DEPARTMENT OF HEALTH CARE SERVICES
Stakeholder Advisory Committee (SAC)
July 16, 2020
9:30 a.m. – 12:30 p.m.

MEETING SUMMARY

Stakeholder Advisory Committee Members (SAC) Attending (by webinar)*:* Maya Altman, Health Plan of San Mateo; Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; 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; Chris Perrone, California HealthCare Foundation; 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; Jonathan Sherin, LA Department of Mental Health; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access CA.

SAC Members Not Attending: Michelle Doty Cabrera, County Behavioral Health Directors Association; Michael Humphrey, Sonoma County IHSS Public Authority; Gary Passmore, CA Congress of Seniors; Andie Patterson, California Primary Care Association; Stephanie Welch, Department of Corrections and Rehabilitation.

DHCS Attending: Will Lightbourne, Jacey Cooper, Lindy Harrington, Rene Mollow, Anastasia Dodson, Adam Weintraub, Morgan Clair.

Public Attending (by phone): There were 318 members of the public attending by phone.

Welcome, Introductions, and Opening Comments
Will Lightbourne, DHCS Director

Director Lightbourne introduced himself to SAC members as the new DHCS Director. As many know, I am not new to state or public service and have served as California Department of Social Services (CDSS) Director in the Brown administration and in

several counties prior to that. I am honored to join the Newsom administration and the incredible team at DHCS. The team's talent and leadership alongside the Health and Human Services Agency, stakeholders, and sister agencies will be critical to address the challenges ahead. We are facing not one, not two, but three pandemics. The coronavirus pandemic -- which is doing so much damage to our communities, our economy, and our budgets at the state and local level -- on top of the pandemic of income inequality that has been steadily worsening since the 1980s. That pandemic has been enabled in many ways by the pandemic of inequity, rooted in racism. Challenges and crises do create opportunities, and the DHCS team is deeply committed to working with all our partners to focus on bringing responses to all three of these crises in the short-term, and then in the long-term. A lot has been done already and we will build on that foundation to move forward. Let us now get to work on the agenda in front of us today.

State Budget Update
Will Lightbourne and Jacey Cooper, DHCS

Will Lightbourne introduced the state budget discussion. The May Revision proposal was significantly different than the January proposal, yet necessary as a starting place given the extraordinary deficit. Subsequent collaboration and negotiation led to a fairly good outcome, maintaining status quo for most DHCS and human service programs.

Jacey Cooper offered an overview of the budget. The approved budget was quite different than the May Revision, with almost all of DHCS reductions being rejected and/or funded. Also, DHCS is not subject to budget triggers that many departments are experiencing. There were slight adjustments to the costs associated with the caseload and COVID from the May Revision. We worked closely with the Department of Finance (DOF), the Legislative Analyst's Office, and Legislature on those changes. We have now turned from budget process to implementation.

The approved budget includes the change in the Skilled Nursing Facility (SNF) payment reform. COVID changed the landscape and we are taking a different approach than the quality-based payment reform originally proposed. We will be working with nursing facilities, (California Department of) Public Health and other partners to implement the changes in the SNF payment items, especially around data metric mitigation plans. We are working with (California Department of Social Services) CDSS and California Statewide Automated Welfare System (CalSAWS) on timelines for the eligibility pieces that remain in the DHCS budget so we can be transparent on go-live dates for new eligibility groups. We will be engaging with California Primary Care Association (CPCA) and California Association of Public Hospitals (CAPH) and other partners on the 340B Supplemental Payment Pool methodology. We will provide updates on State-only Claiming Adjustments. The hearing aid proposal remains in the budget with different start dates. You will see information coming from DHCS in the next few weeks to make everyone aware of timing.

Questions and Comments:

Maya Altman, Health Plan of San Mateo: Can you say more about the SNF metrics for payments? Are you going to put in some kind of metric where they have to achieve certain things to get the 10 percent payment? What are you thinking about here?

Lindy Harrington, DHCS: The 10 percent is not tied specifically to metrics. We will look to cost report auditing to ensure that the 10 percent was spent on COVID-related expenditures, such as increased costs associated with staffing or increased costs for Personal Protective Equipment (PPE), to ensure the money went for its intended purposes. The one requirement is that they have to submit their COVID mitigation plan to the California Department of Public Health (CDPH) in order to be eligible for an annual rate increase in future years.

Anthony Wright, Health Access CA: I understand from your presentation there isn't a date yet when the removal of the senior penalty on income will be implemented. I just wanted to see if there was even a ballpark timing on that. Also, on the budget item to expand Medi-Cal to undocumented seniors, what is the timing of implementation of that? Is it on hold? Is there preliminary work on notices or other things to get ready?

Jacey Cooper, DHCS: For the first question around the Federal Poverty Level (FPL) expansion, I don't want to give you a date that's going to change. The teams are actively working together, DHCS and CDSS, CalSAWS, California Welfare Directors Association (CWDA) and others to discuss timelines and what is possible. DHCS has indicated this is a priority given we were originally going to implement August 1. As soon as we have a date, we will let you know. We also will be required to update our State Plan Amendment (SPA) with the new date so it will be very public. On the second question around senior expansion, it is going to be subject to budget, and we do not have a date or anticipated milestones currently.

Will Lightbourne, DHCS: I think DOF will lead the expansion and they will set timing that would initiate our pre-work.

Linda Nguy, Western Center on Law and Poverty: I appreciate the transparency related to implementation timelines and urge a timely implementation of the Aged, Blind, and Disabled income limit. We've heard this could be delayed to next May. During the current public health crisis, it will be particularly important these individuals have health coverage and access to care without a share of cost that may be over half their income. We recognize that August 1 may not happen but would strongly urge a timely implementation and retroactive eligibility.

Jacey Cooper, DHCS: I want to note that it will operate with the date moving forward from the start date in the State Plan Amendment. There will not be a retroactive eligibility on this. I agree with your sentiment on the priority and the need to move quickly.

COVID -19 Update, Medi-Nurse and Telehealth Continuation
DHCS Staff

Slides available: https://www.dhcs.ca.gov/services/Documents/071620SACWebinar.pdf

Jacey Cooper offered information and an update on COVID actions. As reported previously, DHCS put forward almost five dozen waiver flexibilities to the Centers for Medicare & Medicaid Services (CMS). Most have been approved with the exception of the 1115 Disaster Waiver that has a number of pieces. We are working actively with CMS on the approval and hope to have approval soon, perhaps in stages as with a previous 1135 Waiver. The public health emergency continues, and we continue to evaluate flexibilities for what is needed in the delivery system. We are also looking at flexibilities we currently have that may need to continue outside of the public health emergency and we are having conversations with many of you on these opportunities, such as the telehealth expansion.

We are starting to analyze our data from a utilization and information point of view to have a better picture of services in Medi-Cal during COVID. We are seeing a huge decrease in immunizations for children and are working with managed care plans, stakeholders, and advocates on this. We will continue to do so given the low numbers for children getting preventive and immunization services compared to previous years.

We also are looking at services for individuals who, during the early months of COVID were not seeking regular care for diabetes, congestive heart failure, or other conditions. We are working to ensure people get regular care. We don't want this to build up and become a different crisis a year or so from now. We will continue to review data to identify gaps and work with many of you to provide information and address them.

Rene Mollow reviewed slides to offer an update on telehealth and other flexibilities received as part of the public health emergency. In 2019, prior to the emergency, DHCS engaged in a stakeholder process and deep dive on telehealth policy. Policies previously were narrower and limited to specific diseases. The resulting approach is a more comprehensive delivery of services and decreased barriers for providers. The policy leaves it to providers to identify the best modality and the most appropriate way to leverage the use of telehealth. We received over 500 comments during that process and finalized the policy in 2019. That work was fundamental to the ability to flex in response to the public health emergency.

Providers have the flexibility today, outside of the public health emergency, to determine what service delivery is appropriate for the patients that they serve. That can be in-person, audio visual, two way communication with the beneficiary, or store-and-forward technology. For example, information is captured in one location with one provider and transmitted to another provider for additional review. We allow for e-consult between licensed providers to do consultations (not available for clinic providers). Beneficiaries retain the choice in the type of service modality. These policies are available across the entire Medi-Cal delivery system.

As we looked at the flexibility during the public health emergency, we requested and CMS approved the addition of telephonic services that can serve as an alternative to a face to face visit under specific circumstances. The services have to meet the intent of

the face-to-face visit, but because of the social distancing in place, this flexibility was implemented. Typically, the originating site would either be an office or clinic setting, but again, because of the social distancing, it was allowed for the beneficiary to initiate the telehealth visit from their home/location. This is also allowed across the board for both licensed practitioners and clinic providers. This allows establishing patients using a telephone modality and we hear from clinics this is a value-add flexibility. If it meets requirements for a face-to-face visit, clinics bill their all inclusive rate or prospective payment rate. If the visit does not meet the requirements, they can still bill at a reduced rate established by CMS. Clinic partners can also leverage the use of Associate Marriage and Family Therapists and Associate Clinical Social Workers as billable providers. As Jacey noted earlier, we will be looking at what flexibilities should continue once the public health emergency is lifted, and working with federal partners to determine if additional federal requirements are needed to continue those flexibilities. As I mentioned, the telehealth provisions implemented prior to the emergency did not require additional federal approval.

As we look at our dental programs, dental telehealth is a narrower set of services, but they do have the flexibility to bill. Dental providers and allied dental health professionals can render limited dental services either via live teledentistry or store/forward for specific codes. We also allow for dental providers to do consultation services by telephone or video and they can bill this procedure code in lieu of an in-person visit.

Questions and Comments:

Kim Lewis, National Health Law Program: Related to data, when might we be able to see data related to telehealth and other specific COVID data?

Jacey Cooper, DHCS: We are just starting to look at the information now. As you know, there is a lag on claims and encounter data, typically it is 6-8 months for data to be complete for public reporting – sometimes even a year depending on the data. We know there is a need to start looking at this sooner, so the team is reviewing utilization, specifically on telehealth now, as it is starting to come in from managed care plans.

Anastasia Dodson, DHCS: We also are reaching out to managed care plans to find out what data might be available, even if it is not in our usual structured format or is anecdotal. We are happy to share that and keep you all informed.

Jacey Cooper, DHCS: What is being reported verbally, and we are trying to confirm, is a drop in utilization statewide. We want to see what the visits were for – COVID vs. other health needs and the split between telehealth vs. in-person. We will look at all of the components as we dig into the data.

Kim Lewis, National Health Law Program: My second question is whether DHCS will adopt a more flexible standard around telehealth, including allowing texting, in particular, for people who have issues with privacy or are seeking sensitive services. Other states including Washington have done that on the behavioral health side. Have you explored that, or can it be looked into being allowed in California at least to some extent?

Jacey Cooper, DHCS: We have talked to Washington about their policy but are still considering the options in regard to next steps on texting in California.

Paul Curtis, CA Council of Community Behavioral Health Agencies: California received federal funding to support behavioral health telehealth infrastructure that is being overseen by the Sierra Health Foundation. Apparently, there is a requirement that community based organizations (CBOs) be licensed with both counties and DHCS. Most CBOs are only licensed with county and that precludes them from accessing the funding. It's a barrier that doesn't seem to make sense so I'm hoping you can comment on that.

Jacey Cooper, DHCS: This is the first I am hearing of this issue. We want to follow up on what you are hearing and figure out if it's a true barrier. It may relate to the fact that we can delegate enrollment functions to another entity like a county. Please reach out to Kelly Pfeiffer and Jim Kooler and cc me so we can look into it internally and get back to you. We would not want to preclude you from accessing those funds, so let us see what we can do to remove the barriers.

Anne Donnelly, San Francisco AIDS Foundation: Two comments on concerns about what we are missing due to the impact of COVID. We are very concerned about testing for HIV, hepatitis C and STDs. We are definitely seeing a drop off in both testing and, in some cases, treating, especially in hepatitis C. We will bring forward some ideas about how we might continue to address these important epidemics while we're also dealing with COVID. Secondly, we really appreciate you getting flexibility from the federal government on telehealth. Providers are concerned about how long the flexibility will continue and appreciate the opportunity to continue this discussion. Most providers believe it would be helpful if all of these provisions could continue or at least most of them. They are particularly concerned about group counseling for substance use disorder as it is an important component of the delivery of care. I also want to amplify Kim's requests to look into the possibility of texting as a mode of service delivery as well.

Jonathan Sherin, LA Department of Mental Health: A couple of high level comments about telehealth. You talked about meeting the intent of face-to-face and I would ask us to take a step back and look at the intent of delivering the service and whether the service being delivered effectively, efficiently, and in accordance to the preference of our consumers. Clients and providers are in a great place to drive and sustain what seems like an incredibly good direction for us. This innovation is a wake-up call to the potential of telehealth, and I don't think viewing it from the perspective that face to face is a gold standard makes sense. We are finding in LA that we are actually having more contacts per month and that our clients in general are quite pleased with the telehealth platform and prefer it. I think we cannot ignore that in terms of what we advocate for.

Jacey Cooper, DHCS: I acknowledge what you are saying. The intent is about meeting the billing service requirements that you would normally do if it is in-person. We have seen a remarkable ability to reach beneficiaries. People are more apt to show up to their telehealth and telephonic appointments. We are hearing that across the delivery system and especially on the behavioral health side. We are thinking through making sure that all these touches are resulting in good quality health services and how to assess that

across physical and mental health and would appreciate any thoughts you have. When is it appropriate? When is it not? What are the quality outcomes we should see from this? How do you ensure patient choice is still driven through that process?

Bill Walker, MD, Contra Costa Health Services: I appreciate the work on expanding telehealth. It has been so important, not only in Contra Costa County for behavioral health programs, but particularly for our outpatient maintenance of care. With all of us talking about the benefit of it, what do you see as the federal obstacles for continuing it beyond COVID, if you should so choose?

Jacey Cooper, DHCS: I think there is support from CMS. Medicare is looking at substantive changes to their telehealth policy in light of learnings from the public health emergency. There are historical federal barriers to some of the flexibilities we have now that have to be evaluated and removed for us to make it permanent. There is momentum with a lot of states to expand the telehealth and telephonic footprint. I think you will see momentum across the U.S., including from the federal government for future changes.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: I want to echo the need for data. I have communicated this previously and appreciate that you are working on it. Specifically, we want to see what utilization looks like and what the changes look like by race and language. We can't assume that telehealth is working for everyone. The barriers include access to technology and internet, but also are deeper, such as whether people trust the technology, feel comfortable sharing their private information, and understand the technology. As the conversation moves forward about making these flexibilities permanent, we really need to be careful that we are significantly considering the consumer experience and making sure that this is really working for the people receiving care. Second is the consumer education piece, calling people in advance of their appointments, explaining how the technology works, answering their questions. There is going to be a need for effort that is culturally and linguistically competent to make sure that the modality is effective, particularly for communities of color.

Rene Mollow continued with an update on the Medi-Nurse line implemented during the emergency. DHCS is excited about this service and want to make you aware of it and ask you to promote it. The Medi-Nurse line offers 24/7 advice and is designed for people without health insurance or who have fee-for-service (FFS) Medi-Cal but don't have a regular doctor to oversee their care. Medi-Nurse is not designed for callers who already have a health plan that covers COVID-19 services. The Medi-Nurse line is available in all threshold languages supported by the Medi-Cal program (17 languages, including English). Callers can ask questions about COVID-19 symptoms and get referrals to resources. If callers present with COVID-19 symptoms, they are transferred to a trained nurse for clinical consultation and triage. Uninsured callers are also referred to a qualified provider in the county of the caller who can perform presumptive eligibility (PE) determinations for temporary coverage to obtain COVID-19 testing and treatment services. Since the launch in May, there have been over 11,000 calls with 81% being uninsured. Ms. Mollow also reviewed data by county and demographics.

Questions and Comments:

Erica Murray, CA Association of Public Hospitals and Health Systems: Can you say more about how decisions for referrals are made on the Medi-Nurse line?

Rene Mollow, DHCS: It is focused on giving them information for their local county, like identifying testing sites. We leverage information between CDPH and DHCS as it relates to qualified providers.

Jacey Cooper, DHCS: In addition, if someone is in a managed care plan, we refer them to their plan because they need to be within network. If it is a FFS individual without a regular doctor, we refer to the FFS provider network in that county or local area, and try to guide them to follow up. We tend to refer to public hospital systems and FQHC partners given their role in the safety net.

Kim Lewis, National Health Law Program: Thank you for standing up this service. It is important to have a service for people to get help when they are having difficulty knowing the right information on testing and treatment and what's covered and what's not. One thing I want to report as feedback is that partners from health consumer lines have reported that the Medi-Nurse line staff were not aware of the COVID PE program. What education or training do they receive on coverage of testing and treatment, so they are not just referred to provider, but also know that they can get coverage?

Rene Mollow, DHCS: Thank you for that. That was also relayed to DHCS and we have followed up to ensure they are triaging correctly and that they understand the resources available for those referrals. We have regular calls to follow up on things like this.

Anthony Wright, Health Access CA: What happens if they have non-COVID questions or issues? Also, how does this interact with county programs for the uninsured, like My Health LA or Healthy SF?

Rene Mollow, DHCS: Good question, I will double check. As you know this is focused on solutions for COVID. We can go back to see if they have those types of additional local county resources you mention. We provided them county contact information to apply for Medi-Cal if they are uninsured and that process would lead them to local county support programs.

Anthony Wright, Health Access CA: Thanks, some counties have robust medical home programs and it would be good to connect people when there is opportunity. My other question is how you are marketing this? My organization and I think others would be happy to take that on, but it would be helpful to know what you're already doing. Is there specific targeting given this is focused on an uninsured population.

Rene Mollow, DHCS: Yes, it is both uninsured and Medi-Cal FFS populations. We use our social media platforms to publicize and we are working on outreach materials.

Jacey Cooper, DHCS: DHCS sent a COVID-19 notice to all 13 million beneficiaries.

Adam Weintraub, DHCS: We are also doing an extensive social media campaign in both

English and Spanish and developing information to share with stakeholders they can pass along in their own outreach.

Michelle Gibbons, County Health Executives Association of CA: In terms of the referrals to county or state testing sites, the prioritization is changing. I am curious about how that has been adjusted into the advice of the Medi-Nurse line.

Jacey Cooper, DHCS: We are continually looking at public health guidance for testing and that is what we use as our platform for the materials we provide to the contractor. If public health guidance changes, we align. You raise a good point about county differences. We may not be able to always capture differences county to county.

Michelle Gibbons, County Health Executives Association of CA: I want to mention that the testing task forces put together a county by county database where you put in your zip code and get information on available testing. That may be something to include in the tools that you offer to folks.

Rene Mollow, DHCS: Thanks, that is very helpful. I would appreciate if you and others would follow up to email me directly anything you think would be helpful.

Update and Discussion of Plans for Medi-Cal 2020 1115 Waiver Extension
Will Lightbourne and Jacey Cooper, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620SACWebinar.pdf

Jacey provided a high level overview of the proposed one year extension of the current Medi-Cal 2020 1115 Waiver. During the public health emergency, counties, providers, hospitals, plans and other stakeholders let us know that due to their immediate response to COVID-19 and the significant changes proposed in CalAIM, they would not be able to engage in successful planning and implementation of a new waiver at this time. And we really listened to that feedback and also had concerns with our ability to be successful in light of the COVID response going on across the state. We started engaging with CMS in the spring to extend the current 1115 waiver for one year. We are having good conversations with CMS and are moving forward. Technically, to have an extension, they have to provide guidance to us about criteria for the proposal. They provided that a few weeks ago and we are putting the package together. They were not able to waive the public hearing requirements tied to the submission so DHCS is rolling that out now. To clarify, this is not about the California Advancing and Innovating Medi-Cal (CalAIM) proposal. This is a straightforward proposal limited to a one-year extension. She briefly reviewed the components of what will be included:

- Medi-Cal Managed Care
- Whole Person Care
- Global Payment Program
- Drug Medi-Cal Organized Delivery System
- Low-Income Pregnant Women
- Former Foster Care Youth

- Community-Based Adult Services
- Coordinated Care Initiative
- Dental Transformation Initiative & Designated State Health Programs (DSHP)
- Tribal Uncompensated Care
- Rady's CCS Pilot

The Public Hospital Redesign and Incentive in Medi-Cal (PRIME) will not be part of the extension and will transition to the Quality Incentive Program (QIP) originally proposed as part of CalAIM. The request was submitted to CMS in early 2020, and we had been engaging with CMS. As many of you know, this was one of the larger pieces of the New York extension and there is sensitivity around this item. We are working closely with our public hospital and district hospital colleagues to make this successful and to move this program into the QIP.

We are proposing to continue the Whole Person Care (WPC) program as currently structured. We will request the ability to modify pilots to respond to COVID-19. This is also a part of our 1115 Disaster Waiver. Some pilots have been able to meet the COVID moment already with their WPC pilots, but we want to be explicit in allowing for budget adjustments or minor tweaks to the pilots to address the unique emergency.

On the Global Payment Program (GPP) and Dental Transformation Initiative (DTI), we will be asking for a 12-month extension and are actively working on an amendment with CMS for the GPP program because it had a different time period and technically expired June 30, 2020. The amendment will extend through the end of this year and then will be a part of the one-year extension for continuity. We are also requesting continuation of the Safety Net Care Pool (SNCP) funding as part of the one-year extension. We don't know the outcome of what might happen with SNCP.

On the Drug Medi-Cal-Organized Delivery System (DMC-ODS), CalAIM proposed a large number of potential modifications. As part of the extension, we have included some smaller modifications. One of our commitments to CMS in the one-year extension was to make as few changes as possible to get the extension approved timely and to continue services as California responds to the public health emergency. What we put forward is the removal of the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period.

We are really aligning to subsequent 1115 Waivers on Substance Use Disorders (SUD) Services and Institutions for Mental Disease (IMDs) and clarifying that reimbursement is available for SUD assessments in appropriate treatments, even before a definitive diagnosis is determined. We had extensive conversations about this in CalAIM, and we just want to make it clear in our Special Terms and Conditions (STCs) that it will be allowable. We will be clarifying the recovery services benefit and expanding access to Medication-Assisted Treatment (MAT). We also will be looking to increase access to SUD treatment for American Indians and Alaska natives.
Some eligibility categories require authority through an 1115 waiver, including Low-Income Pregnant Women, Former Foster Care Youth, Community Based Adult Services and the Coordinated Care Initiative. The DTI will continue, including the designated State

Health Program as a mechanism for payment and it will transition to the State Plan in 2022. Domain 4 of the DTI will be discontinued. The Tribal Uncompensated Care waiver amendment will include the requirement for California Rural Indian Health Board to contract with any willing Tribal Health Program enrolled in Medi-Cal. Rady's CCS pilot will continue for one year.

The biggest financing components will be WPC and GPP, specifically the request to extend the SNCP for the additional extension year. We will also maintain all items that were considered budget neutral in the previous waiver. On May 8, we formally requested an extension to the state's 1915(b) Specialty Mental Health Waiver, which was set to expire June 30, 2020. We received a six-month extension to December 31, 2020, acknowledging the need for an additional extension request due to the delay of CalAIM. CMS said that they would work with us to ensure that the Specialty Mental Health extension aligns with the 1115 Waiver and DHCS is now seeking a second extension to the 1915(b) waiver to December 31, 2021. CMS understands the need to align timelines but did not want to do an 18-month extension, as that's not something they typically do.

Public Comment steps are listed below for submission in mid-September.

- The 30-day public comment period will start on July 22, 2020
- Waiver extension request & all other documentation will be posted on the DHCS website
- Comments made at public meetings will be transcribed
- Written comments can be submitted to 1115waiver@dhcs.ca.gov by COB on August 21, 2020
- Written comments on the 1915(b) waiver extension can be submitted to MCBHD@dhcs.ca.gov by COB on August 21, 2020
- Tribal Consultation (held via webinar): Wednesday, July 29, 2020
- Public Hearings (held via webinar): Friday, August 7, 2020, 3:30 p.m. – 5:00 p.m., and Monday, August 10, 2020, 2:00 p.m. – 3:30 p.m.

Adam Weintraub, DHCS: It is worth noting that the 1115 waiver comments mailbox is the same one that's been used for previous waivers. The Behavioral Health mailbox listed for the 1915 waiver is a new email address.

Questions and Comments:

Michelle Gibbons, County Health Executives Association of CA: Can you offer more context about why the DTI Domain 4 is proposed to be eliminated?

Rene Mollow, DHCS: It is primarily because it was a pilot that looked at success under the other three domains of the DTI – the overall success we are trying to accomplish through the DTI. There are projects that have not met the goals and that was taken into consideration for what we wanted to include in the extension request.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I understand that we are exhausting the pilot timeline, however given that many services could not operate in the final year of the pilot due to COVID, is there not a reason to extend the same way

other pilots are extended for one year?

Rene Mollow, DHCS: For Domain 4, we looked over the full term of the waiver time of the pilot – not just this year and we are not seeing the success we wanted. To the credit of the entities approved for funding, they did their best, but just have not been able to achieve the successes that we anticipated that we would see.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I would ask for re-consideration of extending given they were not able to have the final year of the pilot project because of COVID.

Rene Mollow, DHCS: Thanks, we will take that into consideration.

Anthony Wright, Health Access CA: On financing, I understand that WPC requires funding. Does the GPP, especially with the expansion of the SNCP dollars, require additional money from the federal level beyond the flexibility of the Disproportionate Share Hospital (DSH) dollars? Can you help me understand the argument you are making for that in a budget neutrality context? Or is this a waiver of the budget neutrality context because of the extenuating circumstances? And then finally, how can we be supportive of this effort since we have an interest in getting these dollars and getting the support and flexibility from CMS for a year?

Jacey Cooper, DHCS: Sure, there are things in the waiver that do and don't impact budget neutrality. Nothing is changing in regard to budget neutrality with the proposal of a one-year extension. For the extension on WPC and GPP, we will need continued federal funding for the additional year. We were always planning to continue GPP even in our full five-year 1115 renewal. The difference between the two asks is that in the previous five year renewal, we were not going to, and had communicated and committed with CMS, not to move forward on the SNCP portion of that. Now we are asking CMS to include SNCP funding for the one-year extension, especially in light of COVID. We don't know what the outcome with CMS will be, but we have given them a heads up. We are going to want a strong level of support from California for the extension, given the utmost importance for our public hospital and district hospital systems.

Anthony Wright, Health Access CA: What is the SNCP funding amount?

Lindy Harrington, DHCS: The total SNCP is $472 million with $236 million from CMS.

Anthony Wright, Health Access CA: What is the likelihood of approval? Are there pieces you think are more vs. less likely to be approved? My last question is whether CalAIM or some version of it might restart next year?

Jacey Cooper, DHCS: Based on initial discussions, there may be additional conversation with CMS related to the SNCP and funding for the DTI. We expect calculation of the budget neutrality will be an area of conversation. We will submit to them in September. They will go through their own review and federal checklist to make sure it is a complete submission and go through their public posting process. Then we engage in negotiations. There is a possibility we won't have approval for an extension before the end of the

waiver. CMS has in the past given us short extensions to move forward. We don't get those extensions until we have a formal proposal in place with them for negotiations. I meant to mention earlier that CMS does have an expectation that while we are doing this one-year extension negotiation, we also continue conversations with them on the 1115 renewal to come forward the following year. So, we have to get our full proposal in for that renewal which is wrapped around CalAIM proposals. We are evaluating that in light of the public health emergency as well as the budget. We will continue those conversations with stakeholders.

Maya Altman, Health Plan of San Mateo: Can you confirm you are feeling optimistic about the request for WPC?

Jacey Cooper, DHCS: I am feeling optimistic about the one-year WPC extension. It may come down to the numbers on budget neutrality. We have been able to demonstrate to CMS success of the pilots. We have a pathway forward and a plan for the next steps on WPC after the waiver that helps.

Erica Murray, CA Association of Public Hospitals and Health Systems: This is a lifeblood for public healthcare systems to catalyze delivery system transformation. It is especially important in this time of the COVID pandemic to secure ongoing funding. I want folks here to be aware that in parallel, we are working with the Congressional delegation on language in a stimulus bill that would require CMS to approve the extension. This is a backstop to the masterful work DHCS is doing with CMS.

Kim Lewis, National Health Law Program: It is quite an undertaking during an election year to get this approval. I commend the ambition on that. Given there are some changes as part of the extension request, have you settled entirely on the question of other, additional changes for either of the waivers? There are some changes we were hoping to see before 2022 and I am wondering if it is too much to draft and finance this proposal and get it in to CMS in addition to taking feedback on changes that could be made sooner? Are you open to additional changes?

Jacey Cooper, DHCS: Are you referencing primarily the 1915(b) Specialty Mental Health waiver? Our strategy is to secure the extension as is, and then we can always engage. Changes would require additional comment from stakeholders, and we don't know if that could be achieved and still secure the one-year extension. We are looking at whether we can make other changes before 2022, because the changes you are referencing are considered budget neutral, right? We will continue to look at it, but this initial push will just be a straightforward extension. CMS also said that they may have requests for us that result in changes. We do not have details on that yet.

Jacey Cooper, DHCS: There is a question from the chat, regarding recovery services to be posted July 22 for review and comment. It will be similar to the engagements that we had during the CalAIM work groups, if that helps with the comment.

Linda Nguy, Western Center on Law and Poverty: Considering the disproportionate impact COVID-19 has had, it would be worth thinking about how we can ensure that those served in the WPC don't skew white as we saw in the early evaluation. Is there

particular outreach to ensure that people of color and limited English proficient populations have access to this program?

Jacey Cooper, DHCS: We would be happy to engage in those conversations with you. UCLA has produced demographic data regarding who has and has not been reached in WPC. I'm happy to engage in a learning collaborative or information gathering or make it clear to our pilots about DHCS priorities, to make sure that we are providing equitable services and reducing disparities across our population.

Medi-Cal Enrollment Update
Rene Mollow, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620SACWebinar.pdf

Rene Mollow noted a couple of caveats on the enrollment data. This information covers application data coming through the county portal or application pathways, and the information is very preliminary. It shows that we are likely to start seeing increases in our enrollment forthcoming. As we look at the data over time, it becomes more complete and usually by month three, it is a more complete data set.

She reviewed data for 2019 and 2020, including multiple pathways for applications into the county (phone, mail, FAX, email) as well as "other," which includes navigators. The data is at the application level and may include more than one person per application.

- In-person applications showed a dramatic decline, likely related to the public health emergency and reduced hours at County offices.
- Phone applications rose sharply beginning in March 2020.
- Mail and fax applications continued at steady levels.
- Other applications declined somewhat beginning in March.

Ms. Mollow reviewed data from Quarter 1 applications on the California Health and Human Services (CHHS) Open Data Portal (ODP). Applications from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) were 253,000; phone was 11,600; mail/fax were 600 and email were 48. Other application pathways included agents, with 94,000 applications, and certified enrollment counselors, at 15,000 applications.

Ms. Mollow also reviewed data breakouts on new enrollments and demographic data. She noted ethnicity and language data show higher Latinx enrollments in 2019 and a decrease in 2020. This may be a chilling effect resulting from the federal rule changing public charge policy, despite efforts to message that Medi-Cal is available to all. She also presented data on Medi-Cal re-enrollments, individuals who had a gap in coverage and were discontinued but subsequently came back into coverage. The total enrollment data shows a slight dip in March and increasing enrollment following. She also reviewed data on services through COVID-only presumptive eligibility. Enrollment in this category has increased to 11,000. As result of federal guidance, there will be modifications to secure a more formal application for this program and DHCS will provide details as they become

available.

Questions and Comments:

Kristen Golden Testa, The Children's Partnership/100% Campaign: Thank so much for the breakouts. It is helpful to see, although the data is disturbing. I'm not sure I share the optimism of the last slides, given we have a moratorium on re-determination and this data is mostly folks staying on. We should be seeing far larger numbers than last year. It may be a lag in the data but given that Black and Latinx are in a higher proportion of jobs that are at risk, we should be seeing an increase in new enrollments rather than a decrease. National data simulations are showing children more likely to be in the newly qualifying population due to family unemployment and losing coverage. So that is another disturbing trend. I am curious about your thoughts on why public charge is showing up now. There seems to be a problem in outreach and awareness, as well as the compounding aspects of COVID and public charge. I would really like to continue exploring ideas to figure out, as the Secretary has said, how to open those doors more widely.

Rene Mollow, DHCS: I have a couple of thoughts. Based on information you are not seeing; we are beginning to see increases in enrollments. We need to break that data out more to understand it. As others have mentioned, even with job loss, there may be continuing coverage by employers or COBRA that are impacting this. With immigrant populations and public charge, I think that until the rules were finalized there may have been hope they would not become final; therefore, we are just now seeing the impact. As we continue to work with county partners and navigators, we hope to see changes in those enrollment numbers. We recognize the need to be reaching and covering everyone entitled to the services. There has been work organized through the Governor's office and across various state agencies to create appropriate messaging as it relates to public charge. We have taken steps to make sure that people understand our program remains open. Our policies remain that we have coverage for undocumented populations up to the age of 26 and that this remains a viable enrollment pathway for them.

Jacey Cooper, DHCS: A few additional points. Public charge was only finalized in February 2020, so this is the earliest data following that actual finalization of what has been discussed for quite some time. This is also just a slice of data, but clear enough that it is something we will continue to address as we work with stakeholders and advocates over the coming months. The data here is based on applications and it may be that children are included in a parent application and that may influence the decrease we see in children's enrollment. We want to work with all of you, counties and navigators, about public charge. We are committed to ensuring that people understand that they have access to Medi-Cal, especially during the public health emergency, and working with you about how to get that word out; how we get information out through county partners, navigators and others is going to be important. We do hear consistently that people are not seeking medical care right now. This goes back to earlier comments that we are looking at utilization to understand that trend. We know that also has an impact on enrollment and application numbers because oftentimes getting care is what drives someone to submit the application. So, I think there are a number of factors that play into this. We continue to dig into different layers of the data, and we would like to continue

partnering with people about how to move the needle.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I would greatly appreciate the opportunity to talk more about outreach and how to get the message out, on public charge, and also on increasing well-child visits and vaccinations.

Jacey Cooper, DHCS: We can definitely set up a call with you and others to continue the conversation.

Linda Nguy, Western Center on Law and Poverty: We share the concern about low enrollment this year compared to last year. That raises alarms on equity when looking at the demographic data. I appreciate the continued conversation around outreach. On slide 34, this data seems different than what CDSS posted. Is it counted differently?

Rene Mollow, DHCS: It is counted differently. We do a refresh of the data rolling through time, while CDSS data is a snapshot in time. We also include all the pathways for people to come into Medi-Cal and with their data, the CalSAWS applications do not include CalWORK cases whereas the CalWIN data does. DHCS uses a data pull that we report to CMS based on Affordable Care Act requirements.

Linda Nguy, Western Center on Law and Poverty: It would be helpful if there can be one slide that shows the applications from all the sources instead of splitting it up. For slide 43, it looks like the applications for April 2020 versus 2019 are somewhat off. Are applications being processed timely? Is DHCS doing everything to be ready for a wave of new applicants seeking post-enrollment verification?

Jacey Cooper, DHCS: Thanks, that is exactly some of the data we are analyzing and following up on with any counties where there is a backlog more than the average across the state, which may be due to the public health emergency. We want to ensure we get through any applications quickly, and provide technical assistance or other support counties may need. This is a priority for DHCS.

Rene Mollow, DHCS: We continue to work with CWDA to understand and offer assistance to ensure that all of the applications coming in are being processed and beneficiaries get access to critical healthcare services, which they definitely need during a public health emergency.

Linda Nguy, Western Center on Law and Poverty: I appreciate this and urge looking into post-enrollment verification to speed up the process. Lastly, I applaud DHCS for moving ahead on PE. It does look like more needs to be done to get the word out. One of our legal programs was in contact with a hospital that didn't know about COVID-PE. This may require additional provider education to get the word out.

Rene Mollow, DHCS: Thanks, I made a presentation to hospitals in collaboration with California Hospital Association to talk about this uninsured group and remind them of PE. I'm following up on any questions they have.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: I share Kristen's concern that

the race/ethnicity data is alarming. This is what we were concerned about with public charge and hoping wouldn't happen, so we want to work with you on outreach. Navigators are important in this and there is confusion from the budget proposal to eliminate the program as well as information DHCS sent to the counties. We want to work with you on clear communication and messages on this. I urge DHCS to make sure there is clear, accurate messaging to counties and those contracting directly with DHCS to provide navigator services.

Rene Mollow, DHCS: The program will be resuming their regular calls and small work groups.

Kim Lewis, National Health Law Program: I think we previously asked about data on incomplete applications – those who were denied due to incomplete applications?

Jacey Cooper, DHCS: We just received that data and are scrubbing through it to share in the future.

Anthony Wright, Health Access CA: I agree with my colleagues and appreciate the dialogue on enrollment and the mystery of why significant new enrollment is not happening as expected. In conversations with advocates in other states, there are some states seeing significant increases. Does DHCS have comparisons to other states? Are there lessons to be learned or information to pick up from other social services, nutritional support, CalFresh, CalWORKs to ensure they sign up for Medi-Cal? Am I wrong that we have seen increases in some of those programs that are not necessarily reflected in Medi-Cal?

Will Lightbourne, DHCS: We need to conduct the full analysis and identify opportunities.

Rene Mollow, DHCS: Also as a reminder, when people apply for public assistance, i.e. CalWORKS, they have automatic eligibility for Medi-Cal. We need to do a deeper dive.

Cathy Senderling, County Welfare Directors Association: We are in conversation to figure out the data. The CDSS data does show a spike in week 3-4 of the month, perhaps due to impending loss of employer coverage for the following month. We need to see how this trend continues over the next several months. We are talking with counties at all levels about application processing in light of the lower than expected applications. We want to do everything we can to help.

Long-Term Care at Home Concept Paper and Stakeholder Process
Anastasia Dodson and Lindy Harrington, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620SACWebinar.pdf

Anastasia Dodson presented a high-level overview of the Long-Term Care at Home proposal. There is a stakeholder meeting tomorrow to review a detailed proposal on Long-Term Care at Home and the document is on the website. The Long-Term Care benefit proposed would give Medi-Cal beneficiaries more choices in living situations and long-term care settings. In part, this is to decompress SNFs in light of high COVID infection rates. There is a robust array of home and community based services in

California but there are still some gaps to address. This benefit will provide more choices to help transition from hospital to home or allow some to leave a SNF to go home. The primary populations include folks who are in skilled nursing facilities, either short-term or long-term stays, or individuals being discharged from the hospital. The four primary components are:

- Individual, Person-Centered Assessment
- Transition Services
- Care Coordination
- Medical and Home and Community Based Services

There will be individual person-centered assessments conducted by the organization designated to provide this array of benefits. Coordinating the full array of medical and social services, home and community based services for individuals receiving this benefit is important because we know it is a combination of medical and social services that are needed to transition home and stay home in a stable situation.

The federal authority envisioned for this is the 1915(i) state plan to allow flexibilities not available through the current 1915(c) waiver program. Policy focus areas include licensing. We received a tremendous amount of feedback from stakeholders that a new licensing category was too ambitious. We are now looking to leverage existing licensure and expertise of organizations to revise the proposal. We continue to work on other areas of the proposal, such as revising the payment structure. For dual eligible beneficiaries, we have experience through Cal MediConnect and other initiatives and will need to have further discussions for this benefit, particularly about those enrolled in Medicare Advantage plans. We are also working to describe how In-Home Supportive Services (IHSS) participation and enrollment in other home and community based services either precludes or combines with this Long-Term Care at Home benefit. Revisions will be coming soon.

Managed care plans are a fundamental part of our healthcare delivery system here in California for Medi-Cal, so there will be explicit information about our vision for how managed care plans would be part of the benefit and administer the benefit. We don't see this as being carved out from Medi-Cal managed care, but we want to think carefully about what's most appropriate, how to prepare, how to have a robust network. We have been having informal stakeholder conversations and formal meetings. We are reviewing the input carefully and greatly appreciate the feedback and constructive help that you all have been providing.

Questions and Comments:

Maya Altman, Health Plan of San Mateo: One comment is to urge that this be considered within the overall framework of CalAIM. We don't want to advance something disintegrated from WPC or other programs so I hope we will consider how this will fit in the context of CalAIM.

Jacey Cooper, DHCS: We are doing more thinking and working on the intersections that aren't yet reflected in the proposal. A statewide benefit is different than In Lieu of Services (ILOS) so we are still navigating that and appreciate the feedback.

MJ Diaz, SEIU: I would echo Maya's comment about how this will fit in the larger proposal, especially related to Enhanced Care Management and ILOS. There are additional concerns: how we define the population eligible for the benefit; the timeline seems rushed; and, thinking through standards for what will be the required of level of care and patient safety. My colleagues, especially Local 2015, will be engaging at tomorrow's stakeholder meeting. We hear that DHCS is accommodating some of the concerns and will continue to be engaged in the proposal.

Jacey Cooper, DHCS: Just to be clear, we know that January 2021 is unlikely, and we are saying early 2021. We are open to continuing to engage and we have a need to move as soon as we can, given the situation with SNFs across the state.

Will Lightbourne, DHCS: We need to move to public comment. Please send any further comments to us online.

Public Comment

Tracey Rattray, California Alliance for Prevention Funding: Without question, good quality health care is essential for all Californians. Yet, before COVID and today in the midst of the pandemic, we are seeing stark inequity among black and brown Californians, dying in part due to largely preventable conditions like heart disease and diabetes. To promote equity and to contain health care costs, our Medi-Cal program must also invest in keeping people healthy in the first place. One solution would be to require each of our health plans to contribute at least $10 per capita each year to invest in health equity and prevention in communities with high Medi-Cal coverage. Funds could go into a state wellness fund and be distributed to local health departments and community organizers to implement proven prevention strategies. As the pandemic has shown so clearly, we must assure coverage. At the same time, we must invest in prevention, a win-win approach that will reduce unnecessary suffering among our most vulnerable and contain health care costs.

Lynn Silver, Public Health Institute: First of all, I share and salute your dedication to assuring access to coverage. It has never been more needed. But as we are seeing in articles and comments across the country at this time, the pandemic has laid bare the gravity of continuing failure to invest in community based prevention and health equity, particularly in our communities of color, in ways that can reduce the unjust burden of diabetes, heart disease, violence, substance abuse, and the number of people who are landing as complex patients in our Medi-Cal system. So, we need to create that sustained flow of funding to address community-based prevention and health equity, and Medi-Cal needs to be part of that. I'm participating in the Georgia Health Policy Center's national initiative to monitor creation of local wellness funds. And you are seeing exciting initiatives involving Medicaid plans contributing systematically to these needs in other states. As Ms. Rattray suggested, we strongly encourage the group to consider requiring a small but strategic per capita contribution, $10 to $20 a year to a California Wellness Fund or alternatively local wellness funds as part of what we submit in CalAIM.

Makayla Bouchard, California LGBTQ Health and Human Services Network. I would just like to say that as there has been increased access to digital and remote services, we recommend working with LGBTQ community leaders and youth to identify safe methods and spaces for LGBTQ youth to access virtual support. When living with families that are rejecting of their identity, which has come up as a need during several virtual gatherings, youth are literally hiding in their closets and using chat functions so that their parents don't know that they're participating in online LGBTQ youth support groups. We strongly recommend working with LGBTQ community leaders to identify how to make virtual and remote spaces inclusive and safe for our community. Thank you.

Le Ondra Harvey Clark, *California Council of Community Behavioral Health Agencies*: Just wanted to provide just two quick comments. First, welcome to Director Lightbourne, and then really just to express our appreciation to DHCS for the advocacy as it relates to the whole person care continuation and continuing to look at telehealth flexibilities post COVID. Our members are so very appreciative of those efforts.

Jill Kowalski, First 5 Riverside: (submitted via email) I asked to speak during the public comment during the DHCS Stakeholder Meeting and was told I was in the queue to speak and was never called on. I am the program manager of a Local Dental Pilot Project, called IE Smiles that covers the entire Riverside and San Bernardino County region known as the Inland Empire. We are disappointed to see that Domain 4 is not included in the DTI 1115 Waiver Extension. On behalf of the FQHCs and other oral health partners and stakeholders serving this region, I strongly encourage you to include Domain 4 in the extension. In the Inland Empire, community clinics have been providing oral health preventive and restorative services to children in preschools and K-12 schools. If not for Virtual Dental Home, most of these children would not have access to this care. In fact, many have never been seen by a dentist until VDH came to their school. In the Inland Empire, 9,000 children ages 0-5 have been assessed for caries risk through an oral health assessment that also helps provide oral health education to parents and links families to VDH or a dental clinic. The community clinic partners in Domain 4 have made tremendous progress in removing barriers to access for children who would otherwise not receive any oral health care. They have agreements in place with more than 30 school districts in both counties to do VDH when the schools open up again. And, they have been able to shift to teledentistry during the COVID-19 pandemic. By including Domain 4 in the waiver extension, the community clinics doing this work will be able to continue and expand the work once schools are open. They will also have a better chance of sustaining this work after December 2021, since DHCS has allowed the projects to keep the VDH equipment that was purchased. We hope you will reconsider excluding Domain 4 from the waiver extension.

Next Steps and Final Comments
Will Lightbourne, DHCS

Thanks to everyone who has given their time today. Much of the conversation today are things that require continuing work and discussions. I appreciate everyone's contribution. Our next meeting is October 28, 2020.