Paulette Greisner; Email Received August 15, 2022

In March of 2021 [redacted]

For such an affluent community, Santa Barbara has a woefully low level of support for mental health patients. [redacted]

Santa Barbara's limit of 16 beds is not sufficient to accommodate the serious and growing needs of our community.

Please adopt the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Paulette Greisner
Mother- Resident of Santa Barbara

CalOptima Health; Email Received August 25, 2022

Good afternoon,

On behalf of CalOptima Health, please find attached a public comment letter from Chief Executive Officer Michael Hunn regarding the proposed Section1915(b) waiver amendment. Thank you for the consideration, and please do not hesitate to contact me with any questions.

Sincerely,

Donovan Higbee
Manager, Government Affairs

CalOptima Health, A Public Agency
505 City Parkway West, Orange, CA 92868
[redacted]

Weiser & Grant Dentistry; Email Received August 23, 2022

Please adopt the IMD Medicaid Exclusion Waiver for Serious Mental Illness. [redacted]

Sheri L. Rowe
Weiser & Grant Dentistry
1511 State Street
S.B. CA. 93101
805/899-3600
SantaBarbaraDDS.com
Ozonetherapiesgroup.com

August 25, 2022

Sent via email to CalAIMWaiver@dhcs.ca.gov

Ms. Jacey Cooper
Chief Deputy Director and State Medicaid Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

SUBJECT: CalAIM Section 1115 & 1915(b) Waiver Amendment

Dear Ms. Cooper:

Thank you for the opportunity to submit comments regarding the proposed Section 1915(b) waiver amendments being submitted by the Department of Health Care Services (DHCS) to the Centers for Medicare and Medicaid Services. As a county-organized health system (COHS) serving more than 1 in 4 Orange County residents, CalOptima Health has serious concerns regarding language that would allow DHCS to contract directly with Kaiser Permanente (Kaiser) for Medi-Cal services in COHS counties.

The proposed Kaiser Medi-Cal contract would significantly disrupt the Medi-Cal delivery system by creating two tiers of Medi-Cal beneficiaries – one with strict enrollment criteria, and one open-door public system supported by current safety net providers. This contract would destabilize these fragile provider networks and likely lead to fewer providers participating in Medi-Cal. It would also fundamentally alter the COHS model and negate the documented benefits of COHS plans, which are explicitly protected under federal law as Health Insuring Organizations (HIOs) and are currently being expanded by counties throughout the state as part of the 2024 Medi-Cal procurement. Other sections of this same Section 1915(b) waiver amendment, as well as the Section 1115 waiver amendment, even acknowledge that the COHS expansion "will build on the existing COHS model in the State, which are among California's highest performing plans" with "higher scores on 28 of 35 HEDIS measures than commercial plans and local initiatives" from 2009 to 2018. The proposed contract directly contradicts and undermines these outcomes, which will have express negative consequences on our members.

Beyond the harmful policy consequences, it is a damaging process and precedent to pursue no-bid contracts with private interests that may lead to future statewide agreements with other commercial health plans. For all of these reasons, CalOptima Health is opposed to the waiver amendment language implementing a Kaiser Medi-Cal contract in COHS counties. Thank you for your consideration.

Sincerely,

[redacted]

Chief Executive Officer

NAMI Santa Cruz; Email Received August 22, 2022

To the California Department of Health Care,

I'm writing to you today in support of the federal repeal of the IMD Exclusion. For too long the shortage of beds due to this rule has limited the treatment available to the mentally ill in serious times of need, and too many of our loved ones have gone unhelped and had to endure added suffering to their already cruel conditions, which could have been avoided.

As a NAMI family member and advocate, I ask for your understanding and support in doing what is right by adopting the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Respectfully,

Alice Nelli
NAMI Santa Cruz

Hope Street Coalition; Email Received August 22, 2022

To Whom It May Concern:

I am writing to urge adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Unfortunately, the California mental health system excludes many of the most severely ill from treatment. These vulnerable people, many of whom are homeless, rely on MediCal to receive treatment. An antiquated and discriminatory rule, however, prohibits the federal government from reimbursing for care received in mental health institutions if the hospital has more than 16 psychiatric beds.

The Institutions for Mental Diseases (IMD) Exclusion is an institutional barrier to treatment for those who need it most. Because of the IMD Exclusion, people living with untreated serious mental illnesses and substance use disorders end up in jails, prisons, or living on the street. This costs California and California cities significant amounts of money because instead of providing the necessary treatment, the untreated go unhoused and cycle through jail, emergency rooms, and homeless encampments. Instead of getting lifesaving care and treatment, the seriously mentally ill are left to suffer untreated and many die on the street.

The IMD Exclusion has accelerated the shortage of psychiatric beds by giving states an economic incentive to close psychiatric hospitals. California has seen a decrease of 16 percent of public psychiatric beds, reported more than ten years ago. We know that more beds have been lost since.

According to the Treatment Advocacy Center, nearly170,000 people experiencing homelessness suffer from a serious mental illness. UCLA reported that nearly 75 percent of those live on the streets.

The IMD Exclusion has caused jails, prisons, and homeless encampments to become warehouses for the mentally ill and contributed to the increase in suffering on the streets. Incarceration and homelessness are destructive environments. As individuals cycle through jail and homelessness, physical and mental deterioration increases as does the costs of treatment and resistance to housing. Moreover, the IMD Exclusion is discriminatory. It treats diseases of the brain differently than other diseases causing significant suffering by the rationing of care.

Ending the IMD Exclusion in California through the Section 1115 waiver process can help those with mental illness gain access to treatment. It will save California taxpayers the burden of costly emergency room visits and incarceration for patients with severe mental illness. It will also help reduce the number of seriously mentally ill people in the homeless population. It will remove the cap on treatment in hospitals and other residential psychiatric facilities opening-up beds for those living on the streets. Ending the IMD Exclusion will save lives, improve communities, and reduce public costs.

Hope Street Coalition urges the adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Sincerely,

Paul C. Webster
Founder and Director
[redacted]

www.hopestreetcoalition.org
[redacted]

NAMI Santa Cruz; Email Received August 22, 2022

Hello.

My California community is now being “served” by a 16 bed psychiatric facility. “Served” is in quotes because the term is a joke. 16 beds in no way “serves” the huge need and demand for psychiatric treatment in my County. The Medicaid Exclusion is responsible for the death and ongoing misery of hundreds who have been denied services due to this bed limitation.

Please adopt the IMD Medical Exclusion Waiver of Serious Illness. It’s the right, humane thing to do.

Thank you.

Cherry Maurer
NAMI Santa Cruz County parent/volunteer

Sent from my iPhone

Pamela Reeves; August 20, 2022

We are woefully underserved in CA and nationally. As a psychiatrist, I find this shortage not only unconscionable but extremely dangerous. This is especially true for the almost nonexistent beds for child and adolescent patients.

Clare Loewenau; Email Received August 18, 2022

I want my voice heard I am asking for an adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

[redacted] That's impossible.

Thank you,

Clare Loewenau
Studio CIty, California

Elizabeth Boyd; Email Received August 16, 2022

I urge you to adopt the IMD Medicaid Exclusion Waiver for Serious Mental Illness. The IMD Exclusion has resulted in a critically severe shortage of mental health treatment beds as part of the continuum of care. California needs these beds badly. Please adopt the waiver.

Thank you.
- Beth
Elizabeth Boyd
[redacted]

Jenny McLelland; Email Received August 16, 2022

CalAIM Section 1115 and 1915(b) Waiver Amendments

EPSDT Private Duty Nursing for children under 21 is even more difficult to get in MCO counties because when multiple agencies are responsible for approving

1. MCOs are not providing state mandated EPSDT Private Duty Nursing to qualifying children. MCOs have been left essentially on their own to decide if a child qualifies for EPSDT Private Duty Nursing, and if so, how many hours the child qualifies for. MCO internal policies are not consistent between MCOs, and some MCOs make the process of getting approval for hours so difficult that they are simply not providing mandated plan services. Children who require EPSDT Private Duty Nursing are some of the most expensive recipients enrolled in a plan. MCOs have every incentive to make the process of getting EPSDT Private Duty Nursing more difficult in order to save money - at the expense of California's most vulnerable children.

2. For children who have primary insurance through their parents and are enrolled in waiver programs in order to access EPSDT Private Duty Nursing, CalAIM makes it difficult to opt out of MCO enrollment. It absolutely does not work for children to be enrolled in two different MCOs with two different approval processes and two different sets of contracted providers. Form HCO 7101 (Request for Temporary Medical Exemption from Plan Enrollment) needs to have a specific line item for children who use MediCal as secondary insurance to remain on straight MediCal in order to preserve access to EPSDT Private Duty Nursing.

3. It's still unclear what role CCS is supposed to be playing in the approval of EPSDT Private Duty Nursing. CCS frequently denies nursing the has already been approved by an MCO, or refuses to approve nursing that an MCO has decided requires CCS approval. Either CCS should be involved in approving all EPSDT Private Duty Nursing or CCS should not be involved in Private Duty Nursing at all. As an example - [redacted] then bounces the claim to MediCal for payment which adds delay.

4. For children enrolled in the HCBA Waiver, there is an additional step in EPSDT Private Duty Nursing approvals. Even though a Registered Nurse from the HCBA Waiver Agency writes the Plan of Treatment and approves nursing hours (in compliance with IN v. Kent) that approval still doesn't count, and the child has to also seek approval from county CCS and the MCO / MediCal system.

4. Most importantly… why did I have to explain 100 layers of MCO / CCS / straight MediCal approvals that is involved in getting EPSDT Private Duty Nursing? It isn't supposed to be this complicated. The IN v. Kent settlement was supposed to make it clear that the state is obligated to provide these kids with nursing care in the home to avoid institutionalization. Why is the state making things even harder than they used to be?

NAMI Santa Barbara; Email Received August 15, 2022

Please adopt the state waiver for SMI to the federal IMD Medicaid Exclusion that accounts for the critically severe shortage of treatment beds in CA, as an element of the continuum of care. Our NAMI Affiliate, our county Board of Supervisors, and our Behavioral Health Commission has advocated for this critical waiver.

Thank you,
Lynne Gibbs
Chair, NAMI Santa Barbara County Public Policy Chair,
President, California Advocates for Treatment
and
[redacted]

David Wolfson; Email Received August 31, 2022

Hello; [redacted] It is a nightmare at times. I have never understood why there is no federal Medicaid funding for inpatient care for the seriously mentally ill where a facility has over 16 beds. Leaving funding for these treatment options to the states has been an unmitigated disaster nationwide. Absent federal legislation to get rid of the IMD exclusion, the pilot program/waiver is a great idea. Thanks, David Wolfson

Mary Ann Bernard; Email Received September 8, 2022

Mary Ann Bernard
[redacted]

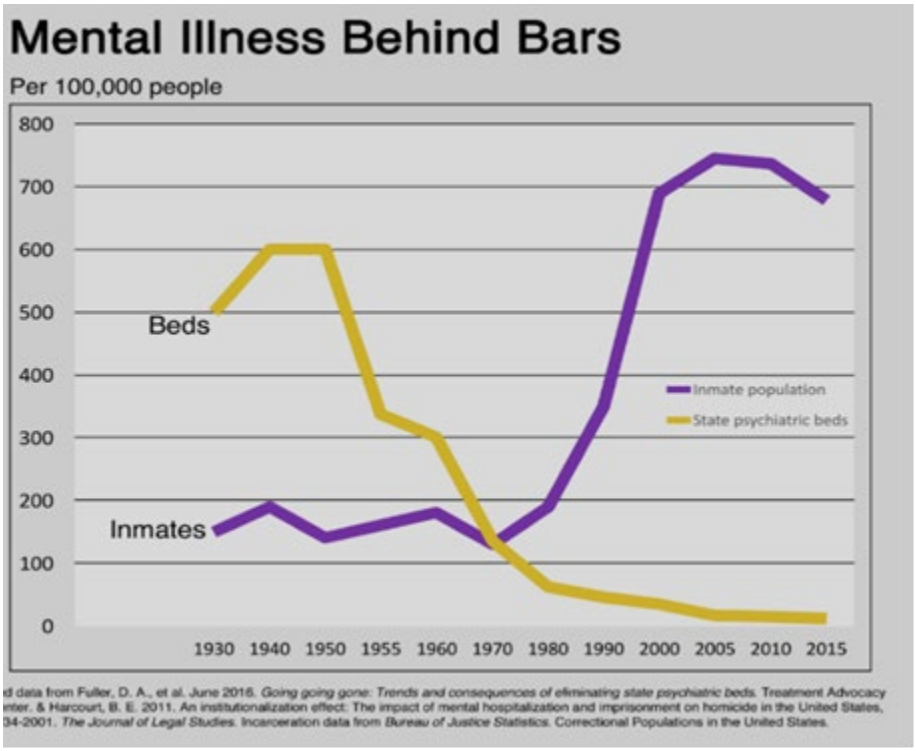
September 8, 2022

Re: Please Apply For the IMD Waiver for California

To Whom It May Concern:

As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more abominably than they were in the old state hospitals that prompted the prohibition against using Medicare/Medicaid funds for "Institutes of Mental Disease"("IMD") to begin with. Though well-intended when adopted, the IMD exclusion also "withholds mental health care from people of color at a disproportionate rate. People with mental illness are already disadvantaged by having an involuntary brain disease and federal Medicaid law denies them life-saving treatment. People of color with mental illness face a two-headed monster of increased risk of death during police interactions due to their race and the fact that they are sixteen times more likely to die in those encounters because of their mental health status." Michael Gray of Treatment Advocacy Center, opinion contributor to The Hill, https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-alaw-that-hinders-treatment/.

Below is a chart illustrating the results of this terrible law nationwide:



California is among the worst states. We have the dubious distinction of having prisons so bad for the severely mentally ill that a conservative Supreme Court affirmed that California prison conditions for them violated the Eighth Amendment prohibition against "cruel and unusual punishment" in the U.S. Constitution, the only state to hold this distinction. *Brown v Plata,* 563 U.S. 493 (2011). California state prisons are still under federal court order to improve those conditions for the severely mentally ill. A number of California's jails—notably in Sacramento and Los Angeles—are under similar court orders for "cruel and unusual punishment"/Eighth Amendment conditions for the mentally ill inmates. To say this is appalling is an understatement.

California jails are now also under order from the Caliornia courts to stop warehousing severely mentally ill inmates who are incompetent to stand trial for months and sometimes years while they wait for restoration to mental competency. They must be evaluated in 28 days or released. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev.den.* (Aug. 25, 2021). The probable result is that many desperately ill and often dangerous individuals will soon be spilling from our jails onto our streets. The danger and costs are incalculable, not only to those individuals and their loved ones, but to the public and the government agencies that try to protect us all.

This is a crisis, and the IMD exclusion has caused or at least exacerbated it. According to the Rand Corporation and Treatment Advocacy Center, "Taking into account how many beds California currently has, the results suggest that California is short 1,971 acute psychiatric beds and 2,796 subacute beds. In addition, the authors conclude that the shortage of psychiatric beds will only worsen over time, predicting a 1.7% increase in psychiatric bed need by 2026."

https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-1-v2/RAND_RRA1824-1-v2.pdf, https://www.treatmentadvocacycenter.org/about-us/featuresand-news/4494-research-weekly-two-new-studies-on-psychiatric-bed-number-targets.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill indiviuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department's failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that "[t]he State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care." Welf. & Inst Code 5890(d). This application is long overdue. Please file it immediately. Thank you.

Sincerely,

Mary Ann Bernard
Stanford with honors '75

U.Chicago Law ‘78

[redacted]

Former counsel to state mental hospitals in another state Plaintiff with MHSA drafter Rose King and counsel in *Bernard & King v CHFFA et al* (Third App Dist. CA—the case that put Prop.2 (2018) on the ballot)

Mothers Advocate for the SMI Los Angeles County; Email Received September 8, 2022

Re: Please Apply For the IMD Waiver for California

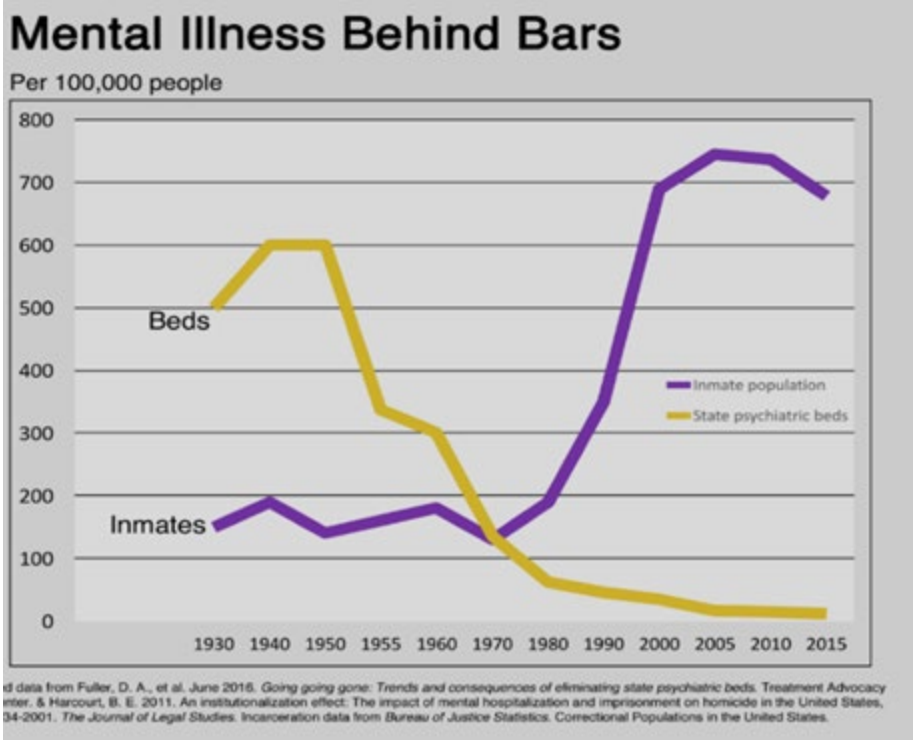
To Whom It May Concern:

[redacted]
Battles with hospitals to not have them discharged before they are stable. Private hospitals do not want to keep a patient in for more than 2 weeks because the insurance payment is less - so if the patient does not have a family fighting for them, they will be put back on the street. IMD's are necessary, and more IMD's need to be opened to allow people that are discharged from hospitals to have the appropriate time to recover.

People who are treatment-resistant can spend 2 months in hospitals while doctors try this and that medication. Then, they wait more months inside the hospital waiting for a vacancy in an IMD. How much does that cost? [redacted] o exclude IMD's from being eligible to receive funds is generating chaos in the system. The waiting lines for an IMD bed are huge. [redacted] More funds will also improve the quality of the programs offered at IMD's. Right now, with such a reduced number of IMD's surviving, there is no incentive for business owners to excel on services provided. And the Dept of Mental Health does not demand any improvement, afraid that business owners will close their doors to the mentally ill and revert the business towards nursing home and elderly care.

As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more abominably than they were in the old state hospitals that prompted the prohibition against using Medicare/Medicaid funds for "Institutes of Mental Disease"("IMD") to begin with. Though well-intended when adopted, the IMD exclusion also "withholds mental health care from people of color at a disproportionate rate. People with mental illness are already disadvantaged by having an involuntary brain disease and federal Medicaid law denies them life-saving treatment. People of color with mental illness face a two-headed monster of increased risk of death during police interactions due to their race and the fact that they are sixteen times more likely to die in those encounters because of their mental health status." Michael Gray of Treatment Advocacy Center, opinion contributor to The Hill, https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-alaw-that-hinders-treatment/.

Below is a chart illustrating the results of this terrible law nationwide:



California is among the worst states. We have the dubious distinction of having prisons so bad for the severely mentally ill that a conservative Supreme Court affirmed that California prison conditions for them violated the Eighth Amendment prohibition against "cruel and unusual punishment" in the U.S. Constitution, the only state to hold this distinction. *Brown v Plata,* 563 U.S. 493 (2011). California state prisons are still under federal court order to improve those conditions for the severely mentally ill. A number of California's jails—notably in Sacramento and Los Angeles—are under similar court orders for "cruel and unusual punishment"/Eighth Amendment conditions for the mentally ill inmates. To say this is appalling is an understatement.

California jails are now also under order from the Caliornia courts to stop warehousing severely mentally ill inmates who are incompetent to stand trial for months and sometimes years while they wait for restoration to mental competency. They must be evaluated in 28 days or released. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev.den.* (Aug. 25, 2021). The probable result is that many desperately ill and often dangerous individuals will soon be spilling from our jails onto our streets. The danger and costs are incalculable, not only to those individuals and their loved ones, but to the public and the government agencies that try to protect us all.

This is a crisis, and the IMD exclusion has caused or at least exacerbated it. According to the Rand Corporation and Treatment Advocacy Center, "Taking into account how many beds California currently has, the results suggest that California is short 1,971 acute psychiatric beds and 2,796 subacute beds. In addition, the authors conclude that the shortage of psychiatric beds will only worsen over time, predicting a 1.7% increase in psychiatric bed need by 2026."

https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-1-v2/RAND_RRA1824-1-v2.pdf, https://www.treatmentadvocacycenter.org/about-us/featuresand-news/4494-research-weekly-two-new-studies-on-psychiatric-bed-number-targets.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill indiviuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department's failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that "[t]he State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care." Welf. & Inst Code 5890(d). This application is long overdue. Please file it immediately.

Thank you.

Anna Penido

Mother Advocates for the SMI, Los Angeles County

Lauren Rettagliata; Email Received September 8, 2022

RE: Apply for the IMD Waiver for California

Lauren Rettagliata
[redacted]

September 8, 2022

RE: Promises Still To Be Kept

Dear DHCS Administrators,

Loved ones of those with a serious mental illness have waited too long for the discriminating practice of not covering the cost of treatment for their loved ones. Instead, quick stays in Psychiatric Hospitals or Crisis Residential Centers are substituted because they cost less than the long term secured intensive treatment that is needed.

A significant number of those with a serious mental illness do not receive the highly structured intensive care needed to treat their serious mental illness. They instead spend their life rotating in and out of crisis treatment, living on the streets seeking relief through illegal drugs and alcohol, and many times endangering their own life and the life of those around them. Their ongoing treatment should be covered by Medi-Cal, but because their best treatment option is the secured option of an IMD or MHRC their treatment and care are left uncovered. *This is discrimination*. If a medical doctor has testified that the best course of treatment is in a secured IMD or MHRC, the patient's right to treatment in the correct environment should not be denied and should be covered by either their public option of Medi-Cal or their private insurance.

It has been mentioned that you have turned a deaf ear to the plea of families like mine. There is discrimination when our loved ones need a secured facility to receive treatment and instead because of the IMD Exclusion they are not granted treatment. [redacted] County Behavioral Health staff and doctors are well aware of the huge financial drain of caring for a person whose treatment is not covered by Medi-Cal, and this may be causing them to opt for treatment that is covered under Medi-Cal rather than the needed treatment in a secured facility.

For over five years, I have been at DHCS conferences where the promise of ending the discriminating practice of the IMD Exclusion has been promised.

Make this the year that all those with a serious mental illness no matter where they are treated can receive the Medi-Cal benefits they are entitled to receive.

Lauren Rettagliata
Past Chair, Mental Health Commission of Contra Costa County

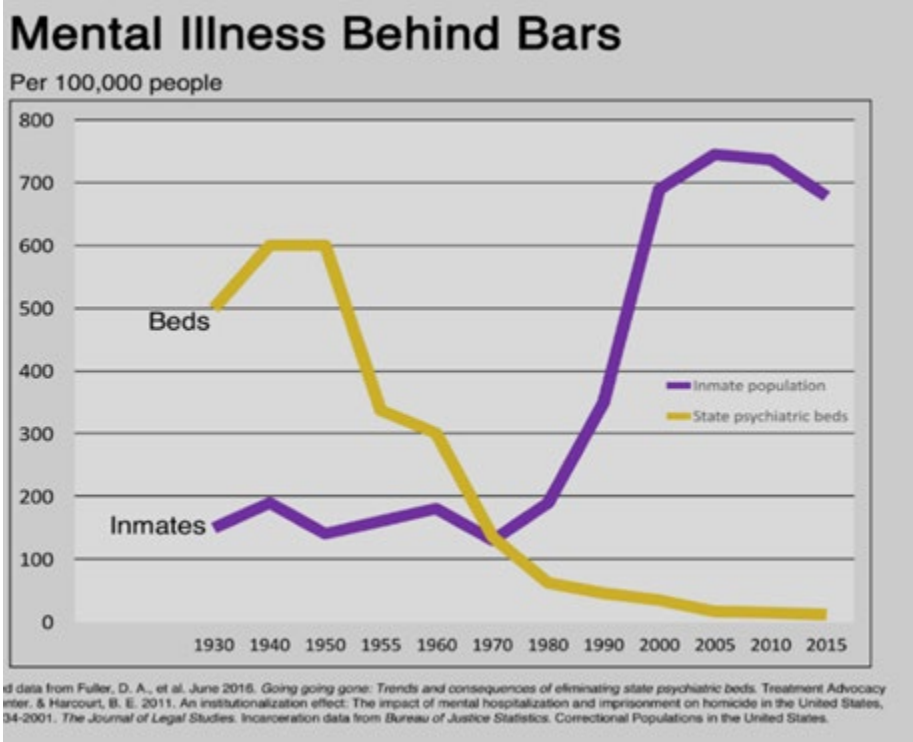
Nurit Baruch; Email Received September 8, 2022

Re: Please Apply For the IMD Waiver for California

To Whom It May Concern:

As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more abominably than they were in the old state hospitals that prompted the prohibition against using Medicare/Medicaid funds for "Institutes of Mental Disease"("IMD") to begin with. Though well-intended when adopted, the IMD exclusion also "withholds mental health care from people of color at a disproportionate rate. People with mental illness are already disadvantaged by having an involuntary brain disease and federal Medicaid law denies them life-saving treatment. People of color with mental illness face a two-headed monster of increased risk of death during police interactions due to their race and the fact that they are sixteen times more likely to die in those encounters because of their mental health status." Michael Gray of Treatment Advocacy Center, opinion contributor to The Hill, https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-alaw-that-hinders-treatment/.

Below is a chart illustrating the results of this terrible law nationwide:



California is among the worst states. We have the dubious distinction of having prisons so bad for the severely mentally ill that a conservative Supreme Court affirmed that California prison conditions for them violated the Eighth Amendment prohibition against "cruel and unusual punishment" in the U.S. Constitution, the only state to hold this distinction. *Brown v Plata,* 563 U.S. 493 (2011). California state prisons are still under federal court order to improve those conditions for the severely mentally ill. A number of California's jails—notably in Sacramento and Los Angeles—are under similar court orders for

”cruel and unusual punishment”/Eighth Amendment conditions for the mentally ill inmates. To say this is appalling is an understatement.

California jails are now also under order from the Caliornia courts to stop warehousing severely mentally ill inmates who are incompetent to stand trial for months and sometimes years while they wait for restoration to mental competency. They must be evaluated in 28 days or released. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev.den.* (Aug. 25, 2021). The probable result is that many desperately ill and often dangerous individuals will soon be spilling from our jails onto our streets. The danger and costs are incalculable, not only to those individuals and their loved ones, but to the public and the government agencies that try to protect us all.

This is a crisis, and the IMD exclusion has caused or at least exacerbated it. According to the Rand Corporation and Treatment Advocacy Center, “Taking into account how many beds California currently has, the results suggest that California is short 1,971 acute psychiatric beds and 2,796 subacute beds. In addition, the authors conclude that the shortage of psychiatric beds will only worsen over time, predicting a 1.7% increase in psychiatric bed need by 2026.”

https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-1-v2/RAND_RRA1824-1-v2.pdf, https://www.treatmentadvocacycenter.org/about-us/featuresand-news/4494-research-weekly-two-new-studies-on-psychiatric-bed-number-targets.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill indiviuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department’s failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that “[t]he State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.” Welf. & Inst Code 5890(d). This application is long overdue. Please file it immediately.

Sincerely,

Nurit Baruch

SF, CA

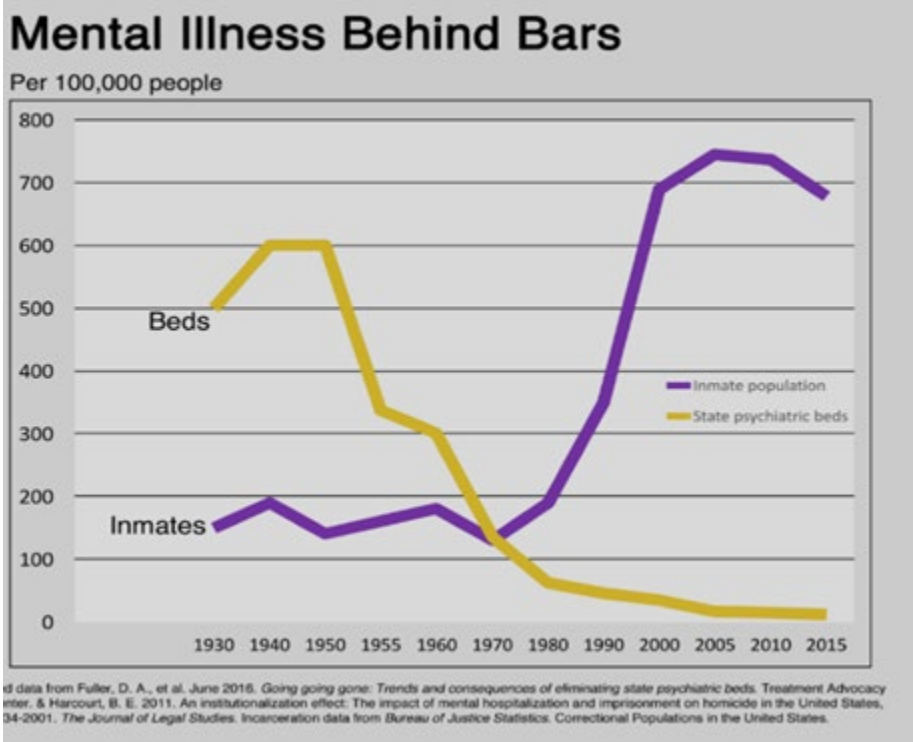
Shelley Hoffman; Email Received September 8, 2022

To Whom It May Concern:

[redacted], and I also facilitate a weekly support group for families who have mentally ill relatives, so I know all too well how critically we need to Apply for the IMD Waiver for California.

As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more abominably than they were in the old state hospitals that prompted the prohibition against using Medicare/Medicaid funds for "Institutes of Mental Disease"("IMD") to begin with. Though well-intended when adopted, the IMD exclusion also "withholds mental health care from people of color at a disproportionate rate. People with mental illness are already disadvantaged by having an involuntary brain disease and federal Medicaid law denies them life-saving treatment. People of color with mental illness face a two-headed monster of increased risk of death during police interactions due to their race and the fact that they are sixteen times more likely to die in those encounters because of their mental health status." Michael Gray of Treatment Advocacy Center, opinion contributor to The Hill, https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-alaw-that-hinders-treatment/.

Below is a chart illustrating the results of this terrible law nationwide:



California is among the worst states. We have the dubious distinction of having prisons so bad for the severely mentally ill that a conservative Supreme Court affirmed that California prison conditions for them violated the Eighth Amendment prohibition against "cruel and unusual punishment" in the U.S. Constitution, the only state to hold this distinction. *Brown v Plata,* 563 U.S. 493 (2011). California state

prisons are still under federal court order to improve those conditions for the severely mentally ill. A number of California's jails—notably in Sacramento and Los Angeles—are under similar court orders for "cruel and unusual punishment"/Eighth Amendment conditions for the mentally ill inmates. To say this is appalling is an understatement.

California jails are now also under order from the Caliornia courts to stop warehousing severely mentally ill inmates who are incompetent to stand trial for months and sometimes years while they wait for restoration to mental competency. They must be evaluated in 28 days or released. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev.den.* (Aug. 25, 2021). The probable result is that many desperately ill and often dangerous individuals will soon be spilling from our jails onto our streets. The danger and costs are incalculable, not only to those individuals and their loved ones, but to the public and the government agencies that try to protect us all.

This is a crisis, and the IMD exclusion has caused or at least exacerbated it. According to the Rand Corporation and Treatment Advocacy Center, "Taking into account how many beds California currently has, the results suggest that California is short 1,971 acute psychiatric beds and 2,796 subacute beds. In addition, the authors conclude that the shortage of psychiatric beds will only worsen over time, predicting a 1.7% increase in psychiatric bed need by 2026."

https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-1-v2/RAND_RRA1824-1-v2.pdf, https://www.treatmentadvocacycenter.org/about-us/featuresand-news/4494-research-weekly-two-new-studies-on-psychiatric-bed-number-targets.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill indiviuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department's failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that "[t]he State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care." Welf. & Inst Code 5890(d). This application is long overdue. Please file it immediately.

Sincerely,

Shelley Hoffman
[redacted]

Contra Costa Mental Health Commission; Email Received September 8, 2022

RE: 1115 SED/IMD 30-day Demonstration Waiver

It is "mission critical" that the Department of Health Care Services (DHCS) file for this 30-day waiver as soon as possible. Because of the Institute of Mental Diseases (IMD) Medi-Cal Exclusion for persons 21-64 years of age, many persons including our loved one and especially persons of color, deteriorate so badly that they spend considerable periods of their lives behind bars. This is especially so for young persons of color.

For example, here in Contra Costa County, I have personally met and worked with over 100 families for the past few years whose loved ones had repeatedly deteriorated so badly that they became so deeply involved in the criminal justice system and finally clinically evaluated and judicially adjudged Incompetent to Stand Trial (IST). Over 60 of these young persons are from families of color. Because of COVID-19 and repeated associated Department of State Hospitals (DSH) admissions halts, the current waitlist for a state hospital Incompetent to Stand Trial bed is over 2,000 persons. Locally, as a result, I've seen over 50 of these persons in court and personally seen how badly they have deteriorated. Families, especially those of color, have repeatedly told me that had their loved ones been provided the type of treatment and services provided by IMD Mental Health Rehabilitation Centers (MHRCs), their loved one would likely have never repeatedly decompensated so badly that they wound up repeatedly in the Criminal Justice system.

Filing for this waiver would greatly help to complement the CARE court legislation recently passed by the legislature and shortly to be signed by the Governor. As it relates to Contra Costa County, this waiver would provide an estimated $1M-$1.5M annually in fully federally matched Medi-Cal care and start opening up badly needed housing and services for this most vulnerable 110–150 person population currently housed and cared for out-of-county.

Over the past 8 months, at Zoom Webinar meetings on this issue, I've repeatedly heard that the DHCS would file for this waiver by October and that the application would include "first in the nation" waiver features. The sooner it is filed and approved, the far better it will be for all concerned, especially persons of color. Thank you for filing for this most important waiver **as soon as possible**.

Sincerely,

Douglas Dunn, MBA, LE
Contra Costa Mental Health Mental Health Commissioner, District 3
Chair, Mental Health Commission Finance Committee
Chair, NAMI Contra Costa Legislation Committee

NAMI Santa Cruz; Email Received September 8, 2022

Hi all influential and appropriate parties -

My name is Hugh McCormick and I work as a Journalist and for the National Alliance on Mental Illness in Santa Cruz, CA. I also serve on the Santa Cruz County Mental Health Advisory board and other local boards.

I'm writing this Email regarding IMD exclusions. Mental health consumers in our County have been shipped (forced to move to unfamiliar and isolated areas) for years. Because there is a cap on beds available at our local and ONLY inpatient unit Telecare. This is because of the current IMD situation. Which I have found to be harsh and downright damaging to our area's mentally ill and their families.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill individuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department's failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that "[t]he State Department of Health Care Services *shall* seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care." Welf. & Inst Code 5890(d). This application is long overdue.

Thanks so much.

Hugh McCormick

Kaiser Permanente; Email Received September 9, 2022

Please find attached Kaiser Permanente's comments on California's proposed amendments to its 1915b and 1115 waivers.

Shannon M. McMahon
Executive Director, Medicaid Policy
she/her/hers
Kaiser Permanente
Washington, DC
[redacted]

Executive Assistant – LaTrelle M. Mixon
[redacted]

---

kp.org/thrive

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.

September 9, 2022

Department of Health Care Services
Director's Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted via email: CalAIMWaiver@dhcs.ca.gov

Re: CalAIM Section 1115 & 1915(b) Waiver Amendments

Dear Director Cooper:

Kaiser Permanente (KP) appreciates the opportunity to submit comments to the Department of Health Care Services (DHCS) on its proposed amendments to its Section 1115 and 1915b waivers. KP is the largest private integrated healthcare delivery system in the U.S., delivering health care to 12.5 million members in eight states and the District of Columbia.[1] Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

In California, KP currently provides high quality care to over 930,000 Medi-Cal beneficiaries in 22 counties through 14 different contracts with local health plans and in GMC counties. The proposed waiver amendments effectuate the requirements of California Chapter 73 of 2022[2], which increases KP's commitment and participation in the Medi-Cal program through a direct contract with DHCS.

Implementing California Chapter 73 of 2022, by transitioning KP to a single Medi-Cal contract with DHCS will:

1. **Improve access to care.** A single contract will create a more consumer-friendly experience as members enroll in KP coverage. Under the single contract, eligible members will have the ability to access KP care and coverage in 10 new counties to allow for continuity of care in KP's entire commercial footprint. Further, our contracting arrangement does not change our commitment to being a partner with all entities at the county level, which we have done in each county for decades. The waiver proposal increases access to critical providers and quality health care services – without negatively impacting the essential roles of the local health plans and safety-net providers.

2. **Advance health equity**. KP will serve more vulnerable populations with complex needs, such as foster children, dual-eligible Medi-Cal and Medicare seniors, and other low-income Californians.

3. **Increase access to high quality care**. KP is the highest quality rated Medi-Cal plan. KP will also expand its Medi-Cal enrollment to 10 more counties – to a total of 32 counties. It allows KP members to keep their same doctors, therapists, hospitals, electronic health records, etc. – no

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the medical care needs of Kaiser Permanente's members.

[2] *See* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2724

matter what county they reside in – rather than having to navigate a new system of health care when they become Medi-Cal eligible.

4. **Reduce administrative complexity and increase state oversight and enforcement.** A direct contract will remove administrative layers, making the Medi-Cal program easier to access for members and will streamline state oversight and accountability of the contract. KP will be subject to the terms of the contract and is going through a full readiness review with DHCS, just like all other Medi-Cal managed plans.

5. **Respect local control.** Through the extensive stakeholder review of California Chapter 73 of 2022, the state and legislators met with local plans and other key stakeholders and adjusted the proposal accordingly. KP will have MOUs with counties and will collaborate with local health plans, counties, and safety net providers on determining enrollment growth, implementation of CalAIM policies, and delivery of community supports.

In sum, these waiver amendments implement a carefully balanced approach that that will allow KP to increase access to high quality care for a broader number of Medi-Cal beneficiaries in a way that is intended to support and complement the local health plans and the safety-net delivery system.

Thank you for the opportunity to comment on these proposals. We stand ready to work with you through the waiver review and contract implementation process. If you have questions, please contact us at [redacted] or [redacted].

Very truly yours,

[redacted]

Julie Miller-Phipps
President, Kaiser Permanente Southern California

[redacted]

Carrie Owen Plietz
President, Kaiser Permanente Northern California

Alice Feller; Email Received September 9, 2022

Good afternoon.

Please do not miss the Monday September 12th deadline to apply for a state waiver of the IMD Exclusion for psychiatric hospital care.

As a psychiatrist, I am outraged at the lack of decent hospital care for my severely ill patients. This waiver would provide desperately needed funds for hospital treatment. As it is, our jails and prisons have largely replaced hospitals as providers of treatment for severe mental illness. Jails are not suited to provide this kind of care. Over the last two years Santa Rita Jail has had an inmate death every seven weeks. Seventeen of those were suicides.

Since the IMD Exclusion was made law in 1965, we have lost nearly all of our psychiatric hospital beds. The few we still have are a small fraction of what we need. For example, out of every 20 people brought to John George Hospital with a mental health crisis, only three are admitted to the hospital for treatment. The others have brief stays in the John George ER, then are discharged to the street to make room for more patients. As we all know, a large fraction of our homeless population today suffers from severe, untreated mental illness.

The IMD Exclusion is a discriminatory law. No other major illness suffers such discriminatory treatment. There is overwhelming support for the repeal of this discriminatory law. A state waiver for California would be an important first step. Please do not let this opportunity go by.

Thank you for your consideration.

Alice Feller, M.D.
Alameda County

Ellie Shukert; Email Received September 10, 2022

I understand that the deadline for writing to the California agency DHCS to file for a waiver of the IMD Exclusion Waiver is Monday, Sept. 12, 2022.

HAVE YOU REQUESTED THE IMD EXCLUSION WAIVER? (and if so, when?)

My searches online, up to Aug. 22, 2022, have so far indicated that there is NOT even a PENDING consideration of such a request, specific to a waiver on the psych bed limit, designed to be so low that it would not be cost effective to expand badly needed mental hospitals. Elaine Howles (now retired), CA Auditor, stressed the need to expand existing or build/ renovate facilities to meet the needs of severely mentally ill Californians who have not been able to access healthcare due to a lack of psych beds and healthcare providers for their illnesses, which are biological/physiological and need to be treated on par with all the many other illnesses for which healthcare is currently provided. The result has been wrongful incarceration, homelessness and threats to general public safety and to the severely mentally ill who often die in the street, or are killed by police while experiencing acute symptoms of their illnesses, particularly schizophrenia and bipolar disorder, often including substance abuse as a means to self medicate, being the victims of ubiquitous drugs and dealers who promise them relief from their sufferings, only to exacerbate their illness and add a ruinous addiction to the challenges of the illness they already have been afflicted with.

How many thousands of families and healthcare workers will have to march on Sacramento before the needs of our severely mentally ill citizens and our loved ones are addressed? Most Californians can access care for almost any other illness, except severe mental illness.

The State of CA and taxpayers will NOT save money by denying healthcare to the mentally ill, but it WILL HAVE TO PAY EVEN MORE TO KEEP LOCKING THEM UP IN JAILS AND PRISONS WITH NO APPROPRIATE HEALTHCARE OR TREATMENT. That is a shameful practice called transinstitutionalization--switching from mental hospitals to incarceration, which has contributed to mass incarceration in the U.S.

With access to proper care (often not possible at the community level, and resisted by counties and hospital systems) a seriously mentally ill person will have a chance to regain insight and learn to manage symptoms. However, the longer care is denied, as in the case of all illnesses, the worse symptoms get and the less likely a SMI person has of regaining some control, some independence. For those who argue that it is a "civil right" for an insane person, visibly suffering in our streets and jails, to refuse care when they don't even comprehend that they've lost their ability to make an informed decision, well that's just nonsense. Severe mental illness robs them of their civil rights to access care on par with other illnesses that are treated without the usual "consent" of a person because of life or death circumstances when someone is incapacitated by illness and can't make such a decision. What we have now is a terrible sort of DISCRIMINATION against those with SMI and THAT is a denial of their Civil Rights.

PLEASE ANSWER THIS EMAIL! Thank you for your attention to this matter! Our advocates and families are TIRED of WAITING! You've had almost 4 years to apply for this waiver. I am speaking specifically to the limit on psych beds currently allowed. I have seen that a waiver for certain "behavioral" services (part of the very insufficient and fragmented so-called community health system, not focused at all on the most severely mentally ill (No Psych beds, no staff, we're constantly told—so open up the psych

beds and give grants to help train people who WANT to work in the professions that are not currently filled and pay them appropriately).

Just how long does California think they can evade the law that says those SMI people who are currently IST (incompetent to stand trial) and held in jails MUST BE ADMITTED TO A STATE HOSPITAL WITHIN 28 DAYS OF BEING REFERRED BY THE COURTS? The last published figure a few months ago indicated that over 1,700 ISTs were on the State Hospital Wait List!!!! The CA Auditor said in her report that the number would continue to grow every month! This logjam of ISTs, many sick for so long from untreated SMI that they have not responded well to care and treatment, not enough to stand trial, cannot be released. Or, under pressure, they do get released when they can't cope at all and the whole cycle starts over again when they are re-arrested for something. THIS IS AN UNTENABLE SITUATION!

Ellie Shukert

Sheila Ganz; Email Received September 10, 2022

To Whom It May Concern:

As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more abominably than they were in the old state hospitals that prompted the prohibition against using Medicare/Medicaid funds for "Institutes of Mental Disease"("IMD") to begin with. Though well-intended when adopted, the IMD exclusion also "withholds mental health care from people of color at a disproportionate rate. People with mental illness are already disadvantaged by having an involuntary brain disease and federal Medicaid law denies them life-saving treatment. People of color with mental illness face a two-headed monster of increased risk of death during police interactions due to their race and the fact that they are sixteen times more likely to die in those encounters because of their mental health status." Michael Gray of Treatment Advocacy Center, opinion contributor to The Hill, https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-alaw-that-hinders-treatment/.

California is among the worst states. We have the dubious distinction of having prisons so bad for the severely mentally ill that a conservative Supreme Court affirmed that California prison conditions for them violated the Eighth Amendment prohibition against "cruel and unusual punishment" in the U.S. Constitution, the only state to hold this distinction. *Brown v Plata,* 563 U.S. 493 (2011). California state prisons are still under federal court order to improve those conditions for the severely mentally ill. A number of California's jails—notably in Sacramento and Los Angeles—are under similar court orders for "cruel and unusual punishment"/Eighth Amendment conditions for the mentally ill inmates. To say this is appalling is an understatement.

California jails are now also under order from the Caliornia courts to stop warehousing severely mentally ill inmates who are incompetent to stand trial for months and sometimes years while they wait for restoration to mental competency. They must be evaluated in 28 days or released. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev.den.* (Aug. 25, 2021). The probable result is that many desperately ill and often dangerous individuals will soon be spilling from our jails onto our streets. The danger and costs are incalculable, not only to those individuals and their loved ones, but to the public and the government agencies that try to protect us all.

This is a crisis, and the IMD exclusion has caused or at least exacerbated it. According to the Rand Corporation and Treatment Advocacy Center, "Taking into account how many beds California currently has, the results suggest that California is short 1,971 acute psychiatric beds and 2,796 subacute beds. In addition, the authors conclude that the shortage of psychiatric beds will only worsen over time, predicting a 1.7% increase in psychiatric bed need by 2026."

https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-1-v2/RAND_RRA1824-1-v2.pdf, https://www.treatmentadvocacycenter.org/about-us/featuresand-news/4494-research-weekly-two-new-studies-on-psychiatric-bed-number-targets.

Psychiatric hospital beds, overwhelmingly occupied by uninsured individuals, will return *if and only if* if California pays for them. The IMD exclusion is an absolute barrier to the a continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive

and stabilize. Many and perhaps most of them, if properly and humanely treated, could return to sanity and avoid neglect and mistreatment in our jails and prisons. If properly treated, it would also prevent the crime and misery caused by their severe mental illnesses. The costs to this Department are far outweighed by the benefits to those desperately ill indiviuals, their families, the people and businesses they harm, and the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs that this Department's failure to apply for the IMD waiver has imposed on them.

The Mental Health Services Act states that "[t]he State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care." Welf. & Inst Code 5890(d). This application is long overdue. Please file it immediately. Thank you.

Sheila Ganz

[redacted]
Emmy-nominated documentary filmmaker
Pandora's Box Productions
San Francisco, CA 94122
[redacted]

Cherry Maurer; Email Received September 10, 2022

Re: Please Apply for the IMD Waiver for California

To Whom it May Concern:

Please approve a Waiver of the IMD exclusion.

The IMD exclusion has had the effect of reducing psychiatric beds, overcrowding jails and prisons, and increasing homelessness - and deaths - among the mentally ill in the State of California. It must stop.

There is a crisis in this State, and the IMD exclusion has caused or at least exacerbated it. This application for a Waiver of the IMD exclusion is long overdue.

Please approve it immediately.

Thank you.

Cherry Maurer
[redacted] victimized by the exclusion)

Michael Verzatt; Email Received September 11, 2022

I am writing to advocate for the IMB waiver. I am a retired government attorney and I have seen far too many mentally ill people sent to jail or state prison instead of receiving the treatment they so obviously need. Prisons are largely à holding facility for the mentally ill. I have long thought that adequate treatment facilities for the mentally ill would result in a decrease in crime and hence the prison population and make it far more likely for them to function in society after treatment as opposed to a period of incarceration.

[redacted] nd the appalling lack of mental health treatment beds.

The IMB exclusion has been horribly punitive and should be waived at a minimum and preferably permanently abolished.

Michael Verzatt
Santa Cruz CA

Sent from my iPhone

NAMI Los Angeles County; Email Received September 11, 2022

September 11, 2022
Mark Gale
[redacted]

Re: CalAIM Section 1115 & and 1915(b) Waiver Amendments: End the IMD Exclusion in California

To Whom It May Concern:

The IMD Exclusion was placed into law that created Medicare and Medicaid in the mid-1960's to ensure that the Federal government would not pay for state hospital systems, and the patients they serve, around the nation. It is ineffective and poor public policy that has led to the dramatic bed shortage for both acute and sub-acute levels of mental health care and to the discrimination of persons with serious mental illness. The time to end this discrimination is long past overdue. In truth, advocates would ask for the outright repeal of the IMD Exclusion altogether, under current consideration in Congress through HR 2611, but until the passage of that bill we must ask the state to support the application for the waiver so people who need access to higher levels of treatment can receive the care they actually need. Without these federal dollars, it has been almost impossible to create the necessary capacity to provide treatment for people who live with the symptoms of serious mental illness.

Our state has been inexplicably dragging its heels for years on this application to utilize the IMD waiver that could help develop federal funding for the more acute levels of care needed by people with more advanced stages of serious mental illness. Our state has starved the areas of our mental health system that serve those who are the most severely ill and need our most intensive care. If people cannot access the levels of care that they need, they become victims of the state mental health system instead of success stories. Without access to these needed services, which could be significantly augmented if California were able to process and receive this waiver and receive federal funds, clients who cannot access care will end up experiencing the catastrophic outcomes of the failure of our mental health system: years in a state hospital, jail, or prison, homelessness and victimization, or even death. The IMD Exclusion has been a major contributor to the "criminalization of the mentally ill" and a leading cause of our Felony Incompetent to Stand Trial crisis in our state.

Let's end this discrimination today. Let's stop talking about doing something and act to create a more fair and just mental health system for all mental health clients. I ask for your "Yes" vote so California can move forward with its application for the IMD Exclusion Waiver now!

Thank you.
Respectfully,

Mark S. Gale
[redacted]

Mark Gale serves as Criminal Justice Chair for NAMI (National Alliance on Mental Illness) Greater Los Angeles County.

Tori Casanova; Email Received September 11, 2022

Dear DHCS,

Please file the Section 1115 & and 1915(b) Waiver Amendment, so Medi-Cal can pay for stays in psych facilities with more than 16 beds. [redacted] Ending this discrimination is urgently needed and is extremely important for my family.

As TAC says, "The Medicaid Institutions for Mental Disease (IMD) exclusion is an outdated, discriminatory federal rule that creates significant barriers to treatment for adults with severe mental illness. Under this rule, Medicaid payments to states are prohibited for non-geriatric adults receiving psychiatric care in a treatment facility with more than 16 beds. Even with recent advances in mental health care afforded by the Affordable Care Act and federal parity legislation, the IMD exclusion remains the only section of federal Medicaid law that prohibits federal payment for medically necessary care simply because of the type of illness being treated. This categorically discriminatory rule is a leading cause of our national psychiatric hospital bed shortage and directly contributes to a host of negative consequences for those with the most severe mental illnesses."

Congress should repeal the discriminatory exclusion for institutions for mental diseases (IMDs.) Until they do so, California urgently needs to file for this waiver.

Thank you,
Tori Casanova
[redacted]

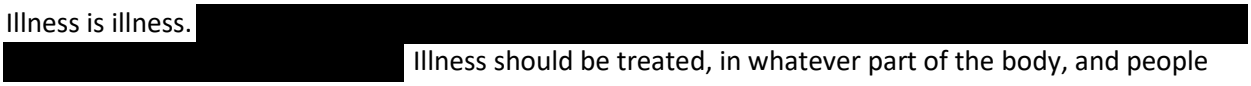
Families Advocating for the Seriously Mentally Ill; Email Received September 12, 2022

Dear Decisionmakers,

I am writing to ask that the State apply immediately to the Federal government for a waiver of Medi-Cal's IMD exclusion for mental illness. This waiver has been promised to us for years but I have not seen any steps taken towards securing it for mental illness, as opposed to substance abuse disorder.

Refusing to pay for treatment of mental illness in a facility of more than 16 beds is irrational and discriminates against those whose illnesses affect their brain and decisionmaking ability.

The IMD exclusion is a main cause of the lack of psychiatric treatment beds in our state and is the main reason that the bulk of the most seriously mentally ill are in jail or homeless. It is a major cause of the backlog of thousands of people in the criminal system who are Incompetent to Stand Trial.

Illness is illness.  Illness should be treated, in whatever part of the body, and people with schizophrenia should be protected and cherished just like those with Alzheimers or other brain disorders.

Thank you for listening, and please let's come out in the open and admit that we can do something right away to address the shortage of mental hospital beds.

Get a waiver of Medi-Cal's IMD exclusion for mental illness.

Alison Monroe
Families Advocating for the Seriously Mentally Ill


NAMI Sacramento; Email Received September 12, 2022

CalAIM Section 115 and 1915 (b) Waiver Amendment

CalAIMWaiver@dhcs.ca.gov

To Whom It May Concern:

September 12, 2022

Please pass (support) the CalAIM Section 1115 and 1915(b) Waiver Amendment. [redacted] however, this is already too long and it is a short time compared to current statistics of which I am sure you are aware.

In addition, [redacted], and the beds were not available and thus practice of release before stable was perpetuated. We need more beds to deliver appropriate care to this section of people whose illnesses, after years of trying everything available to them, are still unwell and severely impaired by their illnesses, and in need of more help than in home (or in room and board or even board and care) can deliver.

By voting to receive a waiver, thus making federal funds available for attaining more IMD beds, a more human system of care will be available to those whose illnesses, at no fault to the patient, render them in need of this added and extended care.

Sincerely,
Elizabeth Kaino Hopper [redacted]

Activist in Support of Family Members/Primary Support for those with SME
NAMI Sacramento, member 11 years
Member of Sacramento 988 Advisory Board
Primary Support person for 12+ years

North East Medical Services; Email Received September 12, 2022

Hello!

Please see attached for our public comment for the CalAIM Section 1115 and 1915(b) Amendments to Implement County-Based Model Changes in Medi-Cal Managed Care Program.

Thank you, and please reach out to Trong Le, NEMS' Assistant MSO Director, if you have any additional questions. Thank you!

Sincerely,

Jessica

Jessica Ho
Government & Community Affairs Manager
[redacted]
Website: www.nems.org

September 9, 2022

Department of Health Care Services
Director's Office
Attention: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Emailed electronically to: CalAIMWaiver@dhcs.ca.gov

RE: NEMS Comments on CalAIM Section 1115 & 1915(b) Waiver Amendments

Dear Ms. Cooper,

On behalf of North East Medical Services (NEMS), I thank you for this opportunity to comment on the CalAIM Section 1115 & 1915(b) Waiver Amendments, specifically DHCS' proposal to contract directly with the Kaiser Foundation Health Plan (Kaiser). As DHCS plans to expand its direct Medi-Cal managed care plan (MCP) contract with Kaiser into 32 counties, we believe that providers, patients, and other stakeholders need additional information to clearly understand the potential impacts on patient access. **Therefore, we ask that DHCS 1) release the Memorandum of Understanding (MOU) between Kaiser and DHCS, 2) ensure that the MOU includes details about Kaiser's 25 percent growth plan, and 3) allow stakeholders to review and comment on the MOU.**

NEMS is a federally qualified health center (FQHC) that serves more than 67,000 patients in the San Francisco Bay Area through 14 clinic sites. A majority of our patients qualify for Medi-Cal, and more than 80% prefer to be served in language other than English. The proposed Kaiser contract expansion may have an impact on our patients – especially those who face cultural and linguistic challenges in navigating the care delivery system. We are also concerned that the Kaiser expansion may impact the resilience of the existing health safety net and our ability to continue serving some of our most vulnerable patients.

The proposed amendments to the Section 1115 & 1915(b) waivers that were released last month include general information about DHCS' intention to expand its contract with Kaiser in current and new counties beginning on January 1, 2024. However, the proposed amendments lack key details about the direct Kaiser contract that would allow the public to examine and understand the potential impacts on patient access to care in those 32 counties. For instance, the proposed amendments do not provide details on how patients can choose their MCP post-expansion, and they do not explicate how DHCS plans to implement patient assignments and auto-assignments. Finally, the amendments do not mention whether patients will be reassigned to Kaiser in order to meet their 25 percent enrollment goal.

For these reasons, we request that DHCS release the MOU between Kaiser and DHCS, include details about how Kaiser will reach its 25 percent growth goal, and allow the public to review and comment on the MOU.

Thank you for your consideration in advance. Please direct any questions to Trong Le, Associate Director MSO, at [redacted].

Sincerely,

[redacted]

Chief Managed Care Officer
North East Medical Services

Marcia Pratt; Email Received September 12, 2022

Dear DHCS,

I am a great grandmother. [redacted] I remember when the state hospitals were closed because it was believed that new drugs and a robust local system would fill the need. We never got that system and [redacted] and others suffer because of it.

Please file the Section 1115 & and 1915(b) Waiver Amendment, so Medi-Cal can pay for stays in psych facilities with more than 16 beds.

As TAC says, "The Medicaid Institutions for Mental Disease (IMD) exclusion is an outdated, discriminatory federal rule that creates significant barriers to treatment for adults with severe mental illness. Under this rule, Medicaid payments to states are prohibited for non-geriatric adults receiving psychiatric care in a treatment facility with more than 16 beds. Even with recent advances in mental health care afforded by the Affordable Care Act and federal parity legislation, the IMD exclusion remains the only section of federal Medicaid law that prohibits federal payment for medically necessary care simply because of the type of illness being treated. This categorically discriminatory rule is a leading cause of our national psychiatric hospital bed shortage and directly contributes to a host of negative consequences for those with the most severe mental illnesses."

Congress should repeal the discriminatory exclusion for institutions for mental diseases (IMDs.) Until they do so, California really needs to file for this waiver.

Thank you,

Marcia Pratt

[redacted]

Sent from my iPhone

Laura Esperanza Surls; Email Received September 12, 2022

Dear DHCS,

Please file the Section 1115 & and 1915(b) Waiver Amendment, so Medi-Cal can pay for stays in psych facilities with more than 16 beds. [redacted] Ending this discrimination is urgently needed and is extremely important for my family.

As TAC says, "The Medicaid Institutions for Mental Disease (IMD) exclusion is an outdated, discriminatory federal rule that creates significant barriers to treatment for adults with severe mental illness. Under this rule, Medicaid payments to states are prohibited for non-geriatric adults receiving psychiatric care in a treatment facility with more than 16 beds. Even with recent advances in mental health care afforded by the Affordable Care Act and federal parity legislation, the IMD exclusion remains the only section of federal Medicaid law that prohibits federal payment for medically necessary care simply because of the type of illness being treated. This categorically discriminatory rule is a leading cause of our national psychiatric hospital bed shortage and directly contributes to a host of negative consequences for those with the most severe mental illnesses."

Congress should repeal the discriminatory exclusion for institutions for mental diseases (IMDs.) Until they do so, California really needs to file for this waiver.

Thank you,
Laura Esperanza Surls
[redacted]

Los Angeles Congregate Living; Email Received September 12, 2022

Hello,

Congregate Living Health Facilities (CLHFs) provide long term care to low-income vulnerable populations in CA. We fit the Cal Aim/ECM model perfectly but have not been mentioned as a benefit from MCP. Can CLHFs be added as a benefit along with all the long term care models such as SNFs, subacutes, recuperative cares.....etc.

Best Regards,

Mariam Voskanyan, RN
Administrator/ DON
Los Angeles Congregate Living, Inc.
[redacted]

The Bread Project; Email Received September 9, 2022

Greetings, and thank you for this opportunity to comment.

One key to successful transitions of the reentry population into society is the ability to access living wage jobs, and receive the training and support necessary to acquire those jobs. Adding 'workforce development' as part of CalAIM's Community Supports would be so instrumental for a formerly incarcerated individual to be able to have an instant community support group; an opportunity to gain new skills, self-confidence, and self-esteem; and the know-how to work toward economic self-sufficiency.

With gratitude for listening,

Lynn

Lynn Luckow
Chief Development & Strategy Officer
The Bread Project
[redacted]

Louise Pratt; Email Received September 12, 2022

Dear DHCS,

Please file the Section 1115 & and 1915(b) Waiver Amendment, so Medi-Cal can pay for stays in psych facilities with more than 16 beds. [redacted] Ending this discrimination is urgently needed and is extremely important for my family.

As TAC says, "The Medicaid Institutions for Mental Disease (IMD) exclusion is an outdated, discriminatory federal rule that creates significant barriers to treatment for adults with severe mental illness. Under this rule, Medicaid payments to states are prohibited for non-geriatric adults receiving psychiatric care in a treatment facility with more than 16 beds. Even with recent advances in mental health care afforded by the Affordable Care Act and federal parity legislation, the IMD exclusion remains the only section of federal Medicaid law that prohibits federal payment for medically necessary care simply because of the type of illness being treated. This categorically discriminatory rule is a leading cause of our national psychiatric hospital bed shortage and directly contributes to a host of negative consequences for those with the most severe mental illnesses."

Congress should repeal the discriminatory exclusion for institutions for mental diseases (IMDs.) Until they do so, California really needs to file for this waiver.

Thank you,
Louise Pratt
[redacted]

River Oak Center for Children; Email Received September 12, 2022

Is it possible to extend the application process until June 2023. The system is overwhelmed with applications and those of us who are trying to meet the criteria need more time, I would like to waive the exam for those that can prove recent education, or previous credentials in other fields. This would be a case by case, application.

I believe this position would be well invested if the criteria were flexible by each application case, not a one size fits all. Human being are not one size fits all, I think a review of the criteria would be warranted.

This input is for the comment section of Cal AIM waiver.

Mary Ponder MS HS - BCP
Neighborhood Navigator
[redacted]

River Oak Center for Children
4625 44th St. #36
Sacramento Ca, 95820
[redacted]

Samuel Verzatt; Email Received September 12, 2022

To whom it may concern:

I am writing to advocate for the IMB waiver. I am a Marriage and Family Therapist and it is my professional opinion that people who struggle with mental illness need to receive treatment before they are sent to jail or state prison. By making our jails and prisons our de facto centers for mental health care we as a society are sending the message that having a mental illness is a crime. And that those who struggle with mental illness are criminals. This only serves to reinforce stigmas and stereotypes that harm some of the most vulnerable citizens in this country. This is before we even consider the degree of trauma and psychological damage that sending individuals who struggle with mental illness to jail or prison will cause to said individuals. Not to mention the fact that this move will only further perpetuate racist and classist structures in America by criminalizing those who are underprivileged and are unable to access mental health care.

Prisons and jails are already overburdened and are unable to provide appropriate care for their current occupants.

Study after study has shown that stabilizing an individual by providing access to stable housing and medical and psychological care leads to positive outcomes. These same studies show that this not only leads to positive outcomes for the individual, it is also less expensive in the long run. We as a society can no longer afford to be reactive to the problems we face.

The IMB exclusion has been horribly punitive and should be waived at a minimum and preferably permanently abolished.

"The true measure of any society can be found in how it treats its most vulnerable members."

Thank you,
Sam Verzatt MA, LMFT

"Not everything that is faced can be changed, but nothing can be changed until it is faced."
-James Baldwin

Karin Napel; Email Received September 12, 2022

Hello,

[redacted] This has been a big struggle for us. [redacted] alone just for the drive from Santa Barbara.

I do think it would make sense to allow more beds.

Thank you for your consideration.

Karin Napel

Gail Osherenko; Email Received September 12, 2022

Dear CA DHCS,

Adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness is vital for California and especially for my County of Santa Barbara. [redacted] This is the shocking and deeply disturbing result of not having sufficient mental health beds in the County. You can help to change that!

The proposed amendment would provide a waiver in California to the federal rule that prohibits using Medicaid funds to cover services provided in secured psychiatric facilities, including residential treatment facilities, with more than 16 beds. This rule, called the IMD (Institution for Mental Disease) Medicaid Exclusion, is what has for years limited the capacity of our Psychiatric Health Facility to 16 inpatient beds. Nationally, and in California, the IMD Exclusion has resulted in a critically severe shortage of mental health treatment beds as part of the continuum of care.

I am proud that my Congressional Representative Salud Carbajal was the second to sign on as co-sponsor to HR 2611, the bill to repeal the Exclusion. But, short of federal repeal, the next best thing is this California waiver. Please adopt it.

Sincerely,
Gail Osherenko
Santa Barbara County resident

NAMI Santa Cruz; Email Received September 12, 2022

Please apply for the IMD Waiver for California. See my attached letter below. Thanks for your consideration.

Susan Beveridge

Re: Please Apply For the IMD Waiver for California

To Whom It May Concern:

The IMD waiver has limited the size of our Santa Cruz County's only psychiatric facility (Telecare) and many others elsewhere to 16 beds. The overage gets diverted to the jail or street. [redacted], I have had first hand experience with the difficulty of getting help when in crisis.

[redacted] The journey was not without obstacles especially the lack of beds at the step-down intensive inpatient programs in our county. [redacted]

As a volunteer for the National Alliance of Mental Illness (NAMI), I have seen the suffering of countless families as they seek help for their loved one during a mental health crisis. Many of the seriously mentally ill do not have the insight into their illness. As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more terribly than they were in the old state hospitals

The IMD exclusion is a barrier to the continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many of these individuals if properly treated, could return to functionality. They would avoid the mistreatment in our jails and prisons that we currently see. With proper treatment, society would experience less crime and misery. Think of the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs.

It is time to end the crisis that the IMD exclusion has caused or at least exacerbated. The time to act is now.

Thank You,

Susan Beveridge

Andi Henrikson; Email Received September 12, 2022

I AM ASKING FOR ADOPTION OF THE IMD MEDICAID EXCLUSION WAIVER FOR SERIOUS MENTAL ILLNESS IN THE STATE OF CALIFORNIA.

Andrea Henrikson
Santa Barbara, CA 93110

NAMI Santa Cruz; Email Received September 12, 2022

Please apply for the IMD Waiver for California. See my attached letter below. Thanks for your consideration.

Susan Beveridge

Re: Please Apply For the IMD Waiver for California

To Whom It May Concern:

The IMD waiver has limited the size of our Santa Cruz County's only psychiatric facility (Telecare) and many others elsewhere to 16 beds. The overage gets diverted to the jail or street. [redacted], I have had first hand experience with the difficulty of getting help when in crisis.

[redacted] The journey was not without obstacles especially the lack of beds at the step-down intensive inpatient programs in our county. [redacted]

As a volunteer for the National Alliance of Mental Illness (NAMI), I have seen the suffering of countless families as they seek help for their loved one during a mental health crisis. Many of the seriously mentally ill do not have the insight into their illness. As you are surely aware, there is a direct correlation between the loss of hospital beds for the most severely mentally ill Americans and their movement into jails and prisons, where they are treated even more terribly than they were in the old state hospitals

The IMD exclusion is a barrier to the continuum of care we desperately need so that the most severely ill individuals can receive the treatment they need to survive and stabilize. Many of these individuals if properly treated, could return to functionality. They would avoid the mistreatment in our jails and prisons that we currently see. With proper treatment, society would experience less crime and misery. Think of the savings to police departments, public welfare agencies, jails, prisons and other public entities which bear the costs.

It is time to end the crisis that the IMD exclusion has caused or at least exacerbated. The time to act is now.

Thank You,

Susan Beveridge

Weiser & Grant Dentistry; Email Received September 12, 2022

Please make the adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness. Had this been in place [redacted]

Sheri L. Rowe
Weiser & Grant Dentistry
[redacted]
SantaBarbaraDDS.com
Ozonetherapiesgroup.com

ViiV Healthcare Company; Email Received September 12, 2022

Greetings,

ViiV Healthcare Company (ViiV), wishes to offer the attached comments to the California Department of Health Care Services (DHCS) regarding the proposed California Advancing & Innovating Medi-Cal (CalAIM) 1115 Demonstration & 1915(b) Waiver Amendments for Managed Care Model Changes and Other Managed Care Updates.

Please reach out if I can provide clarification or additional information.

Thank you!
Kristen

Kristen Tjaden
Government Relations Director, West
ViiV Healthcare
[redacted]
viivhealthcare.com | Twitter | Facebook

September 12, 2022

Submitted via: CalAIMWaiver@dhcs.ca.gov

Director Michelle Baass
Department of Health Care Services
Director's Office
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Attn: Jacey Cooper

Re: Proposed CalAIM Section 1115 & 1915(B) Waiver Amendments for Managed Care Model Changes And Other Managed Care Updates

Dear Director Baass;

ViiV Healthcare Company (ViiV), wishes to offer the following comments to the California Department of Health Care Services (DHCS) regarding the proposed California Advancing & Innovating Medi-Cal (CalAIM) 1115 Demonstration & 1915(b) Waiver Amendments for Managed Care Model Changes and Other Managed Care Updates.[1, 2]

ViiV, a global specialist HIV company established in 2009, is the only company 100 percent dedicated to combating, preventing, and ultimately curing HIV. ViiV specializes in the development of therapies for HIV and is devoted exclusively on advancing science into HIV treatment, prevention and care. From its inception, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. ViiV is proud of the scientific advances in the treatment and prevention of this disease which have helped to transform HIV from a terminal illness to a manageable chronic condition. In collaboration with the HIV community, ViiV remains committed to developing meaningful technologies in HIV treatment and prevention, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care, prevention, and treatment.

CalAIM 1115 Demonstration & 1915(b) Waiver

ViiV recognizes the work DHCS has done in creating this proposal for a new delivery system

[1] State of California Department of Health Care Services. Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Request: CalAIM Demonstration - DRAFT FOR PUBLIC COMMENT. April 12, 2022. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-MCP-Model-Change-Section-1115-Amendment.pdf. Accessed August 26, 2022.
[2] State of California Department of Health Care Services. California Advancing and Innovating Medi-Cal (CalAIM) Section 1915(b) Waiver Amendment Overview. August 2022. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915-b-Amendment-Summary-for-Public-Comment.pdf. Accessed August 26, 2022.

framework and particularly the extensive stakeholder input and feedback process the state undertook in creating CalAIM.[3]

Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for people with HIV.[4] In fact, more than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.[5] Medicaid is an essential source of access to medical care and antiretroviral (ART) drug coverage for people with HIV. This medical care and drug treatment not only preserves the health and wellness of people with HIV and improves health outcomes, but it also prevents new HIV transmissions. Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of people with HIV are retained in medical care, according to the Centers for Disease Control and Prevention (CDC).[6] Therefore, it is imperative that Medi-Cal managed care plans (MCPs) work to preserve continuous access to comprehensive high-quality health care and antiretroviral therapy for people with HIV in order to improve health outcomes and reduce new transmissions, and provide unfettered access to HIV prevention medications and services.

ViiV offers the following suggestions and recommendations:

1. ViiV Applauds California's Open Access to HIV ART

We applaud the state of California for its statutory coverage of access to ART for people with HIV in Medi-Cal. We would be remiss if we didn't mention the importance of continuing policies that ensure open access to life-saving treatment for people with HIV, including newer single tablet regimens and long-acting technologies.

In clinical settings, health care providers work closely with patients to select HIV treatment options with great specificity for each patient. Effective treatment of HIV is highly individualized and accounts for a patient's size, gender, treatment history, viral resistance, coexisting illnesses, drug interactions, immune status, and side effects. In fact, the DHHS Guidelines[7] state that, "Regimens should be tailored for the individual patient to enhance adherence and support long-term treatment success."

Therefore, broad access to the full array of available treatment options is vital in HIV treatment. People with HIV must have access to a robust formulary that provides physicians with the ability to prescribe the right treatments at the right time for their patients.

---

[3] State of California Department of Health Care Services "Department Of Health Care Services Notice Of General Public Interest. April 6, 2021. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-1915%28b%29-Joint-Public-Notice.pdf. Accessed September 8, 2022.

[4] Kaiser Family Foundation. Medicaid and HIV. October 1, 2019. http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/. Accessed September 8, 2022.

[5] Centers for Disease Control and Prevention (CDC). Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. https://www.cdc.gov/hiv/ library/reports/hiv-surveillance.html. Published June 2019. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf. Accessed September 8, 2022.

[6] Centers for Disease Control and Prevention (CDC). Understanding the HIV Care Continuum. https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf. Accessed September 8, 2022.

[7] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines. Accessed September 8, 2022.

2. ViiV Encourages the State to Ensure Patient Access to HIV-Specialized Providers through Medi-Cal Provider Networks

ViiV asks DHCS to apply careful consideration to people living with HIV in Medi-Cal, who may have to change plans as a result of this proposed model change, and take steps to ensure they will have access to adequate and expert HIV care in their new plan. Retention in care is a vitally important part of treatment success for people with HIV, and so we urge the state to take steps within this population to ensure individuals are retained in medical care.

Access to qualified medical care providers is important for people with HIV in order to monitor disease progression and ensure viral suppression is maintained.[8,9] Access to infectious disease specialists and HIV-specialized providers[10] is vital for people with HIV, as HIV patients see better outcomes when treated by an experienced HIV provider.[11]

Since the beginning of the HIV epidemic, providers from a variety of specialties (such as Infectious Disease Specialists and family medicine) and licensures (physician's assistants, nurses, nurse practitioners) have focused in HIV care and treatment and served this vulnerable population. There is no board certification for HIV medicine, but several professional organizations have identified criteria for designation of HIV specialists,[12,13] and some states have also codified HIV specialty.[14]

The importance of continuity of care for medically underserved patients, particularly people living with HIV, is significant. Patients retained in active medical care often have long-standing, trusting relationships with their medical provider, which is a key piece of the successful management of HIV. Exclusion of these providers from coverage networks can lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations. Achieving control of the virus requires regular access to a medical provider. Gaps in HIV treatment of days to weeks can reverse viral suppression, increase risk of transmission to others, and lead to serious complications, including development of a virus that is drug resistant, and more difficult to treat.[15]

We applaud the language included in the proposal:

---

[8] Kitahata MM, Koepsell TD, Deyo RA, et al.. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. N Engl J Med. 1996 Mar 14;334(11):701-6. Accessible at: https://pubmed.ncbi.nlm.nih.gov/8594430/.

[9] Gallant JE, Adimora AA, Carmichael JK, et al. Essential components of effective HIV care: a policy paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition. Clin Infect Dis. 2011 Dec;53(11):1043-50. Accessible at: https://pubmed.ncbi.nlm.nih.gov/22021928/.

[10] HIV Medicine Association. Identifying Providers Qualified to Manage the Longitudinal Treatment of Patients with HIV Infection and Resources to Support Quality HIV Care. March 2013. https://www.hivma.org/globalassets/hivma/logos/revised-qualified-hiv-provider-policy-statement-approved-3-16-13-1.pdf. Accessed September 8, 2022.

[11] Gallant JE, Adimora AA, Carmichael JK, et al. Essential components of effective HIV care: a policy paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition. Clin Infect Dis. 2011 Dec;53(11):1043-50. Accessible at: https://pubmed.ncbi.nlm.nih.gov/22021928/.

[12] American Academy of HIV Medicine (AAHIVM). Credentialing Handbook. March 2019. https://aahivm.org/wp-content/uploads/2019/04/AAHIVM-Credentialing-Handbook-4.4.19.pdf. Accessed August 26, 2022.

[13] Association of Nurses in AIDS Care (ANAC). HANCB AACRN Certification Application. https://www.nursesinaidscare.org/i4a/forms/index.cfm?id=196. Accessed August 26, 2022.

[14] Florida Agency for Healthcare Administration, Medicaid Managed Care Contract, The HIV/AIDS Specialty Plan, Attachment II, Exhibit II-C, HIV/AIDS Specialty Plan, November 1, 2015, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-C-HIV-AIDS_2015-11-01.pdf. Accessed August 26, 2022.

[15] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines. Accessed September 8, 2022.

> DHCS is committed to ensuring smooth transitions for individuals required to switch plans following implementation of the expanded COHS and Single Plan models, including through continuity of care requirements to support continued beneficiary access to providers and prevent disruptions in treatment, robust appeals and grievances processes, member communication and data sharing of member information prior to plan transition. [16]

In addition to these efforts, we encourage DHCS to require that MCPs provide information about HIV educational opportunities, including HIV prevention, to all Medi-Cal providers, as well as resources for consultation for inexperienced health care providers treating people with HIV, or those vulnerable to HIV acquisition.

The federal Health Resource Services Administration (HRSA), which administers the Ryan White program, offers direct provider-to-provider consultation services through the National HIV/AIDS Clinician Consultation Center, including several hotlines: the "HIV Management Service Warmline," the Post-Exposure Prophylaxis Hotline (PEPline), Perinatal HIV Consultation and Referral Services (Perinatal HIV Hotline), the Pre-Exposure Prophylaxis Service (PrEPline), and the Clinical Substance Use Consultation (Substance Use Warmline). [17]

Additionally, the Ryan White AIDS Education Training Centers (AETCs) are regional bodies which offer resources and program for provider education on HIV.[18] MCPs should advise network providers on the offerings of the AETCs.

DHCS would benefit from requiring that all providers in the state fulfill a minimum amount of continuing medical education (CME) training on HIV. Due to the high burden of HIV incidence, the District of Columbia requires licensed health professionals to complete at least ten percent of their continuing education in the public health priorities of the District, including HIV[19] and LGBTQ cultural competency to help health care professionals to better understand the health challenges faced by these communities.[20] This is especially important for those providers who treat only a few people with HIV, as studies show that HIV patients see better outcomes when treated by an experienced HIV provider.[21]

Thank you for your consideration of our comments. We hope that California will continue to lead in its work to end the HIV epidemic, and as such, use this CalAIM initiative to advance these

---

[16] State of California Department of Health Care Services "Department Of Health Care Services Notice Of General Public Interest. April 6, 2021. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-1915%28b%29-Joint-Public-Notice.pdf. Accessed September 8, 2022.
[17] AIDS Education & Training Center (AETC). National Clinician Consultation Center. https://aidsetc.org/aetc-program/national-clinician-consulation-center. Accessed September 8, 2022.
[18] AIDS Education & Training Center (AETC). https://aidsetc.org/. Accessed September 8, 2022.
[19] District Of Columbia Department Of Health. Public Notice: Identifying Public Health Issues For Continuing Education, Register VOL. 66 - NO. 45. NOVEMBER 1, 2019. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/10%25%20CE%20-%20Public%20Notice%20-%2066%20DCR%2014518-14519.pdf. Accessed September 8, 2022.
[20] DC.gov. Board of Medicine. Continuing Education Requirements. https://dchealth.dc.gov/bomed. Accessed September 8, 2022.
[21] Gallant JE, Adimora AA, Carmichael JK, et al. Essential components of effective HIV care: a policy paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition. Clin Infect Dis. 2011 Dec;53(11):1043-50. Accessible at: https://pubmed.ncbi.nlm.nih.gov/22021928/.

objectives. Please feel free to contact me at [redacted] with any questions.

Sincerely,

[redacted]

Kristen Tjaden
Government Relations Director
ViiV Healthcare

Choice in Aging; Email Received September 12, 2022

To Whom it May Concern:

I would like to add Choice in Aging's support to the letter submitted by the National Health Law program. Additionally, we want to emphasize the final bullet of their commentary regarding *Ensuring Transparency of DHCS Monitoring and Enforcing*. In addition to the request for transparency and access to the data, Choice in Aging strongly urges the Department to analyze data and input from caregivers and community based organizations providing care to these beneficiaries. Self-reported data and state review do not always reveal the direct beneficiary experiences - or that of their caregivers when the beneficiary is unable to participate. This is a massive overhaul of systems happening differently throughout the state while dismantling some of the assurances granted through Knox-Keene - so it is vital we do our best to ensure no harm to this fragile population.

Thank you!
Debbie

--

DEBBIE TOTH | President & CEO
she/her/hers (why pronouns matter)
[redacted] | www.choiceinaging.org

Jim Fiolek; Email Received September 12, 2022

To: CA Dept. of Health Care Services

I urge you to support adoption of the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Sincerely,
Jim Fiolek

Sent from a little plastic thing in my hand, which, with the help of a satellite system similar to L.A. traffic, has created millions of Jobs here on Earth.

Dignity Health; Email Received September 12, 2022

Hello,

The following are my concerns about the new Cal AIM Medi-Cal managed care plan model changes.

1) Molina has a history of mishandling claims - excessive denials to access to necessary care, not paying claims. They have a very bad reputation in the field. This is very concerning if they will have LA market as we have a very large population of disadvantaged individuals who regularly have trouble accessing necessary medical care/treatments. The disadvantaged population being covered also have trouble advocating for themselves and staying informed. How will these large changes ensure that the most marginalized covered lives will not get lost in the middle amidst all the confusion?

2) The current Managed Care Plans are already difficult to work with, they deny multiple referrals and keep patients on hold for months while they wait for necessary services. It is already very difficult to get through to someone who can help. The new changes seem like they will add more red-tape, more delays to patient care.

Thank you,
Crystal

Crystal Rocha Torres, RN, BSN, PHN

Ambulatory RN Care Coordinator/ Los Angeles Market for Complex/High Risk Capitated MediCAL Managed & BPCI/MSSP Members

Dignity Health

[redacted]

On Lok; Email Received September 12, 2022

Good afternoon,

On behalf of On Lok, I am submitting the attached comment letter from Grace Li, On Lok's CEO, on the CalAIM Section 1115 & 1915(b) Amendment. Please let me know if you have any questions or need additional information.

Thank you in advance for your consideration of our comment.

Best Regards,
Eileen

Eileen Kunz (she/her/hers)
CHIEF OF GOVERNMENT AFFAIRS & COMPLIANCE • ON LOK
1333 Bush Street, San Francisco, CA 94109
[redacted]
Website: www.onlok.org
[redacted]

September 12, 2022

Ms. Jacey Cooper
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capital Avenue, MS 4502
Sacramento, CA 95899-7437

RE: On Lok Comments – CalAIM Section 1115 & 1915(b) Waiver Amendment

Dear Ms. Cooper,

On Lok is pleased to submit comments on the proposed amendments to the CalAIM Section 1115 demonstration and 1915(b) waiver related to Medi-Cal managed care plan model changes.

On Lok is a family of nonprofit organizations with a 51-year history of serving seniors in the San Francisco Bay Area. On Lok founded the PACE (Program of All-Inclusive Care for the Elderly) model of care, which is a provider-based managed care program that fully integrates all Medicare and Medicaid services, from acute hospital care to long-term services and supports, for individuals 55 years of age and older who meet the Medicaid nursing home level of care criteria. Today, On Lok PACE serves over 1,700 seniors in three counties; this includes over 300 seniors in Alameda County, where we have been operating On Lok PACE and collaborating with health plans and community-based organizations for over 20 years. In addition to On Lok PACE, Center for Elders' Independence has operated PACE for over 30 years and serves both Alameda and Contra Costa Counties.

On Lok supports Alameda County's adoption of the Single Plan managed care model with Alameda Alliance for Health as the local public plan. However, we believe the Department must ensure that currently operational PACE organizations remain a Medi-Cal managed care alternative in Alameda and other model change counties and that Medi-Cal beneficiaries are given the opportunity to enroll in PACE as model changes take effect.

COHS Expansion and Single Plan Counties with Operational PACE Organizations
We urge the Department to update the 1915(b) waiver to clarify that operational independent PACE organizations may continue to serve Medi-Cal beneficiaries in counties newly adopting the COHS or Single Plan model without an additional approval process.

The CalAIM Section 1915(b) waiver as approved by CMS on December 29, 2021 allows Medi-Cal beneficiaries to enroll in PACE independent of the COHS managed care plan in "select Medi-Cal COHS counties (currently Humboldt and Orange)." However, five of the fifteen counties moving to a model with one plan per county in January 2023, including Alameda County, are already home to independent PACE organizations and should also be included in this provision of the 1915(b) waiver.

P: 415-292-8888 | TTY 711
F: 415-292-8745
1333 Bush Street,
San Francisco, CA 94109-5611
www.onlok.org

We recommend that the Department build on current policy allowing beneficiaries in counties that convert to COHS status to continue to enroll in PACE, independent of the COHS plan, and allow existing PACE programs in counties adopting the COHS or Single Plan model to be "grandfathered" in as an enrollment option for eligible Medi-Cal beneficiaries, without requiring a new letter of support from the county's local plan.

Allowing for the continuous operation of operational PACE programs is important to avoiding disruption to care arrangements for current PACE participants, who are older adults with complex care needs. We believe this policy is consistent with the Department's current approach to the independent operation of PACE in COHS counties and would provide a more streamlined approach to ensuring uninterrupted, timely access to PACE in these counties.

We also request that the Department clarify whether PACE organizations applying to expand their service area or start a new PACE program in a Single Plan County will be required to obtain a letter of support from the local public plan (as they are in COHS counties), and whether these requirements will still stand in counties where Kaiser Foundation Health Plan is available in addition to the local public plan.

Model Change Implementation and Transition

We appreciate the Department's commitment to ensuring continuity of care and a smooth transition among plans for Medi-Cal members in model change counties. As part of that transition, DHCS should require that PACE be offered as an enrollment choice and included in all enrollment and outreach materials. Additionally, DHCS should ensure that current PACE participants are excluded from passive enrollment processes and all notices around enrollment transitions. These changes would align with the Department's approach to CalAIM mandatory managed care enrollment transitions effective January 2023 and assure that PACE is accessible to all beneficiaries who could benefit from the program.

Thank you for your consideration of our comments. We value the state's partnership in serving our most vulnerable populations and look forward to your continued support of the PACE model in California. Please contact me at [redacted] or Eileen Kunz, Chief of Government Affairs and Compliance at [redacted] if you have questions or need additional information.

S[redacted]

Chief Executive Officer
On Lok

America's Physician Groups; Email Received September 12, 2022

Submitted comments on CalAIM Section 1115 & 1915(b) Amendments.

Bill Barcellona
Exec. VP Government Affairs | America's Physician Groups
1215 K St. 17th Floor # 0750, Sacramento, CA 95814
[redacted] | www.apg.org

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

September 12, 2022

Department of Health Care Services
Director's Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Sent via email: CalAIMWaiver@dhcs.ca.gov

Re: Public Comments on CalAIM Section 1115 & 1915(b) Amendments

Thank you for the opportunity to submit comments on the proposed amendments to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration and Section 1915(b) waiver related to Medi-Cal managed care plan model changes.

The proposed model changes reflect significant and potentially disruptive changes to the Medi-Cal managed care delivery system. They also impact large urban and demographically complex segments of the state. Providers who deliver care to members of Medi-Cal Managed Care Plans (MCPs) reasonably expect that DCHS will plan on changes of this scale, complexity, and impact very carefully so that the ensuing disruption in networks, access, and the member experience are *de minimis*. Accordingly, on behalf of the physician groups and IPAs that serve approximately 7 million Medi-Cal members in California, APG respectfully expresses its concerns regarding the proposed model changes.

First, given the complexity of the model changes, APG believes that DHCS should have secured federal approval of the model changes before effectuating them in the recent Medi-Cal managed care RFP. Effectuating the model changes, issuing the RFP, and announcing notices of intent to award without federal approval of the model changes does not reflect the appropriate level of careful planning that these changes warrant.

Secondly, these model changes particularly impact dually eligible beneficiaries in the impacted counties that are also in the Coordinated Care Initiative (CCI). Dually eligible beneficiaries in CCI counties will face the December 31, 2022, termination of Cal Medi Connect (CMC) and the proposed transition to D-SNPs in the CMC plans for January 1, 2023. To the extent that certain CMC plans will no longer be able to operate as D-SNPs in the formerly CCI counties, effective January 1, 2024, dually eligible members face a second transition in 2024. APG recognizes and respects DHCS' obligation to administer and update the Medi-Cal program and its delivery system as it sees fit. Careful planning and authentic stakeholder engagement, however, remain critical.

On a final note, we very much hope that DCHS will seek stakeholder input on its MLR workplan to CMS. We note that DHCS has committed to doing a 'landscape analysis.' Careful attention to the strategic implications of network design, access, and disruption from this analysis is warranted in the same manner as model design warrants careful attention.

Thank you for the opportunity to comment.

Sincerely,

William Barcellona, Esq, MHA
Executive Vice President for Government Affairs

Central California Alliance for Health; Email Received September 12, 2022

Good afternoon,

On behalf of Stephanie Sonnenshine, Central California Alliance for Health CEO, please find the attached written comments on DHCS' California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration and Section 1915(b) waiver related to Medi-Cal managed care plan model changes.

Regards.
Danita Carlson

Danita Carlson
Government Relations Director
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
[redacted]

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

September 12, 2022

Michelle Baass, Director
Jacey Cooper, Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Via email: CalAIMWaiver@dhcs.ca.gov

Re: Comments on Proposed 1115 and 1915(b) Waiver Amendments

Dear Directors Baass and Cooper,

On behalf of the Central California Alliance for Health (the Alliance) which is the County Organized Health System (COHS) serving over 400,000 Medi-Cal beneficiaries in our region since 1996, I appreciate the opportunity to provide comments in response to the Department of Health Care Services (DHCS) draft amendments to California's 1115 and 1915(b) waivers.

The Alliance offers our strong support for DHCS' request to seek authority from the Centers for Medicare & Medicaid Services (CMS) for Medi-Cal managed care model change in counties that will join an existing COHS or which will transition to a Single Plan model (hereinafter "model change authority"). However, the Alliance continues to express our strong opposition to the component of the 1915(b) waiver that seeks federal authority to implement a statewide contract for an alternative health care service plan (the statewide contract) which contradicts the exclusive contracting authority of the COHS. The model change policy advances the strong public policy which relies on public entities to address the challenges of the Medi-Cal delivery system, while in contrast the statewide contract undermines that very same public policy.

First, with regards to our support for DHCS's request for model change authority, local plans have been a cornerstone of the Medi-Cal managed care delivery system in California for over 40 years. COHS and Local Initiative (LI) plans were created specifically to meet the health care needs of underserved populations in their communities through a public entity governed locally with input from local stakeholders. COHS and LIs are authorized under state and federal statute and formed through county ordinance. Since the early 1980s, 15 COHS and LIs were established across 35 counties in California for this purpose. The fact that so many counties have sought and implemented the local plan model speaks volumes about the value that local plans bring to their communities.

In 2020 and 2021, in anticipation of the statewide commercial plan procurement, DHCS offered counties the opportunity to select the model of Medi-Cal managed care which best meets the needs of their community and which would best set up the county for success in achieving the State's ambitious CalAIM goals. Fourteen additional counties chose to join an

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

existing local plan and two counties with existing LIs chose to transition to a Single Plan model.

By seeking federal authority to implement these county model changes, DHCS is affirming the critical role that local communities play in determining how to design a local delivery system to meet their local needs while also advancing state and federal goals for the Medicaid program. CMS approval of DHCS's authority to implement the Medi-Cal managed care model change is critical to furthering important public policy.

Second, with regards to the statewide contract, the Alliance continues to express its strong opposition as DHCS seeks federal authority through the 1915(b) waiver amendment to implement this statewide contract. As you are aware, strong and voluminous opposition was expressed by county health departments, Boards of Supervisors, local providers and local health plans about the statewide contract offered by DHCS to Kaiser Foundation Health Plan (Kaiser) and subsequently authorized through AB 2724 (Arambula). DHCS' waiver request to expand COHS plans and the Single Plan model supports the role of local communities in self-determination. In stark contrast, the statewide contract undermines the locally driven public plan model and is, therefore, opposed by local stakeholders. In addition, this statewide contract creates an inequitable, two-tiered Medi-Cal delivery system: one tier for those individuals served by a private, commercial non-profit corporation that prioritizes the commercially covered population, and another for those people experiencing the deepest poverty who are served by the public and traditional safety net delivery system.

For these reasons the Alliance expresses its support for DHCS' request to seek authority from CMS for Medi-Cal managed care model change in counties that will join an existing COHS or transition to a Single Plan model. However, the Alliance is strongly opposed to the 1915(b) waiver request seeking federal authority to implement a statewide contract for an alternative health care service plan.

I appreciate the opportunity to provide these comments on the draft waivers which seek to shape the Medi-Cal managed care delivery system for years to come.

Sincerely,

[redacted]

Stephanie Sonnenshine
Chief Executive Officer

Ian Lewis; Email Received September 12, 2022

Dear Ms. Cooper,

NUHW represents 16,000 healthcare employees, including more than 4,000 licensed and certified non-physician behavioral health clinicians at Kaiser Permanente across California. We write to express our serious concerns regarding proposed amendments to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration and Section 1915(b) waiver related to Medi-Cal managed care plan model changes. Specifically, these grave concerns relate to the proposed expansion of direct Medi-Cal Managed Care Plan contracting with Kaiser Foundation Health Plan to cover all of the 32 counties in which it operates as a commercial plan.

Over the past decade, the Department of Managed Health Care has repeatedly found Kaiser to have failed in its obligation to provide enrollees with timely and appropriate behavioral health care to which they are entitled under the law, and has found in each successive instance that Kaiser has failed to remedy multiple deficiencies that had been noted previously. In part because Kaiser enrollees continue not to receive the timely care they need, California last year enacted SB 221 – obliging health plans to ensure that enrollees in ongoing courses of behavioral health care will be offered follow-up appointments within ten business days, unless their treating providers affirm that longer timeframes will not be detrimental to their health. Kaiser's representatives have repeatedly assured legislators and agency officials that they are now or soon will be in compliance with the requirements of SB 221 as well as the overarching behavioral health access and parity requirements of SB 855, but nothing could be further from the truth.

In May, the Department of Managed Health Care (DMHC) announced it was launching a "non-routine survey" to scrutinize Kaiser's mental health coverage. This investigation was spurred in part by a 20% increase in patient complaints received by DMHC, as well as by testimony that Kaiser is the worst-performing health plan for enrollees needing behavioral health services. Soon thereafter, NUHW documented for legislators and agency officials that in many Kaiser service areas, there were no follow-up appointments available for enrollees receiving behavioral health care until mid- or late-August, and that some clinics had no appointments open till September.

Since August 15, more than 2,000 behavioral health care clinicians at Kaiser health care facilities across Northern California who are members of NUHW have been on strike due to Kaiser's refusal to address their concerns over systemic understaffing that has left them unable to provide care for their patients consistent with the requirements of the law or their professional training.

Since the strike began, Kaiser has, among many other violations of state and federal laws governing the provision of behavioral health services, engaged in the following egregious acts:

- cancelled thousands of appointments without giving enrollees timely and geographically accessible options for appropriate replacement care either in-network or out-of-network;
- curtailed the availability of Intensive Outpatient Treatment programs and Partial Hospitalization Programs for patients at risk with severe behavioral health disorders;
- in at least one high-volume emergency room, suspended the availability of psychiatric care for six hours per day and downgraded the availability of psychiatric care for another eight hours a day, resulting in patients being placed on 5150 holds and being isolated in bare rooms without

appropriate assessment or supervision for extended periods, with some of them being released without appropriate evaluation or plans for follow-up care.

As a result of NUHW's documentation of these violations, DMHC has now launched another special investigation of Kaiser's behavioral health services on top of the one already in progress.

Given Kaiser's severe failures to meet its current enrollees' behavioral health needs, it is inconceivable that Kaiser could possibly meet the needs of many thousands more Medi-Cal beneficiaries without major improvements to its behavioral health system. The fact that these beneficiaries will include large numbers of people requiring services in languages other than English and children from the state's foster care system with needs for specialized behavioral health services makes even more critical the need to condition any expansion of Kaiser's direct contract as a Medi-Cal Managed Care Plan upon the assessment and certification of Kaiser's compliance with all federal and state laws and regulations governing the availability of medically necessary behavioral health services before the health plan is allowed to take on any additional Medi-Cal patients, and the requirement that this compliance be recertified yearly for some time.

Adoption of such a condition would give Kaiser ample time to come into compliance with the law without impacting its ability to take on additional Medi-Cal enrollees in 2024 as proposed. We urge you to adopt this common-sense condition to protect our state's most vulnerable residents and their legal right to timely and appropriate behavioral health care. Expanding the Kaiser's direct Medi-Cal contract without such a condition while DMHC is investigating evidence of multiple, compounding incidents in which the plan is substantively violating the rights of its current enrollees would be highly irresponsible and set a terrible precedent.

Finally, and importantly, we wish to echo the concerns of the Local Health Plans of California, the California State Association of Counties, and other stakeholders that expanding Kaiser's direct Medi-Cal contract under the terms currently proposed would further the existing, arguably illegal disparity between Kaiser and other Medi-Cal Managed Care Plans, by enabling Kaiser on a significantly larger geographic basis to continue restricting its enrollment to a superior risk pool while producing adverse selection for competing public and community-based health plans, and depriving them of enrollee volume necessary to maintain endangered safety-net facilities. These terms of the proposed waiver amendment, along with the process for defaulting preferred classes of enrollees into Kaiser, and allowing Kaiser to assign enrollees' care to FQHCs without the enrollees' agreement, should be repaired in a way that achieves equitable and legal outcomes.

Sincerely,

Ian Lewis
Research Director

John Campbell and Anna Campbell; Email Received September 12, 2022

To Whom It May Concern:

PLEASE ADOPT THE IMD MEDICAID EXCLUSION WAIVER FOR SERIOUS MENTAL ILLNESS!

In Santa Barbara County where we live, there are well over 400,000 citizens. It is pitiful, tragic, and cruel to limit our county's Psychiatric Health Facility to only 16 inpatient beds for over 400,000 residents. This is the result of the Exclusion.

We talk about a continuum of care, but there is no real continuum when there is such a big hole in it, the severe shortage of beds for those who need care the most.

The Exclusion should be repealed at the federal level, but California has long been a leader ahead of the federal government in other important issues such as environmental regulations. This is an opportunity for California to take meaningful action for our citizens, that will actually save lives by allowing more than only 16 people at a time to receive inpatient psychiatric care, when the need is so great. By simply adopting this waiver you can take heroic action for the people of our state.

[redacted] For the sake of others like him and other families like ours, we are respectfully asking you again, please adopt the IMD Medicaid Exclusion Waiver for Serious Mental Illness.

Sincerely,

John and Anna Campbell

National Health Law Program; Email Received September 12, 2022

Dear Jacey,

I have attached the comments of Asian Resources, Inc., California Advocates for Nursing Home Reform, Children Now, Disability Rights California, Health Access California, Health Consumer Alliance, Justice in Aging, Maternal & Child Health Access, National Health Law Program, and Western Center on Law & Poverty. We appreciate the opportunity to comment.

Thank you,
Abbi

--

Abbi Coursolle (she/her/hers)
Senior Attorney
National Health Law Program
-> Note New Suite Number!
3701 Wilshire Blvd., Suite 315
Los Angeles, CA 90010
[redacted]
healthlaw.org

September 12, 2022

Department of Health Care Services
Director's Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Via email to CalAIMWaiver@dhcs.ca.gov

Re: CalAIM Section 1115 & and 1915(b) Waiver Amendments

Dear Director Cooper:

On behalf of Asian Resources, Inc., California Advocates for Nursing Home Reform, Children Now, Disability Rights California, Health Access California, Health Consumer Alliance,[1] Justice in Aging, Maternal & Child Health Access, National Health Law Program, and Western Center on Law & Poverty, we are providing our feedback on

[1] The Health Consumer Alliance is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Community Legal Aid SoCal, Greater Bakersfield Legal Assistance, Legal Aid Society of San Diego, Inland Counties Legal Services, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program.

California's CalAIM Section 1115 & and 1915(b) Waiver Amendments. We appreciate the opportunity to comment.

We take no overall position on DHCS's proposed amendments to implement Medi-Cal managed care model changes. But if DHCS intends to make these proposals to CMS, we recommend that DHCS consider adding more explicit consumer protections to ensure that beneficiaries maintain access to necessary services, providers, and rights during and after the change. Specifically, we urge DHCS to include the below protections:

- **Continuity of Care and Fee-for-Service Requirements**

Under both proposed waivers, DHCS commits to requiring COHS and Single Plan models to provide continuity of care for beneficiaries. This continuity consists of both access to providers and treatment plans. We agree with this requirement and encourage DHCS to standardize continuity of care requests across all plans. As part of CalAIM, Welfare and Institutions Code Sec. 14184.200(a)(2) was enacted to ensure all Medi-Cal managed care models provide continuity of care consistent with best practices in place for certain Medi-Cal and managed care populations: "The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health Safety Code and shall be consistent with and no more restrictive than existing policy and guidance, including All Plan Letter 18-008 and Duals Plan Letter 16-002." We look forward to working with the Department to develop policies and guidance for how continuity of care will be offered in COHS and Single Plan models counties.

On a parallel track with continuity of care for Medi-Cal beneficiaries transitioning plans, DHCS should have a process in place for Medi-Cal beneficiaries to maintain fee-for-service care when needed to treat their health conditions. Many Two-Plan counties, where medical exemptions under 22 C.C.R. 53887 are currently offered, will be transitioning to COHS and Single Plan counties, where the medical exemption process does not currently apply. However, under the CalAIM enacting statute, Sec. 14184.200(a)(3), DHCS must allow Medi-Cal beneficiaries in these counties to disenroll back to fee-for-service Medi-Cal according to existing regulations. As part of the ongoing stakeholder consultation process, we look forward to working with the Department to develop and implement this policy.

- **Network Adequacy and Readiness**

Beyond ensuring access to continuity of care, it will be very important that DHCS actively monitor and enforce network adequacy standards as these plan model changes

occur. In addition, DHCS must conduct a robust readiness review that ensures beneficiaries who will change delivery systems or managed care plans experience as few disruptions to their care as possible. With these changes many additional counties will be moving to a model where there is no consumer choice of plan and therefore no ability to identify and select the plan with the in-network providers each member needs. DHCS must also ensure that the plans contract with a sufficient number of providers, including both high-need and low-incidence specialists, to ensure timely access for all members.

- **Knox Keene Licensure for COHS and Single Plans**

If DHCS moves forward with these changes, it is critical that DHCS set a timeline to require Knox-Keene licensure of **all** Medi-Cal health plans. In 1981, Congress passed a federal law aimed at encouraging the proliferation of Medicaid managed care programs by allowing states to waive certain Medicaid Act requirements if they contracted with government-run prepaid plans that did not federally qualify as Health Maintenance Organizations (HMOs).[2] Under federal law, only a limited number of such plans may operate, and they are exempt from certain provisions of federal law and regulation as long as their enrollment does not exceed 16% of all Medi-Cal enrollment.[3] In addition, under state law, COHS plans are not required to obtain Knox Keene licensure for their Medi-Cal lines of business, and unless they choose to obtain a Knox-Keene license, they are not directly regulated by the Department of Managed Health Care (DMHC).[4]

As DHCS notes in its Public Notice of the proposed waiver changes:

> Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to **all** [COHS plans] currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.[5]

---

[2] Omnibus Reconciliation Act of 1981, ch. 2, sec. 2176, § 1915, 79 Stat. 286; *see also* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40989, 40994 (June 14, 2002) (preamble language giving history of regulation of "health insuring organizations" or HIOs—the federal name for COHS plans); 42 U.S.C § 1396u-24(a)(3)(C); 42 C.F.R. § 438.2 (federal definition of HIO).

[3] *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 9517(c), 100 Stat. 82 (1986) (codified as a note under 42 U.S.C § 1396b) (allowing, as of 2008, up to 5 HIOs, serving not more than 16% of Medi-Cal beneficiaries, to operate in California).

[4] Cal. Welf. & Inst. Code § 14087.95.

[5] Cal. Dep't Health Care Servs., *Notice of General Public Interest Proposed CalAIM Section 1115 Demonstration and Section 1915(b) Waiver Amendments for Managed Care Model Changes and Other Managed Care Updates* 2 (2022),

As a threshold matter, we urge DHCS to confirm that it intends to require all COHS plans to abide by the federal rules--other than the plan choice provisions it is explicitly proposing to waive--after the implementation of the model changes, even if COHS enrollment remains slightly less than 16%.

Further, DHCS should ensure that all COHS plans (and plans in Single Plan counties) are Knox-Keene licensed. Existing disparities in the protections available to beneficiaries enrolled in licensed plans compared to those enrolled in unlicensed plans are stark, and should be remedied. These changes will only exacerbate those existing disparities. To avoid this exacerbation and address existing disparities, DHCS must require all Medi-Cal health plans to become Knox-Keene licensed.

The expansion of COHS plans into Butte, Colusa, Glenn, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba counties will result in beneficiaries in those counties losing the Knox-Keene protections **currently available** to them. These include important consumer protections including access to Independent Medical Review (IMR) when there is a dispute between beneficiaries and their plan about whether a particular benefit is medically necessary. IMRs provide an important mechanism for managed care enrollees to appeal adverse benefit decisions and obtain a third-party clinical perspective on the need for a service that their health care provider has recommended. The Medi-Cal fair hearing system, where disputes are adjudicated by legal experts, not clinicians, is not well-suited to resolving these disputes.[6] In addition, the fair hearing process is considerably slower than the IMR process (90 days to resolve disputes vs. 30 days), which can create serious delays in beneficiary's access to care. The loss of access to the IMR process will have a particularly negative impact on Californians with disabilities and complex healthcare needs as the IRM process is the most effective and accessible consumer protection available to ensure access to specialized durable medical equipment and services.

---

https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-1915b-Joint-Public-Notice.pdf (emphasis added).

[6] IMRs have resulted in significantly favorable results for Medi-Cal beneficiaries challenging adverse benefit determinations, as compared to those who go through state fair hearings. *See* Department of Managed Health Care, 2019 Annual Report (59% of the qualified cases resulted in enrollee receiving requested treatment); 2018 Annual Report (62% of the qualified cases resulted in enrollee receiving requested treatment); 2017 Annual Report (61% the qualified cases resulted in enrollee receiving requested treatment). In contrast, less than 10% of state fair hearings involving individuals in Medi-Cal managed care plans were granted, while about half were withdrawn or dismissed for non-appearance. *See* Department of Health Care Services, Managed Care Performance Monitoring Dashboard (13% of state fair hearings between July 2018 to June 2019 were granted. 6% of state fair hearings between July 2017 to June 2018 were granted. 6% of state fair hearings between July 2016 to June 2017 were granted or granted in part. Note, this data does not break down hearing results by dispute type so the data includes all Medi-Cal issues, including eligibility issues).

The plans in the three counties that DHCS has approved to proceed as single-plan counties – Alameda Alliance for Health in Alameda County, Contra Costa Health Plan in Contra Costa County, and California Health & Wellness Plan in Imperial County – are currently Knox-Keene licensed for their Medi-Cal lines of business. Our understanding is that these plans would remain Knox-Keene licensed after the model change is fully implemented. We appreciate that this change will ensure that beneficiaries in these counties will maintain Knox-Keene protections that are currently in place for all plans in those counties. However, the move to single-plan counties where the single plan is Knox-Keene licensed throws into sharp relief the disparities that already exist in Medi-Cal: most beneficiaries have the benefit of Knox-Keene protections as a result of the requirement that the Medi-Cal health plans in their counties be licensed, yet a significant minority (2.47 Million as of July 2022[7]) already do not have access to these important protections, simply because they live in a county whose plan has been exempted from licensure by the application of arcane and outdated rules.

Putting aside whatever rationale may have been appropriate to justify exempting COHS plans from licensure when the legal framework was first created in the 1980s, COHS plans are no longer significantly distinct from the Local Initiative and Commercial plans that operate in the Medi-Cal managed care marketplace and they should be subject to the same rules.[8] DHCS should require all Medi-Cal plans to be licensed, and set a timeline for unlicensed COHS plans to complete the licensure process. This is particularly important now, when DHCS is proposing to expand the COHS model to twelve additional counties.

- **Ensuring Transparency of DHCS Monitoring and Enforcing**

We appreciate the steps DHCS has taken through the CalAIM process to improve its monitoring of Medi-Cal plans, and its commitment to appropriate enforcement when plans fail to meet their obligations. Robust monitoring and enforcement is particularly important to ensuring that these proposed model changes are successful and do not result in harm to beneficiaries. To that end, we strongly encourage DHCS to make the audit tool it uses to review plan compliance publicly available. It is certainly possible to publish the tool, since the tool DHCS uses to review County Mental Health and DMC-ODS plans is already publicly available and has been for many years. Making its

[7] Cal. Dep't Health Care Servs., *Managed Care Performance Monitoring Dashboard Report* 3 (2022), https://www.dhcs.ca.gov/dataandstats/reports/Documents/MC_Performance_Dashboard/MC-Performance-Monitoring-Dashboard.pdf.
[8] *See* Kelly Green, Cal. Sen. Health, *SB 260: Assembly Floor Analysis* (2015), https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520160SB260.

counterpart tool used to evaluate Medi-Cal health plans would improve transparency and help advocates to ensure that DHCS's monitor efforts are well-calibrated.

Thank you again for the opportunity to comment. If you have any questions, please reach out to Abbi Coursolle at the National Health Law Program at [redacted].

Sincerely,

Asian Resources, Inc.
California Advocates for Nursing Home Reform
Children Now
Disability Rights California
Health Access California
Health Consumer Alliance
Justice in Aging
Maternal & Child Health Access
National Health Law Program
Western Center on Law & Poverty

Local Health Plans of California; Email Received September 13, 2022

Hello –

Please see attached for LHPC's comments in response the proposed 1115 and 1915(b) waiver amendments.

Thank you,
Linnea

September 12, 2022

Michelle Baass, Director
Jacey Cooper, Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Via email: CalAIMWaiver@dhcs.ca.gov

Re: LHPC Comments on Proposed Section 1115 and 1915(b) Waiver Amendments

Dear Directors Baass and Cooper,

The Local Health Plans of California ("LHPC") represents the 16 non-profit, community-based health plans which cover 70% of all Medi-Cal managed care enrollees. We appreciate the opportunity to provide comments in response to the Department of Health Care Services ("DHCS") draft amendments to California's 1115 and 1915(b) waivers and strongly support the request to seek authority from the Centers for Medicare & Medicaid Services ("CMS") for Medi-Cal managed care model change in counties that will join an existing County Organized Health System ("COHS") or which will transition to a Single Plan model. As DHCS is aware, local plans have had significant concerns with the statewide contract with the Kaiser Foundation Health Plan ("Kaiser") since it was proposed earlier this year and authorized in AB 2724 (Arambula), so we must continue to convey our opposition as DHCS seeks federal authority through the 1915(b) waiver amendment to implement to this statewide contract.

Support for 1115 and 1915(b) waiver amendments to expand the local plan model. Local plans have a long history of serving their local communities. The COHS and Local Initiative ("LI") plans were formed through county ordinance to meet the health care needs of underserved populations in their communities through a unique model that is publicly operated. Since the early 1980s, 15 COHS and LIs were established across 35 counties in California for this purpose. In 2020 and 2021, in anticipation of the statewide commercial plan procurement, 14 additional counties chose to join an existing local plan and two counties with existing LIs chose to transition to a Single Plan model. By seeking federal authority to implement these county model changes, DHCS is affirming the critical role that local communities play in determining how to design a local delivery system to meet their local needs.

In addition to supporting county agency through these model changes, DHCS is also

supporting expansion of a model of Medi-Cal managed care that has demonstrated consistent delivery of high-quality care. As noted in DHCS' 1915(b) waiver amendment, COHS plans are among the highest performing plans in the state, and both COHS and LIs outperform commercial health plan quality scores which suggests, "better access to services via county-driven plans when compared to commercial models." Quality scores were one of the key areas DHCS evaluated prior to granting conditional approvals of proposed county model changes. We believe expansion of the public plan model will continue to demonstrate that the public plan model delivers care that is both community-based and high quality.

Opposition to statewide Kaiser contract. LHPC must again convey our opposition to DHCS' request to seek federal authority to implement a statewide contract with the Kaiser. While the request to expand COHS plans and the Single Plan model upholds the role of local communities, this statewide contract runs contrary to the notion of a locally driven delivery system and is being pursued despite the concerns of local plans and their county partners. It will also create an inequitable system wherein the most vulnerable populations will be excluded from having the option to enroll in Kaiser, resulting in Kaiser serving a population that is generally healthier and with fewer needs related to social determinants. Although the waiver amendment describes a default enrollment process that will be based on county-specific capacity, we have not received details about what this process will look like or how capacity will be determined. Given that DHCS is moving forward with the statewide Kaiser contract regardless of stakeholder concerns, should CMS approve the 1915(b) waiver amendment we request that DHCS provide transparency as it develops unique policies related to implementation, including the policy for default enrollment.

Thank you again for the opportunity to comment on these important waiver amendments.

Sincerely,

Linnea Koopmans
Chief Executive Officer

Paul Erickson; Email Received September 13, 2022

Please adopt the IMD Medicaid exclusion waiver for serious mental illness. We have too few beds and need the waiver. The exclusion is discriminatory of the mentally ill- no other medical condition faces such an exclusion.

Thank you,
Paul Erickson, MD

Monica Nunez; Email Received September 13, 2022

Good afternoon. My name is Monica Nunez and We are in desperate need for all continuing help weather it be for Medicaid payment for beds, housing and treatment. [redacted] Please I ask for those who have no saying and all rights are taken from them to let you all know. They need everything all programs payments and we definitely need more state hospital beds for IST wellness. As many suffer in jail and Mental health all IST need to be in the catáfora of Emergency help as anyone going into the emergency with a broken arm, leg. This is life threatening for them as we seen time and time again. They commit suicide and get lost in there head to fend for themselves as they get treated in any jail facility as everyone else. Us family morn and are not healed as well as we go through this process with them. We need more education on there health, condition and meds to better be of assistance to them and we as well need to be better equipped and trained in our loved one's illness. Stop Hippa laws, this just makes it easier for those in this fragile condition be done with them as they please. Our Loved one's loose there voice and we as well as Hippa laws separate families not unite them and allow the whole family to heal and wellness! Please approve all help for our most fragile humans! In God I trust.

All Minds Matter

All Lives Matter

Stop the revolving doors and we need more beds!

Wake up compassion for the weak!

Sincerely: Monica Nunez
[redacted]

Sent from my iPhone

Don Notoli; U.S. Mail Received September 12, 2022

SEP 1 2 2022

BOARD OF SUPERVISORS
COUNTY OF SACRAMENTO
700 H STREET, SUITE 2450 • SACRAMENTO, CA 95814

DON NOTTOLI
SUPERVISOR, FIFTH DISTRICT
[redacted]

September 6, 2022

The Honorable Dr. Mark Ghaly
Secretary, California Health & Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

The Honorable Michelle Baass
Director, California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, Ca 95899-74133

Dear Secretary Ghaly and Director Baass,

In recent days, I have received numerous letters from a variety of health and human services providers in Sacramento County regarding the decision by the California Department of Health Care Services (DHCS) to award contracts to managed care plans (MCPs) to provide Medi-Cal services throughout the State of California.

It is my understanding that by reducing the number of MCPs in Sacramento County, consistent with a prior request by counties to do so, DHCS has made a determination to no longer contract with Health Net to provide Medi-Cal managed care services to eligible Sacramento County residents.

Though I am confident many factors were considered in the procurement process, it is concerning as expressed in recent correspondence from community members, that Health Net, a trusted and vital partner in health care services for some of the most vulnerable and underserved people in our community, will no longer be a designated plan, thereby affecting nearly 150,000 existing clients.

Notably, more than 40 partner organizations and providers supported Health Net's application and Sacramento County's Health Authority found, in its review some months ago, the qualification's put forth by Health Net to be among the best of all the MCP's in Sacramento County.

Elements such as health care delivery, equity, quality and community enrichment are important to MediCal providers, stakeholders, community based organizations and partners and, of course, the Medical eligible members. Importantly as well, is the diversity of it's local workforce which directly affects the need to best serve a diverse patient makeup an issue Health Net recognized and addressed in its plan.

In summary, as you take this matter under review in the formal appeal process, it seems reasonable to give serious consideration to adding Health Net to the complement of managed care plans to better reflect community support and avoid the disruption and inconvenience which will inevitably result from the reassignment of 150,000 Medi-Cal clients to different plans.

Thanking you in advance for your consideration in this matter.

Sincerely,

[redacted]

Don Nottoli, Supervisor
Fifth District

DN:mdd

Bayshire Senior Communities; U.S. Mail Received September 6, 2022

BAYSHIRE
SENIOR COMMUNITIES

August 30, 2022

Mark Ghaly, MD, MPH, Secretary
California Health and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814

Re: Letter of Support for Community Health Group (San Diego County)

Dear Doctor Ghaly:

I am personally and professionally apalled the CHHS Agency failed to select Community Health Group (CHG) as a contracted health plan beginning in 2024! Instead, the selected plans are, at best, taxing and detrimental to the care of patients. In fact, we know Health Net uses a private company to deny services to Medi-Cal and Medicare patients. They routinely deny patient service authorization requests which interrupts or interferes with the cardiac care they need. It is truly unimaginable Sacramento would select these plans without significant weighting of input from patients and physicians.

I am confident that if patients and physicians had been surveyed about their preferences, Community Health Group would be, by far, the number one plan in San Diego County. Conversely, both Molina and Health Net would not even make the list! CHG's local ties to the community are fundamental to the care of our patients. Other plans have come and gone, but CHG has withstood the test of time. If this proceeds with them, these commercial plans will attempt to cut physician payments to compensate for giving up some of their profits to community services, leading to their eventual withdrawal from Medi-Cal. I am shocked Sacramento has not learned from this pattern and history dealing with these plans. As the saying goes, if you don't learn from the lessons of history, you are condemned to repeat it!

There is a long and consistent history of why Community Health Group has been the largest Medi-Cal and Medicare health plan in San Diego County for 40 years! Our experience with CHG for for the last 15 years has resulted in the delivery of quality patient care while, at the same time, as appropriate, reduced the cost of nnecessary hospitalizations. As the largest independent cardiology group in San Diego County serving Medi-Cal and Medicare patients, we implore you to please find a way to correct this travesty!

Sincerely,

[redacted]

Scott B. Kirby
Bayshire Senior Communities
President & CEO

Escondido Post Acute; U.S. Mail Received September 6, 2022

Escondido
post acute rehab

August 30, 2022

Mark Ghaly, MD, MPH, Secretary
California Health and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814

Re: Letter of Support for Community Health Group (San Diego County)

Dear Doctor Ghaly:

I am personally and professionally apalled the CHHS Agency failed to select Community Health Group (CHG) as a contracted health plan beginning in 2024! Instead, the selected plans are, at best, taxing and detrimental to the care of patients. In fact, we know Health Net uses a private company to deny services to Medi-Cal and Medicare patients. They routinely deny patient service authorization requests which interrupts or interferes with the cardiac care they need. It is truly unimaginable Sacramento would select these plans without significant weighting of input from patients and physicians.

I am confident that if patients and physicians had been surveyed about their preferences, Community Health Group would be, by far, the number one plan in San Diego County. Conversely, both Molina and Health Net would not even make the list! CHG's local ties to the community are fundamental to the care of our patients. Other plans have come and gone, but CHG has withstood the test of time. If this proceeds with them, these commercial plans will attempt to cut physician payments to compensate for giving up some of their profits to community services, leading to their eventual withdrawal from Medi-Cal. I am shocked Sacramento has not learned from this pattern and history dealing with these plans. As the saying goes, if you don't learn from the lessons of history, you are condemned to repeat it!

There is a long and consistent history of why Community Health Group has been the largest Medi-Cal and Medicare health plan in San Diego County for 40 years! Our experience with CHG for for the last 15 years has resulted in the delivery of quality patient care while, at the same time, as appropriate, reduced the cost of nnecessary hospitalizations. As the largest independent cardiology group in San Diego County serving Medi-Cal and Medicare patients, we implore you to please find a way to correct this travesty!

Sincerely,

[redacted]

Thomas Solum
Escondido Post Acute
Administrator