DEPARTMENT OF HEALTH CARE SERVICES
Stakeholder Advisory Committee (SAC)
February 11, 2021
9:30 a.m. – 12:30 p.m.

MEETING SUMMARY

SAC Members Attending (by webinar)*:* 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; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; MJ Diaz, SEIU; Anne Donnelly, San Francisco AIDS Foundation; Michelle Gibbons, County Health Executives Association of California; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, California Dental Association; Michael Humphrey, Sonoma County IHSS Public Authority; Barsam Kasravi, Anthem Blue Cross; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights California; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Erica Murray, California 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; Janice Rocco, California Medical Association; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access California.

SAC Members Not Attending: Richard Chinnock, MD, Children's Specialty Care Coalition; Lisa Davies, Chapa-De Indian Health Program; Gary Passmore, California Congress of Seniors; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Jonathan Sherin, Los Angeles Department of Mental Health.

DHCS Staff Attending: Will Lightbourne, Jacey Cooper, Rene Mollow, Michelle Retke, Brian Hansen, Norman Williams, Jeffrey Callison, Morgan Clair.

Public Attending: There were 161 members of the public attending by phone.

Welcome, Introductions, and Today's Agenda
Will Lightbourne, DHCS Director

Director Lightbourne welcomed members and introduced a new DHCS staff member, Jeffrey Callison. Director Lightbourne reviewed the agenda and thanked the California Health Care Foundation for its ongoing support of SAC.

Director's Update
Will Lightbourne and Jacey Cooper, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf

Director Lightbourne provided a review of the DHCS budget for fiscal year (FY) 2021-22. He commented that the budget was prepared with the assumption that the COVID-19 public health emergency (PHE) would continue through the calendar year. The Centers for Medicare & Medicaid Services (CMS) has confirmed the PHE with its enhanced federal match and continued eligibility for all current Medi-Cal enrollees through December 2021. In addition, the current budget assumed suspending Proposition 56 payments on June 30, 2021, but the budget proposes delaying the suspension by one year. Other items, including HIV/AIDS waiver providers, home health providers, and pediatric day health care facilities services, have been removed from the suspension. The budget includes investments for behavioral health infrastructure and behavioral health initiatives in schools. The budget includes the creation of a DHCS Office of Medicare Innovation and Integration, a component of the Master Plan for Aging, that aims to lead innovative models for dual eligibles and Medicare-only individuals. There are also resources, both agency-wide and within DHCS, to address disparities and equity. And significantly, California Advancing and Innovating Medi-Cal (CalAIM) was re-launched.

Jacey Cooper provided an update on the revised proposal for CalAIM, which re-launched in January. She reviewed the major upcoming milestones, including the release of Enhanced Care Management (ECM) and In Lieu of Services (ILOS) model of care documents that include Whole Person Care (WPC) and Health Homes transition plans. The components scheduled for January 22 implementation include:

- ECM
- ILOS
- Managed Care Plan Incentives
- Mandatory Managed Care Plan (MCP) Enrollment for Non-Duals
- Mandatory Fee-For-Service (FFS) for Omnibus Budget Reconciliation Act (OBRA) and Share of Cost beneficiaries
- Major Organ Transplant Carve-In
- Multipurpose Senior Services Program (MSSP) Carve-Out in Coordinated Care Initiative (CCI) Counties
- Specialty Mental Health Carve-Out in Solano and Sacramento Counties
- Cal MediConnect to Dual-Eligible Special Needs Plans (D-SNP) Aligned Enrollment Transition Preparation
- D-SNP "Look-Alike" Enrollee Transitions Begin in CCI Counties
- Phase I – Regional MCP Capitation Rates
- Phase I – Improving Beneficiary Contact Information
- Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal
- Behavioral Health Medical Necessity Criteria

Ms. Cooper provided an update on the extension of current waiver programs and commented that discussions with CMS are going well. The Medi-Cal 2020 Section 1115 demonstration was extended through December 31, with the exception of the Designated State Health Programs (DSHP). There are some remaining items under discussion, such as the Global Payment Program, DMC, and Dental Transformation Initiative (DTI). Once finalized, DHCS will post updates on its website. CMS also approved a short extension of Medi-Cal's Specialty Mental Health Services (SMHS) 1915(b) waiver for three months through March 31. CMS has verbally committed to extending the waiver through 2021, but extension approvals will be approved through incremental three to six month extensions.

DHCS is working with CMS on a new 1115 waiver and consolidated 1915(b) waiver for approval by January 2022. DHCS will start a public stakeholder process for both waivers in spring prior to submission to CMS.

Mr. Lightbourne thanked members for the rich and informed dialog on racism and equity at the last SAC meeting. The state budget is framed with an equity perspective and provides resources, especially in health and human services, to develop externally facing data dashboards and measures to close disparities. DHCS is restructuring its quality management systems into a single operation that will be led by a to-be-named Chief Quality Officer. With the support of CHCF, a consultant is examining existing data and identifying gaps. The next step of this process will be the development of recommendations on metrics across the whole system for implementation over the coming months and years to identify, and start to close, disparities through contracting, purchasing, planning, and evaluating systems. Updates will be provided to the SAC as recommendations emerge.

Questions and Comments

Barsam Kasravi, Anthem Blue Cross: I want to offer Anthem's support to inform the race/equity approach. Anthem has been looking comprehensively across the state at this topic related to the COVID vaccines. In volunteering at a vaccination site in a predominantly African-American neighborhood, I noted only about 5% African Americans getting vaccines. There is opportunity with vaccinations and education as well as the disparities we are noting more broadly with Healthcare Effectiveness Data and Information Set (HEDIS) scores and other long-term components. This is an important priority.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I am grateful and appreciate DHCS speaking to the goal of making specific recommendations related to disparities. Is there a timeline on when those recommendations may come to the SAC? One item we have been pushing for is a race and ethnicity breakdown on COVID Medicaid coverage for the uninsured. What are the budget assumptions post-PHE about the number of individuals who will lose Medi-Cal coverage?

Jacey Cooper, DHCS: The budget assumes that once the PHE approved through December 2021 ends, there will be a 12-month timeline for completing the re-determinations for Medi-Cal eligibility. CMS guidance indicates six months; however, California is large, and we expect it will take longer. Medi-Cal's enrollment peak of 13.5 million beneficiaries from several years ago was declining pre-PHE and then increased back up to 13.5 million during the PHE.

Will Lightbourne, DHCS: I expect that bringing metrics to the SAC will be an ongoing process beginning with the next meeting.

Erica Murray, California Association of Public Hospitals and Health Systems: Public hospitals are ready to partner in this important race and equity work. It seems there is an interest in consistency across state agencies on quality measures, and it is appropriate for DHCS to take the lead. Are there also conversations with Covered California or other entities for a broader approach?

Will Lightbourne, DHCS: Yes, there are workgroups across Covered California, CalPERS, and others on how we are capturing and measuring disparities. As we move forward, and given the different populations for each entity, the priorities and strategies may differ.

Linda Nguy, Western Center on Law and Poverty: We really appreciate your willingness to ask CMS for clarification to remove the immigration status question on the application form for COVID coverage to make the process less scary. When might DHCS complete this update?

Jacey Cooper, DHCS: We are working with CMS as quickly as possible, and we will update you soon.

Linda Nguy, Western Center on Law and Poverty: I appreciate that. On CalAIM, I don't see any milestones related to plan readiness for the transition to mandatory Medi-Cal managed care. For example, will there be a network adequacy review, continuity of care? Will DHCS share that data?

Jacey Cooper, DHCS: Yes, we are working on those pieces and timelines and will share soon. There is current focus also on data sharing with plans on the number of lives and other information. We brought in Manatt to assist us in this, and as soon as we have current information, we will share.

Linda Nguy, Western Center on Law and Poverty: We appreciate that housing support services will be a statewide benefit and are wondering if there is a timeline for when that will happen.

Jacey Cooper, DHCS: We hope that many of the MCPs will embrace this via ILOS outside of WPC to help get the infrastructure started. We don't have a timeline now and expect that we will know more later in 2021 when plans provide more information on ILOS.

LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies: I am excited to hear about the new quality position and the leadership focus on race and equity. I want to highlight that I am hearing about vaccine hesitancy from Black and other providers of color who are educated on health and yet have their reasons for not wanting to engage in vaccination. It is not solely community or consumers who are hesitant. The National Council for Behavioral Health has an excellent resource on demystifying vaccine for staff.

Anne Donnelly, San Francisco AIDS Foundation: My comment is to encourage DHCS to partner with the Department of Public Health on disparities work. My question is whether there is any progress or update on gathering COVID-19 data related to sexual orientation and gender identity.

Jacey Cooper, DHCS: We will get back to you.

Michelle Doty Cabrera, County Behavioral Health Directors Association: Will there be upfront

stakeholder engagement on the quality work or will that follow the recommendations? I commend you all for really integrating equity into the CalAIM proposal. As we broaden the scope of how Medi-Cal can reimburse for community-defined practices, investments through the Mental Health Service Act is important as well.

Will Lightbourne, DHCS: The consulting group is from Sellers Dorsey supported by CHCF.

Ryan Witz, California Hospital Association: We are pleased to see the significant investments in behavioral health commitments and infrastructure and services given the past year's experience. Will both the $750 million for behavioral health infrastructure and the $400 million for student mental health go out by June 2022 to be expended over three years?

Will Lightbourne, DHCS: Yes, they are one-time appropriations to be spent over three years.

Jacey Cooper, DHCS: There will be an application process for the $750 million and a local match required for the infrastructure funding. We will use an incentive on top of capitation rates to health plans for the $400 million that will start in January 2022 and draw down over three years.

Ryan Witz, California Hospital Association: The budget establishes health care affordability as a priority with new positions and an Office of Health Care Affordability in the Office of Statewide Health Planning and Development. The intent is that the office would establish limits on growth in health care spending beginning in 2022 and eventually enforcement of those limits. Will the new office work on Medi-Cal affordability? Will we see a shift to the Oregon approach that would limit growth in overall Medi-Cal spending?

Will Lightbourne, DHCS: DHCS is the single state agency responsible for Medi-Cal. We develop budgets for the Agency and Governor. We are strategically informed by thinking across state agencies.

Ryan Witz, California Hospital Association: If the new office were to establish a 3% cap on growth, would DHCS modify their budget to align with this?

Will Lightbourne, DHCS: The reality is that we do not yet have experience on this to speak from. The goals will need to reflect the reality of almost one-third of the population in Medi-Cal.

Jacey Cooper, DHCS: I would add that there are additional complexities in Medi-Cal financing, and we would have to be involved.

Maya Altman, Health Plan of San Mateo: You mentioned some agencies you are working with related to equity, and I want to put a plug in for including the Department of Managed Health Care because I think they are also looking at this related to health plans.

Barsam Kasravi, Anthem Blue Cross: What is the level of risk associated with CalAIM being approved? Do you foresee formal approval before the launch date?

Jacey Cooper, DHCS: Similar to other waivers, we do need CMS, approval and CalAIM has multiple federal funding mechanisms that fall into different parts of CMS. We have already had kickoff calls and conversations with CMS and are starting early engagement. However, there can be negotiation all the way to the end. We will communicate changes and progress as we go.

Carrie Gordon, California Dental Association: It is great to see the delayed suspension of Proposition 56 and backfilling the budget gap. I am pleased to report that we have doubled the enrollment of dental providers to 2,000 new providers since the beginning of Prop. 56. We appreciate the work to transition the DTI into Medi-Cal. We have thoughts about how oral health can be more fully integrated into CalAIM and will submit those as comments on the CalAIM proposal.

Cathy Senderling, County Welfare Directors Association: We appreciate the focus on equity. We see the race and equity impacts on the communities we serve and are all in to work on this. I also appreciate the focus on accountability measures. On the PHE and eligibility work on renewals that are on hold, I will note that some are now two years old and have been pulled out from batch systems. The cases need to go back into these systems, and we are committed to an orderly process so people don’t come off Medi-Cal unnecessarily.

Stephanie Sonnenshine, Central California Alliance for Health: Can you say more about the timeline for applications on the $400 million for school health and conversations with community partners?

Jacey Cooper, DHCS: We will work with health plans during 2021 on what the incentives and the process will be, and roll out those incentives in 2022.

Stephanie Sonnenshine, Central California Alliance for Health: There is language in the budget about data sharing and health information exchange.

Jacey Cooper, DHCS: We want to set a vision for where we're going with data sharing in the future and make sure people are tracking it, but there is no actionable item at this time.

Michelle Gibbons, County Health Executives Association of California: We are pleased about the future dialogue on race and equity. We need to hold on to the lessons learned from COVID that public health needed to go upstream to prevent people from getting sick, not just supporting them once they were sick. From an equity perspective, public health looked at where a person lived and what the risk factors were to go broader and make sure that we were addressing the other challenges communities were facing to make sure that they did not show up in the health care system. I would ask that public health be looked at as a core partner in this effort. They have been working on equity for quite some time and have good ideas to bring to the table. Health equity is broader than health care; it spans home visitation to where individuals live and grow.

Will Lightbourne, DHCS: Absolutely, equity work will be embodied within CalAIM. In addition, CalAIM has population health as a key focus, and that is where it intersects with public health.

COVID-19 and Impact on Medi-Cal Program, Medi-Cal Enrollment Update and COVID-19 Dashboard
Jacey Cooper and Rene Mollow, DHCS
https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf

Jacey Cooper provided updates on COVID-19. The U.S. Department of Health and Human Services (HHS) had issued a renewal of the PHE through April 20, 2021. The Biden Administration announced it intends to renew the PHE through the end of calendar year 2021 and will provide a 60-day notice prior to the end of the PHE. Ms. Cooper also provided an update on recent federal flexibilities during the pandemic, including COVID-19 testing in schools for Medi-Cal children, a State Plan Amendment to increase rates for oxygen, flexibility on behavioral health to stay in crisis units beyond current time limits, and others.

SAC members received extensive data slides with details on Medi-Cal enrollment in advance of the meeting. Rene Mollow highlighted enrollment data and commented on key metrics for data through December 12, 2020. Medi-Cal applications are increasing, but the application numbers still trail 2019 levels. Online applications continue to increase and the numbers are higher than in 2019, but in-person applications are significantly lower. She reviewed new enrollment data and commented that new enrollment is lower because beneficiaries are not being dis-enrolled and are able to stay continuously enrolled in Medi-Cal. DHCS is not seeing the churn that is normally present. Total Medi-Cal enrollment is significantly higher with13.4 million enrolled in 2020, up from 12.6 million in 2019. Ms. Mollow provided data by age, gender, race/ethnicity, and primary language. The total enrollment for COVID-19 coverage is 93,000. She reported that the problem of inadvertent enrollment discontinuances is no longer happening. DHCS has been working closely with county partners since November on this issue.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can you review the pie charts for the total number of kids on slide #45? It would be helpful to see the total new enrollment for children. Is it possible to get that before our meeting?

Rene Mollow, DHCS: We will follow up with you and work on a different way to display the data for the next posting on the website, and let you know when it is available.

Kristen Golden Testa, The Children's Partnership/100% Campaign: From the numbers here, it looks as if total enrollment for children has not increased as much as the general Medicaid population, and that is concerning.

Linda Nguy, Western Center on Law and Poverty: On enrollment data, it is clear new enrollment is down. What is DHCS' take on that?.

Jacey Cooper, DHCS: Normally, new enrollments would have included those reapplying

because they dropped off Medi-Cal for various reasons. Because of the policy to provide continuous enrollment during the PHE, the new enrollments due to this churn is low. When we go back in time, we see that 2016 is the peak and as the economy improved, people started dis-enrolling from Medi-Cal and not staying on the program. The lowest point of total enrollment was pre-COVID and now we are back up to the 2016 enrollment levels. Some of that is due to continuous enrollment, and some is due to the economic downturn. California has a high saturation of Medi-Cal enrollment compared to other states.

Linda Nguy, Western Center on Law and Poverty: We appreciate DHCS' work to request extending coverage for vaccines and are wondering about CMS' approval timeline?

Jacey Cooper, DHCS: We are engaging with CMS, but I don't have information on the approval timeline.

Barsam Kasravi, Anthem Blue Cross: Unemployment has increased, yet we aren't seeing an increase in enrollment. Are you saying we expect to see increases in the future?

Jacey Cooper, DHCS: Previous data indicated that some of the populations going onto unemployment were already enrolled in Medi-Cal. However, we do expect new enrollments in the program to occur. There are likely a number of factors explaining the lack of significant enrollment numbers up to now, including stimulus checks and the rent moratorium. Many people enroll when they seek services, and there is a steep decline in utilization. COVID is different than other downturns so it is challenging to understand. We continue to look at the data. CHCF is helping us dig into data and analyze it to identify any populations that we need to target for outreach.

Barsam Kasravi, Anthem Blue Cross: It may be interesting to look at potentially eligible members by race and ethnicity. It seems that African American and even Latino enrollment percentages are low, and it may be useful to examine the enrollment process and whether the process creates barriers; whether language, culture, ethnicity, and race are barriers; and how we can be creative to make the enrollment process work for different populations.

Maya Altman, Health Plan of San Mateo: Can you offer an update on the pilots you mentioned last time we met to expand enrollment and use social media to address the drop-off?

Rene Mollow, DHCS: We launched the social media toolkit and met with stakeholders to fine tune messages. We put that information out to enrollment navigators, added it to the website, and are having the information translated into all of our Medi-Cal threshold languages. There are active efforts to work through operational issues for accelerated enrollment through the CalHEERS portal as well.

Michelle Doty Cabrera, County Behavioral Health Directors Association: I want to mention that the county behavioral health safety net is seeing an increase in uninsured individuals with psychiatric emergencies. We are trying to understand this increase and will keep you informed.

Kristen Golden Testa, The Children's Partnership/100% Campaign: This is a valuable conversation. Looking at the CMS data, California is at the very bottom of enrollment, even though we're average on the economic impacts. I'm not sure why we would be so different than other states experiencing similar high saturation of Affordable Care Act (ACA) expansions. The conversation on new enrollment makes sense for adults, but for kids, their income eligibility is so much higher that I wouldn't expect the same movement due to economic changes. It should be steady and yet the enrollment is low for kids and new enrollments are low. It will be valuable to get that breakout of the new enrollment for kids.

Jacey Cooper, DHCS: Another difference in California is that we have a coverage mandate that other states don't. We do think our ACA saturation is higher than other states. We provided the data on presumptive eligibility (PE) and see a decline in enrollment through the Child Health and Disability Prevention (CHDP) Gateway that hasn't gone back up. The trend is the same for women through PE. These trends track with the decline in outpatient services. We hope that as people re-engage in health care, it will reverse this trend because we know that the in-office visits that drive PE enrollment have been lower.

Rene Mollow, DHCS: We are also looking at why people do not follow through with the full application following PE. We have streamlined the process as much as possible, but continue to look at what challenges people experience because we are not netting enrollment from PE.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Does the continuous eligibility in place as part of the PHE apply to PE?

Rene Mollow, DHCS: It does not.

Cathy Senderling, County Welfare Directors Association: I want to flag another recent trend. We've been receiving a high number, as much as twice as many as in prior years, of the quick-sorts from the Covered California call center representatives sent over to county call centers. We are thinking this may signal an uptake. We will be tracking this and will provide more information as we know more.

Will Lightbourne, DHCS: We should not underestimate the lingering effects of the public charge and anti-immigrant policies in the past administration. There are subtle patterns apparent in the increase in "not reported" on ethnicity categories and the shift in language choices that are showing up. Policy changes from the new administration may reverse this trend.

Jacey Cooper continued with information on the COVID-19 dashboard. The focus areas for utilization of services include COVID-19 cases, hospitalizations, and testing as well as utilization of services prior to and during the pandemic. The data are subject to encounter claims being submitted so it may continue to evolve, and DHCS will post updates to the website as the data are refreshed. Ms. Cooper highlighted data on new COVID cases by month, age of the individual, race and ethnicity, and comparisons of FFS and managed care. She also reviewed data on hospitalizations for 2019 compared to 2020 and data on COVID-related hospitalization showing higher rates for older adults and non-White

populations. COVID testing data include total numbers for any tests billed to Medi-Cal by age, gender, race/ethnicity, and delivery system. She noted there were lower testing rates for the Asian/Pacific Islander population. Total emergency department visits were lower after March 2020. There was higher utilization for African Americans and Native Americans than other populations.

Ms. Cooper also presented data on telehealth visits, which increased sharply in April 2020 and remain high, although they are declining. The total outpatient visits were higher in 2020 over 2019 during January and February 2020 pre-pandemic, but are down sharply through the remainder of 2020 even with telehealth visits included in the totals. Dental visits had a stark decline in March 2020, but visits across the rest of 2020 are trending up faster than some medical data. Ms. Cooper reviewed behavioral health data for mild-to-moderate and non-specialty mental health visits. Utilization is trending up after a dip in April 2020. More than one-third of the non-specialty mental health visits and more than half of the mild-to-moderate visits were provided via telehealth. Visits were higher for males than females, and higher for White than other populations.

Finally, Ms. Cooper reviewed data for prescriptions, noting they declined overall in 2020 compared to 2019 and were highest for women and for White populations. The Vaccines for Children program totals show upward trends through 2020 after the lowest utilization in April 2020, but Ms. Cooper noted that there are not sufficient increases in recent months to catch up with the missed vaccinations in the early months of 2020.

Questions and Comments

Carrie Gordon, California Dental Association: The lower dental utilization during COVID is concerning, and we have not yet seen a return to pre-pandemic utilization. We want to partner with DHCS to encourage patients into care, through such messages that it is safe and shouldn't be put off, because complications can arise fast, especially for kids.

Jacey Cooper, DHCS: Yes, even with an assumed data lag, dental is not back to pre-pandemic levels. We are pleased to see dental increases, which are even faster than outpatient care.

Carrie Gordon, California Dental Association: We appreciate the commitment to include dentists as vaccinators and want to ask for DHCS to resolve the challenges in reimbursement for vaccine administration.

Status of DHCS Telehealth Policies
Jacey Cooper, DHCS
https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf

Jacey Cooper presented on existing and proposed telehealth policies. She noted there was a significant expansion of telehealth services implemented in 2019 prior to the PHE. Given the experience through the PHE, DHCS conducted a deep dive across all delivery systems to identify telehealth changes for the post-PHE timeline. During the PHE, Medi-Cal extended all applicable Medi-Cal services to be provided via telehealth. Notably, this

included both Home and Community-Based Services (HCBS) and the Local Educational Agency (LEA) and Targeted Case Management (TCM) program services that were allowed to have telehealth services when they were not previously available. The PHE flexibilities also included new and established patients and telephone/audio as well as video with payment parity to in-person visits.

CMS guidance is that if DHCS allows telephonic visits to be reimbursed, they would have to be reimbursed at the clinic PPS rate. Given the principle of payment appropriateness, and since California is not doing this across all delivery systems, we chose not to recommend this flexibility going forward for clinics. DHCS is engaging in discussions of Alternative Payment Methodologies with health centers to maximize telephonic and other virtual communication. She noted that the budget includes $94.8 million total funds ($34 million General Fund) to implement remote patient monitoring services as an allowable telehealth modality in FFS and managed care delivery systems. This will require a State Plan Amendment.

Questions and Comments

Erica Murray, California Association of Public Hospitals and Health Systems: Thank you for recognizing the importance of telehealth services for low-income and minority communities during the pandemic. It has been a lifeline for so many patients. As we engage with leaders on their experiences, the modality of telephone comes up often. We hope there can be a reconsideration on voluntary phone visits. They are especially important for vulnerable patients without access to technology for a video visit, or for individuals where there are challenges in getting on a video visit, as well as for public health care systems still putting in the infrastructure to provide video services. When I asked whether it is really the same kind of care if you can't see a patient, one physician leader said it is more detailed and takes longer for a telephone visit than a video visit because without those visual cues, you have to ask many more probing questions. I appreciate the dialogue and want to continue talking about this.

Chris Perrone, California HealthCare Foundation: I echo the comments and would flag the health equity considerations we are seeing from video and phone telehealth. Is CMS saying if you wanted to extend telehealth telephone coverage that it is not an option to have a PPS carve-out or to have a service specific PPS rate for telephone visits?

Jacey Cooper, DHCS: No, CMS indicated that a physician doing a telephonic visit would have to be paid at the established PPS rate. If the visit was not provided by a billable provider, it could potentially be paid at a carved-out rate, but it is our understanding that the visits are primarily provided by billable providers.

Anne Donnelly, San Francisco AIDS Foundation: Can you clarify if telehealth reimbursement is for both individual and group visits?

Jacey Cooper, DHCS: Yes, it is.

Bill Walker, MD, Contra Costa Health Services: I echo the significant value of telehealth and

telephone-only. What we may have uncovered from this PHE experience is not necessarily only behavioral health implications from COVID, but underlying access issues for behavioral health. Continuing telehealth proposals in behavioral health is extremely important. I'm wondering if the reluctance to adopt a policy that would allow telephonic access is based on questions about the quality of telephonic access or concerns about fraud and abuse.

Jacey Cooper, DHCS: I want to clarify that DHCS is allowing telephonic audio-only services to be provided across all delivery systems with the exception of FQHCs. It will have a separate fee schedule. FQHCs are not included because of the payment parity complexity.

Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers: What is the rationale for not including payment parity for telephonic visits?

Jacey Cooper, DHCS: I can follow up with you.

Update on Medi-Cal Managed Care Procurement
Michelle Retke and Brian Hansen, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf

Michelle Retke and Brian Hansen presented an update on DHCS Medi-Cal managed care commercial health plan Request for Proposal (RFP) procurement and timelines. Brian Hansen outlined the opportunity for counties to transition to a managed care model that includes a local plan for the implementation of new commercial and potential new local plans in January 2024, with DHCS review and approval. This is up to the counties to initiate. If the county transitions to a model that includes a local plan, DHCS may remove that county from the commercial plan procurement (for a single local plan model) or reduce the number of commercial plans procured in the county (for a Two-Plan or Regional model). Mr. Hansen reviewed the timeline that would accompany a decision by a county to change its model. This includes a Letter of Intent (LOI) to be submitted with the plan by the county to DHCS by March 31, 2021. DHCS is available to offer technical assistance. He also went over the required review and potential statutory changes required depending on the county proposal. For example, a new County Organized Health System (COHS) requires more complex federal review and a potential legislative change or waiver. Mr. Hansen also reviewed the information required in the LOI. DHCS will also review current and historical quality data and performance for the plan and readiness information. He concluded with the overall timeline for model changes and noted that the commercial plan RFP will commence soon after the final model change information is completed in fall 2021.

Michelle Retke provided feedback on the Request for Information for commercial plan procurement timeline and process. Feedback was received from 76 entities, such as health plans, associations, advocates, and others. There were 1,135 comments. Ms. Retke summarized five highlights.

Ms. Rekte reviewed the timelines. The final RFP will be released in late 2021 or early 2022, and implementation will begin in January 2024. She commented that there will be 60 days between the release of the final RFP and its due date.

Questions and Comments

Ryan Witz, California Hospital Association: Given the RFP is focused on commercial plans, will DHCS re-evaluate local plans, or is the LOI for regions where there is no local plan? Is there an opportunity to break off from a current regional model county?

Brian Hansen, DHCS: The LOI is for potential new local plans, not existing local plans. Yes, a county can pursue a different model from a current regional model, if they wish.

Bill Walker, MD, Contra Costa Health Services: In the event a county wants to pursue a new COHS status, how will federal approvals impact the timeline?

Brian Hansen, DHCS: We encourage any county considering this to reach out as soon as possible to DHCS for technical assistance because there are scenario-specific topics that would impact the timeline. It may require federal legislation or an 1115 waiver expenditure authority. DHCS can't guarantee approval so there is risk. The process would be a LOI to DHCS, then a county ordinance and state statute process by mid-2021. If CMS approval is required through a waiver, DHCS would pursue that after 2021. If federal legislation is required, the county would pursue that.

Will Lightbourne, DHCS: One element to add is that if it is an 1115 waiver process, it is subject to renewal every five years.

Barsam Kasravi, Anthem Blue Cross: On the LOI, will there be transparency for public review?

Jacey Cooper, DHCS: We will make clear who has filed an LOI, and that will be public. We don't have any intent to post the LOI documents sent for internal review, but they are public documents.

Barsam Kasravi, Anthem Blue Cross: As plans prepare, we need to invest in collaboration, particularly in new counties. This requires considerable investment of time and effort. The timeline for notifying us that a county is not an option for us to pursue application is too close to the final submission date. I would request you revisit the proposal timeline because if we really wouldn't know until 30 to 60 days ahead that a county is no longer an available option for a commercial plan, this may be after considerable effort.

Jacey Cooper, DHCS: That is helpful. We will take that back and let you know if there is a change.

Medi-Cal Rx Update
Rene Mollow, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf

Rene Mollow provided an update of the Medi-Cal Rx initiative. In January 2021, Magellan successfully launched the vast majority of Transitional Supports and Services it will be providing before full implementation of Medi-Cal Rx. These include:

- Medi-Cal Rx Customer Service Center, which is available to take calls 24 hours a day, 7 days a week, 365 days per year.
- Expanded web portal functionalities for providers, health plans, and beneficiaries, such as the Medi-Cal Rx Provider Manual, Pharmacy Locator Tool, and searchable Contract Drug List.
- Expanded outreach to health plans and prescribers, inclusive of targeted meetings and trainings.

Since the last update, DHCS received formal written notice of a merger agreement between Centene and Magellan. This merger is subject to regulatory oversight from the Department of Managed Health Care and federal agencies. The merger is expected in the third quarter of 2021, which would be after scheduled Medi-Cal Rx implementation. The contract with Magellan does include a conflict-avoidance plan for any real or potential conflicts. There must be independence from any pharmaceutical company or health plan. DHCS will be reviewing the conflict avoidance plan and will continue to update you. The slides provide additional data on progress related to provider registration and call center metrics. There is ongoing outreach to pharmacies and providers to make them aware of Medi-Cal Rx.

Public Comment

Hector Ramirez, Consumer, Los Angeles County: I am a person with autism, a psychiatric disability, and I am hard of hearing. I am a consumer of mental health services. I thank the Department for the investment in the stakeholder process that went into creating CalAIM, which will be important to our community. We are now dealing with so many pandemics we don’t know where to start. Moving forward in the conversation of racism and equity, it is important to note that for heavily impacted communities like Latino, Native American, and Black communities, terms like “justice” are up for determination. And, for Black, Indigenous and People of Color (BIPOC) and the disability community, terms like “justice” and “health” mean different things to different groups. There is a need to have conversation about the word “equity.” The pandemic has changed this. It is a privilege of wealth and opportunity to be able to engage here, and I am very aware that so many don’t have a place to sleep or food. The work the state is doing is fantastic, but don’t leave us behind. We are used to getting information in clinics, but that no longer happens. I am requesting that you consider how access to the stakeholder process has equity, and how to take into consideration someone who is not part of an agency.

Next Steps and Final Comments; Adjourn
Will Lightbourne, DHCS

Director Lightbourne requested that members submit any additional questions that were not included during the meeting due to time constraints. The questions and comments will

be included in the meeting summary. Mr. Lightbourne thanked participants for attending and sharing their thoughts. He reminded members of the quarterly meeting dates for 2021.

2021 DHCS Stakeholder Advisory Committee Dates

- April 29, 2021 – 1:30 p.m. – 4:30 p.m.
- July 29, 2021 – 9:30 a.m. – 12:30 p.m.
- October 21, 2021 – 1:30 p.m. – 4:30 p.m.

Addendum: Additional Questions from SAC Members and DHCS Responses

Question: There are significant parity ramifications for not reimbursing FQHC audio-only appointments at parity with video appointments. What data and evaluation components will the department be using to investigate the impact of lower reimbursement for audio-only on access to telehealth for marginalized communities-- including those who lack access to broadband or are unable to use more advanced technology?

> **DHCS Response:** We have begun to analyze our data on the use of telehealth services by select stratifications and delivery systems. These analyses are in the early stages due to data reporting lags and will continue to be refined over time. As information becomes more available, we will report our findings.

Question: What is the department's plan to collect data, evaluate, and report on the impact of telehealth on not only access to care, but also health outcomes? We support strong evaluations to look at how diverse populations are differently impacted by virtual care, including access to technology and language access. We also need stronger examinations of not just access and utilization of telehealth, but how the modality affects clinical health outcomes.

> **DHCS Response**: We plan to continue to report on telehealth utilization and access to care across our delivery systems and covered populations. Tying these modalities to health outcomes will take time and will depend on having quality data. We will continue to work and report on this area, as well as evaluate any available research to help inform our work going forward.

Question: What counties have expressed interest in changing their Medi-Cal managed care model?

> **DHCS Response**: No counties have submitted an official letter of intent. If a county submits the required letter of intent, this will be an official statement to DHCS that the county is pursuing a model change. DHCS will then make this information available to the public. DHCS is continuing discussions with association stakeholders, including Local Health Plans of California, County Health Executives of California, California Association of Public Hospitals, and California State Association of Counties. DHCS has provided responses over the last two years to many stakeholder technical questions about changing the model type. DHCS will

inform stakeholders if counties submit an official letter of intent.

Question: Are we doing not just reprocurement, but recontracting for county health plans that are not changing their status? Would that be on the same or a different timeline as reprocurement?

DHCS Response: The managed care plan (MCP) Request for Proposal (RFP) is a procurement for commercial plans only. The timeline for any new local plans that join a county will be the same timeline as the RFP, and will become effective on January 1, 2024. Current local plans, either Local Initiative (LI) plans or County Organized Health Systems (COHS), will also be held to any new contract requirements effective January 1, 2024, and the new requirements will be reflected in their 2024 contract amendments.

Counties interested in shifting to a model that includes a local plan must, along with the accompanying MCP, submit a letter of intent (LOI) to DHCS by March 31, 2021. To request a one-month extension to submit a LOI, the county must contact Brian Hansen at brian.hansen@dhcs.ca.gov before the March 31 deadline. The purpose of the extension is to allow sufficient time for counties and plans to complete the LOI information submission, including coordination between counties and plans, and securing county Board of Supervisors' approval.

Question: How does the dashboard and metrics discussed in the health equity part of the agenda interact with the reprocurement process? How are those racial justice and disparity reduction goals included in the RFP process?

DHCS Response: DHCS is addressing health disparities in a number of ways, which is informed through data sources, including the annual health disparities reports and dashboard data. DHCS is working to improve and expand on our reports while also diving deeper into existing data to better understand identified disparities. DHCS will also work with the MCPs to identify and address the root causes of disparities, particularly within CalAIM's Population Health Management (PHM) initiative. PHM requires MCPs to aggregate information at a population level to design programs, utilize multiple data sources to risk-stratify their population, and address risk and needs through various levels of care management and community partnerships. Based on these efforts, DHCS will develop comprehensive requirements that MCPs must meet to drive efforts in addressing health disparities.

Question: Can you confirm that beneficiaries will now need both their managed care card and a BIC due to the transition? How will DHCS ensure access if people seek the COVID vaccine or prescription drugs without a BIC? Are beneficiaries and pharmacies being told about other ways to ensure that a prescription is filled in the event someone doesn't have the physical BIC?

DHCS Response: Once Medi-Cal Rx is operational, beneficiaries will need both their managed care card and their BIC. As a reminder, the BIC is needed for any services the beneficiary accesses that are not part of the managed care plan, which today include such services as dental, specialty mental health, and prescription

drugs that are carved out of managed care, such as blood factor.

Question: We are concerned about the Magellan-Centene merger and its impact on the success and goals of Medi-Cal Rx. What would constitute enough conflict avoidance that would allow the Magellan participation in Medi-Cal Rx to continue? If what the company proposes is not sufficient would the contract be rebid? Since the merger is slated to be final after Medi-Cal Rx starts, does this change the April 1 start date for Medi-Cal Rx?

> **DHCS Response**: DHCS announced on February 17, 2021, the delay of Medi-Cal Rx due to the need to work very closely with Magellan on having acceptable conflict avoidance protocols and adequate firewalls in place between the corporate entities to protect the pharmacy claims data of Medi-Cal beneficiaries and other proprietary information. DHCS takes very seriously this proposed merger and understands the concerns that have been raised by our plan partners and others. The Department will work to ensure transparency in this matter as these protocols are developed, and will engage with an independent third party entity that will assist in this matter. A new Go Live date has not been determined, and further information will be provided in May.

Question: I heard that Medi-Cal data comes from claims. What is source of the state data? A reporter inquired about this slide. I didn't take call, but suggested that comparison presented here is likely apples to oranges and likely not a good reflection of differences between Medi-Cal population and all Californians. Would you agree?

> **DHCS Response**: As noted on slide 64, the Medi-Cal data comes from DHCS MIS/DSS Claims and Eligibility data. The state data are derived from the California Open Data Portal (ODP), which is based on the data collected by the CDPH California Reportable Disease Information Exchange (CalREDIE) system. The Medi-Cal data represent claims and encounters received by DHCS, but does not represent all people in Medi-Cal who have been tested. This preliminary data provide a view on the current available information.

Question: What do you make of this decline in ED visits? One interpretation (or hypothesis) is that this lower rate reflects ED use that is unavoidable, and this is a benchmark for what ED use should look like post-pandemic – i.e., if it rises again, it's an "early warning" that that people are using ED for care that could be provided elsewhere, and that would be if access to care outside ED was better. I'd be interested in your perspective on this hypothesis.

> **DHCS Response:** While we agree that the hypothesis you present may be one explanation, we believe that more analysis is necessary before drawing conclusions. We will be working on this in the coming months. In particular, we must understand changes in utilization by condition and population. Some considerations that may inform the analysis include:
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> - Nationally, the decrease in ED use was most pronounced among those ≤14 years of age, females, and located in the Northeast.
> - There are many studies, including some by the CDC, that have demonstrated that people are presenting to the ED with more severe symptoms (as

reflected by corresponding increase in hospital admissions with complications).

- Stay at home orders reduced exposures to risk factors: schools were closed, athletics canceled, telework replaced driving, and curfews reduced late-night contact. There were mostly likely fewer individuals with illness and injury that would have needed to visit the ED.
- Data are preliminary, and additional claims are expected to be received, although the general trend line will most likely hold.

At this point, it may be premature to conclude that we should use COVID ED rates as a benchmark for ED use post-pandemic.

Question: The California Medical Association (CMA) continues to urge DHCS to postpone the implementation of the Medi-Cal Rx program. DHCS' initial implementation delay to April 1, 2021 is insufficient to ensure a smooth and safe transition for beneficiaries. A very small percentage of the tens of thousands of prescribing providers have registered for the CalRx program, and an even smaller number of them have received the necessary information to begin to use the portal – the primary mechanism that will exist for providers to submit authorization requests for their patients. Sticking with the current timeline has the potential to impact (and disrupt) millions of prescriptions for patients.

CMA recommends aligning the Medi-Cal Rx implementation with the implementation of the CalAIM initiative, as was previously envisioned. Postponing implementation until such time as the CalAIM transition occurs and a significant majority of Medi-Cal prescribers have registered and are trained to use the Medi-Cal Rx portal will help make it possible for Medi-Cal Rx to be successful.

DHCS Response: Please see our prior response on Medi-Cal Rx and our delayed implementation.

Question: My question is related to DHCS' planning for the redeterminations after the COVID pandemic period (post-public health emergency): DHCS has indicated that they are now working with counties on planning for staging their redeterminations. Could stakeholder/consumer advocates be included in these planning discussions (rather than bringing stakeholders in later in the discussions)?

DHCS Response: DHCS is still in the planning stages of this effort, and is working closely with our county partners and representatives of the Statewide Automation Welfare Systems on our initial thinking for the unwinding efforts, which will also be informed by federal guidance. We will provide periodic updates on the status, and will engage with stakeholders once we have a better sense of what is feasible and allowable from the federal perspective.

Question: I also had asked in chat to get the more detailed budget assumptions on enrollment that Jacey offered in response to my question. I was interested in getting the budget assumptions for the monthly drop in enrollment due to the 12-month post-PHE redetermination process (e.g. starting in Jan. 2022, the monthly estimated number of

enrollees dropped from coverage due to the PHE redetermination process).

> **DHCS Response**: The budget assumes that between the continuous coverage population and the labor market impact population, enrollments would decrease by approximately 275,000 eligibles each month beginning in January 2022. Please note that caseload projections will continue to be revised as actual data become available.

Question: We wanted to know if telehealth participants are allowed to consent remotely, so providing their signatures remotely to treatment plans, service consents and other documentation required for services to be eligible for reimbursement under title 22. This is important for the folks we serve with disabilities and other challenges, for whom local providers are not available, including those with HIV, etc. and those who can't for a variety of reasons attend face to face sessions on a regular basis, including many LGBTQQI and BIPOC folks.

> **DHCS Response**: Individuals may consent remotely. To the extent electronic/remote consent is obtained, providers must ensure that those signatures, and communications related to them, comply with all federal and state privacy rules.

Question: The second question is whether we can discuss additional flexibilities in communication with clients. As an example, the guidance allows for texting, but limits what can be discussed to appointment reminders, cancellations, that sort of thing. Some folks want to utilize text for more. We aren't suggesting engaging only via text, but allowing for a broadening of the limits can be useful for some clients in more meaningfully supplementing other forms of contact and encouraging a deeper level of engagement. So we would like to know if DHCS is open to exploring more flexibility in engagement modalities (always in the context of HIPAA compliance) because the more limitations there are around how we engage participants and on which platforms, the more likely we are to lose those with the least access to traditional health care systems.

> **DHCS Response**: MCPs and providers may use text messaging and phone calls to contact their members within the restrictions of the Telephone Consumer Protection Act (TCPA). The TCPA allows "health care" messages, as long as they comply with HIPAA's marketing restrictions. If MCPs and providers want to expand their use of text messaging to beneficiaries, DHCS recommends that they obtain the members' written consent to be contacted by phone or text.