safely at home. We will be engaging with stakeholders over the next two months in policy development. There has also been discussion on this with the Master Plan on Aging Advisory Group. What is proposed is a hospice-like benefit, minus end-of-life, that would include nursing, social work and other services. We would pay an agency a per diem rate to provide the services in the home. Not all MSSP or CBAS participants would be eligible. We are working now on the benefit and will engage CMS to go live in 2021.

*Kim Lewis, National Health Law Program*: It is great you are thinking about that. Have you considered not having the MSSP and CBAS cuts while you are working on this benefit given it will be very short-term savings? So that we do not force individuals into institutions and then transition back to home.

*Jacey Cooper, DHCS*: Yes, the Legislature raised that, and we are taking it into consideration. The main piece is ensuring they get services and we will look at that through the budget process.

*Anthony Wright, Health Access CA*: Are offsetting costs for other optional benefits booked? Is there a cumulative calculation of the multiple cuts to optional benefits, dental, senior care?

*Jacey Cooper, DHCS*: The short answer is no. We did not score any costs based on the optional benefit cuts especially in light of the fact that many were only restored in January. This includes no cost scored on the dental roll-back of benefits.

*Anthony Wright, Health Access CA*: On the nurse anesthesia benefit, my sense is this is a replacement for situations when anesthesiologists are not available? What is the option to get care in this case? It seems it would be more expensive to eliminate the benefit.

*Jacey Cooper, DHCS*: There are no reductions in hospital or pregnancy related services. Only the nurse anesthetists in outpatient settings are impacted. There is a continued requirement to offer this in inpatient settings. We are working with the nurse anesthetist association to work out the details of the impact, especially for rural areas.

*Anthony Wright, Health Access CA*: Colleagues and I sent questions on take-up and enrollment.

*Jacey Cooper, DHCS*: I tried to cover those caseload questions in the budget

presentation. We are posting on the open portal data but there is a several month lag in the data. I am happy to follow-up with a separate meeting or email responses to you and colleagues.

*Anthony Wright, Health Access CA*: We want to be your partner in figuring out if this is a data or lag issue or are people having trouble finding their way to Medi-Cal due to other barriers.

*Cathy Senderling, County Welfare Directors Association*: It is critical to talk about getting quick updates without the lag we are seeing. Currently we only get application data. It may be some had extended employer coverage, however, many didn't have coverage before so, where are they? Are they waiting until they get sick to apply? Are they not willing to seek services right now? How can we work together to overcome barriers to signing up for coverage before you need it? As counties reopen, County Departments of Human Services also will open, and we can track to see if it is partly about people wanting to enroll in person. Particularly for non-English speaking populations, they may feel better with in-person enrollment.

*Jacey Cooper, DHCS*: We appreciate the partnership as we figure out the data of enrollment vs. application. The recent data posted is enrollment data. We want them to get access early and look forward to partnering on this. Covered CA is doing a media push and including Medi-Cal. County offices opening will help. We have surveyed them and have heard about the innovative ways enrollment is happening.

*Bradley Gilbert, DHCS*: Any feedback from county staff or advocates, and from people on the ground is helpful. Are they on employer extended coverage or are they making choices related to not needing coverage?

*Hector Ramirez, Consumer Los Angeles County*: One observation is that there is miscommunication. Some worry that health providers are closed or that even if open, they may not be safe because of COVID-19. I am hearing from shelters and food sites that people have medical needs but choose not to access care out of fear or not knowing if services are open.

*Jacey Cooper, DHCS*: That is very helpful and is in line with what we are hearing as well. We want to get the message out to people and are sending out a beneficiary notice with Frequently Asked Questions (FAQ) about this out to those who are enrolled, but that does not get to those who are not enrolled.

*Bradley Gilbert, DHCS*: Thank you. While it doesn't work for everyone, we can use telephonic and telehealth services. The beneficiary notice will talk about that, so they know they can get care safely and don't have to go into an office.

*Aimee Moulin, UC Davis/ Co-Director, California Bridge Program*: Yes, that is what I see in the emergency department. I think telehealth works well for those enrolled with a provider, but not as well for those newly enrolled, not in care, or not able to access telephonic care. We are doing lots of medication refills via phone from the emergency

departments.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: CPCA is thinking about a survey of members on this topic to hear about their experiences. There does seem to be hesitation to use services and perhaps a pent-up demand behind that. I welcome the conversation about how we can look at policy options and solutions to work on this.

*Jacey Cooper, DHCS*: This is of great interest to us and we can add folks to ensure we have the right people for the conversation.

*Anne Donnelly, San Francisco AIDS Foundation*: We are also seeing a dramatic drop in testing for HIV and Hepatitis C due to concerns about seeking care and coverage.

*Kiran Savage-Sangwan, California Pan Ethnic Health Network*: We appreciate this is difficult and that DHCS is trying to figure this out. To the discussion of barriers to enrollment and services and using different modalities for care, this is why we are concerned about elimination of the enrollment navigator program. It's an important way to help people get services they need, use new technology and understand what's available. We urge more consideration around that program as a way to help us with these barriers we're seeing.

*Cathy Senderling, County Welfare Directors Association*: I echo that. We have heard concerns from counties about losing those assistors. The application is much more likely to be complete when there is an assistor.

*Anne Donnelly, San Francisco AIDS Foundation*: Yes, because we do have some navigation outside of Medi-Cal we see that being hooked up with a navigator is the difference for the most vulnerable folks to get the coverage and services they need.

*Andie Patterson, California Primary Care Association*: Clinics and consortia rely on navigator grants. Health centers have been allowed to do presumptive eligibility COVID-19 enrollment. We're wondering if you have considered accelerated enrollment post-emergency – especially if navigator grants can't come back. Health centers are very grateful and love virtual care. Telephone has been the most predominant method because it seems easier for our populations, which surprised us. Through the survey that we will share, we are hearing challenges on the patient side about technology; not comfortable with the technology; hesitations about the quality when it is not face-to-face. We are putting all this information together and thinking through how to improve. We have concerns about the decline in well-child visits and have some creative ideas on how to improve this, like starting with a telephonic survey on well-child visits, with drive-through immunizations. We would love to follow up on accelerated enrollment.

*Jacey Cooper, DHCS*: We are continuing to look at accelerated enrollment but haven't moved forward. There are challenges with this from previous experience. We will continue to evaluate this, and understand this has come to us from a few people. We do want to look at the well-child issue and are very interested in your survey results to

understand what is working, what is not and how to ensure quality and what is the beneficiary experience. Anything you can share is appreciated.

*Jevon Wilkes, California Coalition for Youth*: There are youth surviving on the street that need access and there is huge divide on technology and what they have access to. Telehealth is a challenge. Talking about barriers, there are many youth within families, unaccompanied minors, and youth – we're behind in employment rates – and only 21 counties have services for youth experiencing homelessness. We need to think about them and build out support for this population to make sure everyone has access to care.

*Bradley Gilbert, DHCS*: Thank you.

*Bill Walker, MD, Contra Costa Health Services*: Taking a broad view of the past discussion, I'm sure DHCS staff did not sign up for the unraveling of 10 years of progress in Medi-Cal. How does all of the discussion fit into the budget process, possible federal funding and cuts? How does the delay fit into implementation for the proposed cuts? What do you see regarding the overall budget process?

*Jacey Cooper, DHCS*: This is unlike any budget process we have experienced. I don't have many answers. DHCS is working around the clock on responses as we go through discussion with the Legislature and think through the federal ask related to the complexity of the timing. We are working toward the requirement to have a balanced budget by June 15.

*Bradley Gilbert, DHCS*: We are trying to figure out exactly how this is going to work because it is so different.

*Carrie Gordon, CA Dental Association*: We understand the severity of the budget situation. The Proposition 56 cut will undermine the voters' will and is against the definition of the proposition so this will be a pointed conversation in the coming weeks. We have spoken of the double-digit improvements in the last years after decades of decline, and for dental this takes us back to the 1980s. This rate supplement is fundamental. We are also concerned about student loan repayment and the partial dental benefit elimination. Thinking back to 2014, patients couldn't get consistent care across different providers and were in pain. In the current economy, dentistry has been hit hard. We have a 60% decline in dental employment from March-April. We were 90% closed and are now back to 30% of caseload due to workload and infection control requirements. This is not sustainable. We are estimating we will lose 10-15% of the profession overall and 15-25% in vulnerable communities. I hear about partnership, but I don't see partnership with this one. Even if we get relief from the federal level, the triggers will have already done the damage; we will lose providers and can't get that back. We are open to partnering on alternatives and know this is a tough budget situation. Did you consider less disruptive approaches that would not require a total stop and rebuild of the program? Are you looking at return to care efforts … that help in a programmatic way; help beneficiaries feel safe and build back confidence?

*Jacey Cooper, DHCS*: Thank you for the comments. As you know these were really hard recommendations for DHCS to put forward given the progress in recent years. We looked at many alternatives before proceeding. We want to work with you to make the best of this situation. Your partnership is important to us and we understand how hard this hit is for you and others. We are working with many people to gather guidance on messages for beneficiaries about reopening. We want to partner to get the message out and look forward to continuing the conversations with you.

*Bradley Gilbert, DHCS*: Thank you. We are working hard to get the Protective Personal Equipment (PPE) and worked with CDPH to get detailed guidelines for dentists for resuming care. Let us know if there is more to do on that and appreciate your comments regarding the budget.

*Carrie Gordon, CA Dental Association*: Yes, we are still struggling with PPE and that's one of the reasons they are only open for 30%. As small businesses, it's hard to sustain a full time practice on 30% of revenue. I'm hearing sad conversations about dentists who can't afford to come back.

*Farrah McDaid Ting, California State Association of Counties*: We are experiencing a huge hit on providers of many types. For realignment funds and the social services, public health and behavioral health services it funds, there is a $3.3 billion hole in revenues. This is a hidden cut on top of the other proposals. It is a trickle down. The state is experiencing a contraction that affects providers and access, whether it is medical, dental, behavioral health or public health. There is no new funding proposal in the May Revise or other mechanisms to help. We are all in the same ecosystem and all suffering. The people who need services will be the ones who truly suffer.

*Bradley Gilbert, DHCS*: We have seen the letters and appreciate the information.

*Cathy Senderling, County Welfare Directors Association*: Coming back to the navigator funding, eligibility staff mentioned they will be sending notices to existing navigator contractors that FY19-20 signed contracts will be eliminated within 30 days. That is not consistent with my reading - that the $15 million already in signed contracts was going to play out and then new expenditures will be eliminated. Which is the correct interpretation? Will existing contracts be pulled?

*Jacey Cooper, DHCS*: What was scored in the May Revise is no change to the current year. The $15 million is untouched. The reduction is only in the budget year 2021. The intent of the notice is to make them aware of future cuts based on the new budget year given the budget will be so late. I'm happy to work with you offline if there is a misinterpretation.

*Cathy Senderling, County Welfare Directors Association*: Thank you for the helpful clarification and not what I heard previously. I'll circle back so understanding is clear.

**COVID -19 Update and Feedback from SAC/BH-SAC Members**

***Jacey Cooper, DHCS, DHCS Staff, and Members***
Slides available: https://www.dhcs.ca.gov/services/Documents/SAC-BH-SAC-Presentation.pdf

Jacey Cooper began the update with appreciation for the many stakeholders who have been engaged with DHCS during the public health emergency to feed information we need to consider from the community and offer input to materials and notices. Thank you for working with us and giving us such quick feedback over the past few months. The pandemic and the federal and state declarations of emergency triggered Medicaid flexibilities. In addition, the President signed the Families First Coronavirus Response Act (H.R. 6201) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act that provides increased federal funding in Medicaid and options for states. We have submitting waiver flexibilities and are working with CMS on the items listed below. There have also been many blanket waivers issued by CMS for Medicare/Medicaid providers and we have requested those apply to Medi-Cal-only providers as well. I think we were the first state to implement and could move quickly based on lessons from our previous experience with the fires. CMS has been a partner to DHCS. We have multiple calls with them every week to move the flexibilities that we have through this pandemic.

Ms. Cooper walked through the details of each request listed below (see slides).

- 1135 Waiver Requests (3): We have received some approvals and have a grid from CMS on remaining elements.
- Home and Community-Based Services (HCBS) Appendix K Requests (5): These are approved.
- 1115 Waiver Request (1): The 1115 Waiver has not been approved. DHCS is engaging with CMS on significant aspects although there are elements of the waiver CMS has not engaged us on. We are hoping to see it approved shortly.
- Disaster SPA Request (1): The Disaster SPA was approved retroactive to March.
- Implemented provisions of Children's Health Insurance Program (CHIP) SPA Request to waiver premiums and cost sharing (March 13, 2020)

An Executive Order was signed by Governor Newsom to give Medi-Cal providers and DHCS flexibility with State law. This includes:

- Extending time limitations for administrative hearings and issuance of final decisions related to administration or services.
- Allowing CCS fair hearings by phone or video conference and allowing CCS Medical Therapy Programs to operate in non-school settings.
- Waiving signature requirements for deliveries of certain Medi-Cal covered drugs.
- Authorizing SUD residential treatment facilities to operate beyond limitations of license, for the purpose of ensuring sufficient bed capacity.
- Allowing DHCS and MCPs to delay or suspend annual medical audits, surveys of physician offices, facility site reviews, plan and county data collection from providers, and similar audit or review activities.
- Extending timeframes for MCPs to conduct beneficiary risk assessments.
- Extending deadlines for FFS providers to submit information required for a Medical Exemption Request.
- Permitting DHCS to reimburse county behavioral health departments

administrative costs up to 30 percent of the total actual cost of directed client services.
- Waiving state law, to the extent necessary, to implement federal waivers.

Additional actions and flexibilities related to eligibility were reviewed.

- DHCS issued a Medi-Cal Eligibility Division Information Letter (MEDIL) to delay processing of Medi-Cal annual redeterminations, discontinuances and negative actions for Medi-Cal and CHIP enrollees.
- DHCS established a new uninsured coverage group, COVID-19 Presumptive Eligibility (PE) to provide access to diagnostic testing, testing-related services, and treatment services, including all medically necessary care such as the associated office, clinic or emergency room visit.
- Guidance for applications without applicant signature.
- Allowed for telephonic enrollment in FPACT and Every Women Counts.
- Expand Hospital Presumptive Eligibility (HPE) to include the over 65, aged & disabled.
- Flexibility to cover two HPE periods in a given 12-month timeframe.
- Waive share-of-cost for testing for COVID-19 and if positive, all treatment of services thereafter (pending CMS approval).

Ms. Cooper also reviewed a series of actions and flexibilities related to care delivery such as DHCS guidance and flexibility for providers and managed care plans. In particular, she referenced the pivot to services by telephone and telehealth services as something DHCS wants to learn about for the future. We need to understand how beneficiaries experience this. There were modifications in the policy in 2019, however there was more uptake during the COVID-19 public health emergency than previously observed. Getting lessons learned is critical to know what this benefit should look like going forward. DHCS has minimized administrative burdens for providers including moving to virtual audits, postponing audits and other flexible deadlines. We issued a large number of guidance announcements on the DHCS website and our office of communications is working to revamp the page to reorganize it and make it easier to find information. DHCS has been monitoring managed care health plan networks through daily reporting on physician office and facility closures, even if temporary and due to the emergency. She also outlined ways that managed care plans support providers, such as providing advance payments, accelerating P4P and incentive payments, advancing capitation or claims payments, shifting to capitated provider payments, enhancing rates, providing grants and funding PPE.

Ms. Cooper outlined flexibilities for behavioral health providers as well, including flexibility in opioid treatment and licensing. DHCS implemented new flexibility in payments to county partners for behavioral health services, on both the interim methodology and the county administrative portion.

DHCS received an award of $1.7 million in immediate Federal Emergency Management Administration (FEMA) funding and requested $84.6 million

additional funding over nine months for three elements.

- Expand the Media Campaign as an intervention to normalize the feelings and increase access to the CalHOPE website and the CalHOPE Warm Line.
- Expand the CalHOPE website and app-based tools for mental wellness
- CalHOPE Support provides the personal connection to a crisis counselor.
    - Expand the CalHOPE Warm Line to 24/7, include Spanish language line.
    - CalHOPE Support Crisis Counseling including up to six sessions with a counselor of concordant culture and language with targeted outreach to American Indian/Alaskan Native and student supports.

DHCS launched a new nurse advice line, Medi-Nurse, for FFS Medi-Cal and uninsured to get help related to COVID-19 symptoms, testing, enrollment and self-isolation. A Medi-Cal beneficiary notice and FAQ are being mailed to all 13 million beneficiaries with information related to eligibility, benefits, COVID-19 testing, and resources such as mental health services and what to expect during a telehealth appointment.

In addition to getting flexibilities in place, stabilizing provider payments and ensuring access, DHCS wants to understand the future impacts of COVID-19 and how we need to pivot for health systems and beneficiaries. We are working closely with the CDPH on the decrease in immunization rates. A large number of preventive services were cancelled. We need to focus on how we can increase the immunization rate for beneficiaries. Comparing levels in January/February, we had similar numbers last year for immunizations. However, for March/April, we're seeing a decrease of 40% in immunization rates for children 0 to 2 years old. In March, there was an overall decrease for 0 to 18-year-olds of 40%, increasing to 50-55% in April. We are working on flexibilities for well-child visits to allow for multi-modal, like telehealth, for some pieces and other things in person, like immunizations. How can we work together, learn from the emergency response and make sure children get the visits and immunizations they need? We issued guidance on options to increase immunization rates, especially for those eligible during the pandemic.

That is the overview of efforts on COVID-19. Huge appreciation for everyone at DHCS, working every weekend to make sure people have access. We thank all of you who worked with us to get us information. We have a series of questions for you for discussion.

1. As providers begin to resume deferred and preventive health care, what should DHCS consider?
2. What are the **new** emerging issues and challenges that are appearing as a result of COVID-19?
3. What opportunities, including new flexibilities (e.g., telehealth), have presented themselves that DHCS might explore to improve the effectiveness of the Medi-Cal delivery system moving forward?

**Questions and Comments:**

*Bradley Gilbert, DHCS*: When you put it all together as we just reviewed, the level of flexibility and activity across all of the efforts is phenomenal. We look forward to your input.

*Hector Ramirez, Consumer Los Angeles County*: I receive many services from the county and have recently spoken to stakeholders that will address the first question. First, there is a barrier to information. There is a national disinformation campaign that is confusing people. There is stigma and fear, especially on telecare and difficulty getting access even as far as Wi-Fi, safe spaces to talk and computer services. Language access is a challenge. Being from the Latino community, we are struggling to get timely information and that is one of the reasons for the continuing rise in people contracting COVID-19. Second, accessibility around the ADA and disability accommodations is an issue. Many of us, including myself, are struggling to get information through captioning or interpreters. When it is broadcast, it is not accessible to us and many are forgoing information or paying out of pocket (for captioning). There are issues with regulatory oversight. A complaint can take up to 60 days. I have a family member who died, and I have had to negotiate how to get tested. It is an incredible added stress to fight about not getting access. This is a significant, undue burden to our community, and some have died due to lack of accessibility. We have issues of depression, isolation, anxiety, violence, substance abuse relapse, domestic violence and grief. We have lost our jobs, lives, work and families and many are dealing with suicidality. It is a disenfranchisement of the stakeholder process, the Executive Order and many of the events don't include input from us due to access challenges. I appreciate the leadership DHCS has taken to model how to make it accessible. Another thing I want to address is the increase in hate violence, especially in our Asian, LGBTQ, disabled and other communities. Even those surviving COVID-19 are feeling backlash. I want to offer suggestions shared from community stakeholders: continue to fund the most essential services; maintain supportive housing for psychiatric and co-occurring disorders. I am thankful for Project Roomkey and wonder what will happen when funding goes away. We need targeted training and outreach to the disability community about how to access services during a pandemic and how to modify strategies. We need to look at Child Welfare to ensure whole system collaboration, so families don't drop out of sight. I encourage the expansion of chat lines/help lines. Many of us cannot access services because we don't have the equipment or bandwidth to do it. One suggestion was to encourage DHCS to provide technical assistance to counties and organizations. We need standard practices so access is improved. The IHSS cuts are creating fear they will go to congregate settings and this is making them consider suicide. I can't help but wonder what we can do differently?

*Jacey Cooper, DHCS*: Thank you for these thoughtful and meaningful comments on the impact of COVID-19. DHCS wants to be successful to reach out and serve all beneficiaries. We strive to do better and appreciate the on the ground feedback to help us.

*Bradley Gilbert, DHCS*: Thank you Hector, it is extremely helpful that you reached out and brought us your input. Our condolences on your loss.

*Kiran Savage-Sangwan, California Pan Ethnic Health Network*: I appreciate Hector's comments. We circulated recommendations to DHCS. When we see the striking disparities during the pandemic, it calls for all of us and the state to bring an equity lens to all of the response. What we see in California is not different than across the country, all kinds of issues and racial disparities that are horrifying. I would appreciate spending time now or at a future meeting to think about how we narrow in and focus on addressing disparities.

*Jacey Cooper, DHCS*: That is helpful. What are the top three areas you think DHCS should focus on around disparities as we move forward, especially on accessibility and communication?

*Kiran Savage-Sangwan, California Pan Ethnic Health Network*: On outreach education and accessibility, we think it is really important to have trusted community messengers; this goes back to the comments on the navigator program and is also broader. How do we invest in community resources and structures that are going to be most effective to get information to vulnerable communities? We want to ensure data collected is complete and reflects the disparities. We are concerned about holes in the testing data. It is hard to separate this from the budget conversation because so much of what we are seeing is happening on top of generations of inequity. We need to be clear about what cuts will have disproportionate impact.

*Veronica Kelley, San Bernardino County*: We are absolutely seeing discrimination specific to those with serious mental illness and substance use (SMI/SUD). We have alternative care sites saying no SMI/SUD with COVID-19 may come in. That is stigma. At the same time, we are getting increased mental health requests from the general public. We tend not to incorporate SMI/SUD into the bigger picture of public health. Addiction and mental illness continue, and now people languish in the emergency department or hospital because we can't admit into facilities. Telehealth is a positive option. We have decades-old ethical guidelines on how to provide the service.

*Jacey Cooper, DHCS*: I will follow up with the team on access to services you mention.

*Andie Patterson, California Primary Care Association*: I want to thank DHCS and say that I am proud to live in California. Telehealth has saved the clinics and we want to keep it going. Many pieces of the waivers are contingent on the declared emergency that may be lifted in the summer. Most predict this will return in the fall. How can we be supportive of retaining the flexibilities into the future and not just during the emergency?

*Jacey Cooper, DHCS*: Thank you, we are thinking about this as well and talking to other states to collectively brainstorm the best ways to maximize the flexibilities. One of those includes telehealth with FQHCs. We look forward to continuing to discuss.

*Maya Altman, Health Plan of San Mateo*: You've done a fantastic job. I want to talk about long-term care. The pandemic has had a devastating impact on those in congregate care situations. Two-thirds of the deaths in our county are in these settings

and it has cast a harsh light on the weaknesses. I applaud you and echo Kim's comment that it is hard to build something as you are taking apart community-based services. Just to focus on SNFs, there are two departments involved in oversight. CDPH is the regulator and DHCS, often through managed care plans, is the payer. We need to think about how SNFs can do better. It is not just about money. How can we engage health plans to do creative things with incentives if we offer money and demand quality and behavior change in return? I've been shocked at how hard it has been to do testing in the SNF. We see them struggling with infection control. I see this as an issue that needs to be addressed.

*Jacey Cooper, DHCS*: Thanks. I understand the comments on the transition and the new benefit. I look forward to working with you. I will definitely follow up on rethinking SNF and engaging managed care and public health.

*Kim Lewis, National Health Law Program*: We need consistent policy moving forward to build the changes and think progressively about where we want to go as a system. This is not the time to hold back but be more aggressive to set our vision to make the system better. We need to see this as an opportunity to maintain changes we have made so we can be more effective through telehealth and other ways. We can talk to CMS early to see how we can modify the State Plan Amendment to keep these or other new changes to have continuity going forward. This will be with us for some time and we need to see this as a longer-term agenda.

*Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation*: I want to make sure that transgender-related health care is on the radar. This wasn't considered essential care, so much of their care was deferred or cancelled with no reschedule date. I want to ensure there is support to resume care as both a physical and mental health issue. Access to gender-affirming care is suicide prevention within the trans community. We have been doing gatherings in different parts of the state. We heard that virtual/telehealth support is not safe for LGBTQ youth to use in the home because they may be with rejecting families and can't have the conversation where others can overhear them. Many are participating in virtual support groups sitting in closets and using the chat function so that family members do not know they are participating in a support group. As we consider extending telehealth, we need to think about what it looks like, not just for LGBTQ youth, but also for others living in abusive homes where those supports are not safe. Many LGBTQ elders rely on in-home services to remain in a safe home and are afraid that when IHSS cuts happen they will be unsafe in a SNF or assisted living environment and what that means for mental and physical health. The lack of culturally affirming language access for LGBTQ comes up in every gathering. Folks experience barriers in accessing care and intersectional marginalized identities experience complex barriers. There are delays in immigration and getting documentation and barriers being the primary earner or caregiver for their family. Providers may be LGBTQ-affirming but don't speak their language, don't understand the culture or the reverse. Please keep this in mind as you discuss marginalized identities that we are talking about a context of intersectional identities. We have taken a poll at each gathering and uncertainty about the future is the top concern. I appreciate the Governor laying out the road map for opening up and I encourage DHCS to reduce the uncertainty of the process as much as possible. Lastly,

please ensure the warm line is affirming of sexual orientation and gender identity.

*Bradley Gilbert, DHCS*: Thank you and really appreciate the comment that the number one stress is uncertainty and worry about how is everything going to work for reopening.

*Linda Nguy, Western Center on Law and Poverty*: I want to underscore the need to focus on equity and appreciate the hard work of DHCS getting flexibilities approved. Another issue we hear about, particularly for renewal issues, is that packets are going out with inaccurate information requesting information be turned in or Medi-Cal will end. In addition, CDSS doesn't show all applications coming in. Is DHCS allowing application processing beyond 45 days? We want to reiterate our support for the need for accelerated enrollment and self-attestation. Thank you for waiving the premium for CHIP. Would DHCS consider a blanket waiver for premiums for the working disabled program, the Medi-Cal Access Program (MCAP) and targeted low-income children's program?

*Jacey Cooper, DHCS*: Yes, we are allowing applications within the 45-day window. We continue to think through the mechanisms for the redetermination window. CMS says we can't move redetermination dates but should not issue discontinuances, with the exception of the few allowed. We have issued guidance on this and continue to think about how to reduce administrative burden. That is why we have bulk processing to move forward on applications that don't require follow up. Any system changes in eligibility are a challenge and we are trying to balance all the factors in the decisions we make. We look forward to continuing the conversations.

*Michelle Gibbons, County Health Executives Association of CA*: As COVID-19 continues, there will be hesitation from beneficiaries to share they are having COVID-19 symptoms because of the quarantine requirements. We all need to offset those fears and connect them to resources so they can safely quarantine and not spread COVID-19 among the community. In addition, COVID-19 attacks those with chronic conditions and vulnerable communities at higher rates. These are communities that also don't have prevention strategies. One thing we can do is bridge health care services and public health in thinking through how prevention, such as chronic disease and wellness services, and other prevention, can be integrated into the work as the state starts to rethink how to move Medi-Cal forward. As we pick up CalAIM or a new version, we need to think of prevention and integrate that into Medi-Cal.

*Jacey Cooper, DHCS*: Thank you and if others have comments or information, please reach out to continue the conversation outside of today.

**Status of Waivers, Discussions with CMS and Update on CalAIM**
***Jacey Cooper, DHCS Cooper, DHCS***
Slides available: https://www.dhcs.ca.gov/services/Documents/SAC-BH-SAC-Presentation.pdf

Jacey Cooper reported that DHCS has been working with CMS on a one-year extension

to the current 1115 waiver. CMS has been amenable to the concept. There are details to work out. We want a straight extension. We are waiting for CMS to provide a list of procedural aspects since this falls outside of the normal process we would follow. It is promising that they said we can extend the Specialty Mental Health 1915(b) waiver to December 31, 2021, to align with the timing of the requested 1115 waiver extension. As announced, CalAIM is not in budget and is postponed to future date. We do not have dates and timing at this point. We were excited about the work proposed in the January budget. However, in light of the deficit and budget reduction, as well as hearing from providers that they were not ready to take on significant delivery system changes in the midst of COVID-19, the timing is postponed. It may look different in the future as we pick up this discussion and we look forward to continuing engagement.

**Questions and Comments:**

*Erica Murray, CA Association of Public Hospitals and Health Systems*: I want to thank you and the team for recognition of the need to extend the waiver. We are hopeful the negotiations with CMS will be successful. We have concerns about the budget neutrality aspect of the extension. For that reason, we are pleased to see in the HEROES Act there is a requirement for CMS to approve a waiver extension for any state and waive budget neutrality. We hope this budget stimulus bill will be on a parallel track with DHCS discussions with CMS to extend the waiver with budget neutrality waived.

*Jacey Cooper, DHCS*: CMS is working with several states on waivers. They did mention the stimulus bill on our call yesterday, so they are clearly tracking this issue.

*Anthony Wright, Health Access CA*: Is there a ball-park dollar amount associated with the extension outside of budget neutrality? Is it a positive sign that the 1915(b) waiver was extended?

*Jacey Cooper, DHCS*: We took it as a positive sign. I think it helps that we have been working closely with CMS on CalAIM for a year and a half. They know we are committed to next waiver. I don't have a dollar amount at this time.

*Adam Weintraub, DHCS*: If you have input, you can send it to SACinquiries@dhcs.ca.gov.

**Public Comment**

*Sherry Daley, California Consortium of Addiction Programs and Professionals (CCAPP)*: I am hearing national and state legislators as well administration officials ringing the bell about increases in substance use disorder (SUD) cases. CCAPP produced a white paper, "The Disease of Addiction Thrives on Isolation," that shows an upward trend in deaths from SUD, a relationship between SUD and recession, SUD and individual unemployment, and temporal spikes in deaths after 9-11, the Oklahoma bombing and Hurricane Katrina. All this is creating a dramatic increase in need for services. How will the need for services be measured? In the last recession, many were on wait lists and

didn’t receive needed services, so we don’t have data from that time. Therefore, what metrics will we use now? What is the strategy to expand the physical spaces and workforce levels to meet the urgent and increasing need for services?

*Marty Omoto, Family Member and Executive Director, California Disability Community Action Network:* I was moved and appreciate the words from Hector Ramirez. There are no words to express the issues and what he brought up on a personal level. A lot of us are feeling that. I appreciate DHCS reaching out to communities in this emergency and appreciate the all the hard work of DHCS to help us. Although not the focus here, I want to state our opposition to the trigger cuts in health and human services, those impacting CBAS, IHSS, MSSP and Regional Centers. We want to work together with you as the emergency continues.

*Toni Panetta, National Office of Nurse-Family Partnership (NFP):* Thank you to DHCS staff for the hard work you have done during the pandemic to secure federal waivers, ensure continuity of care, and to provide flexibility in leveraging technology such as telehealth. We recognize the difficult decisions made in the budget. On behalf of the NFP nurses -- who are specially trained nurses working in public health departments to provide specialized nursing services and case management services to at-risk, first time expectant mothers -- we would appreciate the opportunity to continue to partner with you in mitigating the difficult impacts of the proposed cuts, as well as continuing the conversations about the role FNP nurses can play in helping to mitigate the concerns around the reduction in infant and childhood immunization rates and the increased concerns around maternal mental health needs, particularly as a result of social isolation during this time. We have been in conversation with the DHCS Benefit Division and we seek to continue having those conversations and support DHCS’ work.

*Carol Brown, California Foster Care Model of Care Workgroup:* I want to offer what I am seeing on the ground. I am experiencing and witnessing the stress and uncertainty among foster parents and the children they serve, especially non-minor dependents as they navigate new services, mental health and health care. This is especially compounded with out of county placement. Two examples I can offer. One is a teen in school in Los Angeles with diabetes, trying to negotiate a telehealth appointment for care and get needed medication that was quite an effort. Another teen that delivered her first baby. Luckily, she was in our county, but the rules of not having anyone with her that she hadn’t been with for a period of time took a lot of work to make sure she had support during her delivery. What has been discussed about the disabled and high risk elderly populations mirrors what foster parents and youth experience with the lack of computers for school and phones. The iFoster mobile phone program still hasn’t gotten to everyone who needs it. I wanted to add this to the list of populations suffering on the ground.

**Questions and Comments:**

*Ryan Witz, California Hospital Association*: Related to the CalAIM proposal, I understand there are no clear dates or timeline for the discussion. Is there information you can share about what items in CalAIM will continue to move forward? We understand the Medi-Cal Rx proposal is continuing to move forward? Are there items that are budget-neutral that

are continuing to move forward?

*Jacey Cooper, DHCS*: Medical Rx is going live 2021. All other items are being postponed. We don't have dates and won't have information out until later in 2020.

*MJ Diaz, SEIU*: I want to reiterate our budget letter comments and echo the concerns many organizations have shared on the budget cuts, especially CWDA, CBHDA, CSAC and other consumer groups about making sure the Medi-Cal program is sufficiently funded. We understand you have to make difficult decisions. In our point of view, we can't have a cuts conversation without having a revenue conversation. SEIU is trying to find alternative solutions for the significant budget cuts and hope the administration and legislature will have a conversation about revenues.

*Anthony Wright, Health Access CA*: On COVID-19, is there data on utilization on the new aid code for uninsured and presumptive eligibility work? What is the thinking on whether this includes follow up care after hospitalization for COVID-19? Does it cover both uninsured and underinsured – a wrap around for underinsured? Can you dive deeper on new eligibility code?

*Jacey Cooper, DHCS*: The recent data is that 1,400 enrolled in the uninsured aid category although that is a bit old and we have seen an uptick in last few weeks. It does cover testing and treatment although restricted to COVID-19-related services in hospital or clinic. We have issued guidance on how providers need to bill so they don't receive a denial. There were work-arounds in the system to get this implemented rapidly. It will remain in place through the emergency.

*Rene Mollow, DHCS*: As of yesterday, 1,579 are enrolled in the uninsured aid category. We rely on the provider for enrollment and the individual for self-attestation to say if they don't have coverage or coverage for COVID-19-related services.

*Jacey Cooper, DHCS*: The self-attestation would indicate if their insurance doesn't cover the services for COVID-19-related services. Also, they need to ensure they aren't eligible for Medi-Cal.

*Steve Fields, Progress Foundation*: I want to add my appreciation for the COVID-19 response and CalAIM proposal. 2019 was the 20th anniversary of the Olmsted Act – landmark mental health decision of the Supreme Court. I notice as we respond to COVID-19 emergencies and as we look toward congregate treatment, I want to urge us not to lose sight of the principles of the Olmsted Act that say people have a right to live in the community. Those communities that have not been developing a range of 24-hour community alternatives may be tempted to go back to the 1980s and 90s. As we come through the crisis, we can't lose sight of the commitment to develop community systems of care that don't rely on institutional treatment, just because it may be easier in the midst of this emergency.

*Maya Altman, Health Plan of San Mateo*: Another huge issue in this crisis is social isolation, especially for those older, with underlying health conditions or disabled, is a big issue. It will be a long time for things to improve for this group. Health plans are well

situated to do outreach and help people. I encourage DHCS to think how we can encourage and sustain this, how this might be considered a medical cost. It is social isolation, access to food, basic needs. Perhaps through in-lieu-of services or other mechanisms, we can maintain this?

*Jacey Cooper, DHCS*: We are thinking this through and need input from all of you about the impact of social isolation and how we can do this statewide and comprehensively.

*Chris Stoner-Mertz, California Alliance of Child and Family Services*: It has been stunning to see the rapid response by DHCS. As others have said, we are concerned about how to backfill the realignment losses. Given we are starting a conversation on foster youth, how are we going to ensure benefits and that youth get the services they need? We have put in place flexibilities, like technology, and there are other options that don't require waivers. For example, documentation, statewide credentialing, and other flexibilities to reduce costs and bring in additional revenues.

*Jacey Cooper, DHCS*: With the delay of CalAIM, we are looking at timelines for items we can move forward on. We know providers are stressed to get their practices up and running and it has been hard to have policy discussions. We do look forward to continuing to move forward.

*Kim Lewis, National Health Law Program*: Thanks for response on COVID-19. As I mentioned, I want to work with you on how to ask for additional flexibility to sustain existing changes after the emergency, perhaps by amending the 1115 and 1915(b) waivers to prepare for when we come out of this. Even if we have an extended waiver, we need to time this and prepare.

*Anne Donnelly, San Francisco AIDS Foundation*: I echo the thanks. Also echo the importance of using an equity lens moving forward as we ramp up. COVID-19 has illuminated the link between public health and health care as well as the disparities. We see community organizations financially impacted and redirected to COVID-19 testing so they are putting off HIV testing. We worry we will see a surge in HIV, STD and Hep-C cases. There are ways to deliver an integrated testing panel to improve rates. Less than 55% of those with Hep-C know they have it. We want to work with you to effectively address these epidemics at the same time we deal with COVID-19.

**Next Steps and Final Comments; Adjourn**
***Bradley Gilbert, MD, DHCS***

Our next meeting is July 16. We don't yet know the format for that meeting.

This was a really helpful meeting and we appreciate all of you and your comments. It makes it very real for us to hear your input. Special thanks for Jacey and her team. Please continue to send comments and work with us so we can do our bestr going forward.