**DEPARTMENT OF HEALTH CARE SERVICES**
**Stakeholder Advisory Committee (SAC)**
**October 28, 2020**
**1:30 p.m. – 4:30 p.m.**

**MEETING SUMMARY**

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

**SAC Members Not Attending**: Lisa Davies, Chapa-De Indian Health Program; Michael Humphrey, Sonoma County IHSS Public Authority; Gary Passmore, California Congress of Seniors; Jonathan Sherin, Los Angeles Department of Mental Health.

**DHCS Staff Attending**: Will Lightbourne, Jacey Cooper, Rene Mollow, Michelle Retke, Norman Williams, Morgan Clair. Stephanie Welch joined in her new position as Deputy Secretary for Behavioral Health with the California Health and Human Services.

**Public Attending**: There were 186 members of the public attending by phone.

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

Director Lightbourne welcomed members and introduced a new member, LeOndra Clark Harvey of the California Council of Community Behavioral Health Agencies. Director Lightbourne also announced that Stephanie Welch has joined SAC in her new position as Deputy Secretary of Behavioral Health at the California Health and Human Services Agency. He thanked the California HealthCare Foundation for its ongoing support of SAC.

**Director's Update**

***Will Lightbourne and Jacey Cooper, DHCS***

Slides: https://www.dhcs.ca.gov/services/Documents/102820-SAC-Presentation.pdf

Jacey Cooper provided updates related to the public health emergency (PHE). On October 2, 2020, California's PHE was renewed for a 90-day extension through January 21, 2021. Previous extensions were provided only days ahead of the expiration of the PHE. This extension of the COVID-19 PHE was provided with several weeks of notice. In September 2020, DHCS formally wrote to U.S. Health and Human Services Secretary Azar requesting at least three to six months of notice prior to ending the PHE. She noted that sufficient notice is critical to communicate and prepare systems across providers, health plans, and beneficiaries that flexibilities would be ending.

DHCS has obtained more than 50 programmatic flexibilities through CMS spanning the delivery system. These flexibilities impact Medi-Cal eligibility, health care service delivery (e.g., telehealth), provider reimbursement, behavioral health, Targeted Case Management (TCM), and Local Educational Agencies (LEAs). DHCS has engaged in early planning related to the end of PHE, and it will take months of work to unwind these changes safely and successfully when the PHE ends. For example:

- DHCS estimates there are 100,000 to 200,000 Medi-Cal beneficiaries per month since the PHE began who may no longer be eligible. DHCS estimates that it will take county eligibility offices 6 to 12 months to clear the Medi-Cal renewal backlog. There is guidance forthcoming from CMS.
- Approximately 200 providers who were enrolled in Medi-Cal under streamlined emergency rules will need to enroll through the complete enrollment process.
- DHCS must clear backlogs of all auditing, licensing, and onsite oversight visits that were delayed/impacted due to the PHE.

Ms. Cooper continued with updates related to the Home and Community-Based Alternatives (HCBA) waiver and Assisted Living Waiver (ALW) in the Central Valley. During the PHE, waiver applicants in an inpatient facility in regions of the state identified as COVID-19 "hot spots" are prioritized for intake processing, without having been in an institution for 60 days, and before all other sub-populations. CMS approved DHCS' waiver for this transition. In addition, a Medi-Cal managed care plan (MCP) memo was sent to request that MCPs in Central Valley counties participate in county-level collaboration meetings or work with local county partners to set up meetings with hospitals, nursing facilities, and HCBS waivers/providers. DHCS is actively working with CMS to obtain approval of a Benefits Improvement and Protection Act (BIPA) waiver that would temporarily allow Program of All-Inclusive Care for the Elderly (PACE) organizations, in partnership with discharge planners, more flexibility to contact potential PACE-eligible beneficiaries in DHCS-designated COVID-19 surge areas and present PACE as an enrollment option to meet their needs. California received overall hot spot authority and can implement these same flexibilities in new hot spot areas as deemed by the DHCS Director.

Ms. Cooper provided an update on the CalHOPE Crisis Counseling Regular Services Program (RSP) that was approved by FEMA and SAMHSA. The RSP is a nine-month program to expand the media campaign, CalHOPE website, and counselor support. Target populations include African Americans, Hispanics, middle-aged white men with access to guns, youth, isolated seniors, and other high-risk groups. California is hoping to get full FEMA approval for a larger effort on behavioral health and the crisis intervention needs related to the PHE.

Additional federal flexibilities were rolled out, including:

- Added assistive technology in the Developmental Disability Waiver
- Retainer payments for Personal Care Services
- Waiver Personal Care Services (WPCS) providers can exceed 12-hour days and take sick leave
- Drug Medi-Cal Organized Delivery System (DMC-ODS) interim rates and DMC-ODS stay and day limitations
- Adjustments to the public health care system thresholds for the Global Payment Program (GPP)
- Temporary alternative services to allow Community-Based Adult Services (CBAS) providers to offer limited individual in-center activities, as well as telephonic, telehealth, and in-home services.

Ms. Cooper reported that DHCS is continuing to provide weekly stakeholder updates and guidance for providers, including:

- Updates to the Uninsured Group Program to come into compliance with federal requirements based on CMS guidance . The new COVID-19 Uninsured Group Program was implemented on August 28, 2020, and covers COVID-19 diagnostic testing, testing-related services, and treatment services, including hospitalization and all medically necessary care, at no cost to the individual, for up to 12 months or the end of the PHE, whichever occurs later.
- California Children's Services (CCS) Medical Therapy Program (MTP) guidance that describes "Urgent Need" criteria under which in-person services may be provided in Medical Therapy Units (MTU).
- Updated guidance regarding COVID-19 virus and antibody testing, which includes frequently asked questions and resources from CDPH, CMS, and the CDC.
- New Behavioral Health Information Notices (BHIN), which describe DMC-ODS interim reimbursement during the PHE, waiver flexibilities applicable to Driving Under the Influence (DUI) programs, and flexibilities across behavioral health delivery systems to ensure access to care.

**Medi-Nurse Line Update**

The Medi-Nurse Line was developed to offer fee-for-service (FFS) Medi-Cal beneficiaries and uninsured Californians, who suspect they may have COVID-19 and need guidance, clinical consultation and triage with nurses as well as covered clinical assessments,

advice, test sites, and behavioral health and stop smoking resources. DHCS has received more than 60,000 calls from 57 counties in 17 different languages (of the 19 available), including 87% uninsured and 13% FFS callers. Ms. Cooper provided utilization data from the Medi-Nurse line, including demographics, county location, and language.

**CalAIM Update**
On September 16, 2020, DHCS submitted a request to extend the 1115 waiver through December 31, 2021. CMS let DHCS know that the extension was determined to meet completeness requirements. The extension request was posted on the Medicaid.gov website for a 30-day federal public comment period that ended on November 1, 2020. DHCS will continue to work with CMS on the 1115 and 1915(b) waiver extension requests, and to develop applications for new waivers to begin on January 1, 2022. Ms. Cooper mentioned that DHCS is hoping to have feedback on the 1915(b) waiver soon in order to submit it prior to the end of the year.

**Questions and Comments**

*Barsam Kasravi, Anthem Blue Cross*: How likely is it that CMS will provide the advance notice you are requesting before the end of the PHE?

*Jacey Cooper, DHCS*: We are advocating with CMS and Secretary Azar for 3-6 months prior notice before the end of the PHE. Many other states are also advocating for this advance notice.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: On telehealth flexibilities during COVID, the administration said it will globally evaluate the telehealth policy. Can you share the timeline and process for stakeholder input on this?

*Jacey Cooper, DHCS*: We are continuing the conversation internally to look at telehealth comprehensively across all systems. Prior to PHE, we had robust policy on the physical health side. We are working closely on community health centers and evaluating behavioral health and HCBA, LEA, and TCM as well. It is a comprehensive dive. CMS issued guidance on telehealth after the PHE ends, and there are a variety of things we would and would not be able to continue. We are working on questions for CMS; once we have more information and an actual proposal, we will update stakeholders.

*Kim Lewis, National Health Law Program*: Has CMS offered updates or guidance on unwinding the backlog?

*Jacey Cooper, DHCS*: We are working with CMS to track that issue. We know that CMS is actively working on it. We think certain pieces may come out in the coming days to propose changes in the eligibility elements because there have been many questions from Medicaid programs requesting guidance from CMS on how to appropriately unwind the protections that have been in place for more than a year for beneficiaries. We will include that in stakeholder updates.

*Kim Lewis, National Health Law Program*: Do you think there is flexibility for each state to

come up with a plan? Will they ask for a state plan and then approve, or will it be one size fits all approach?

*Jacey Cooper, DHCS*: Historically, they have not used a state-by-state process. I expect broad guidance on timelines, documentation, and records. There may be a few million beneficiaries total, and we need to make sure that beneficiaries understand their rights and protections through that process. We hope CMS guidance will be comprehensive.

*Erica Murray, California Association of Public Hospitals and Health Systems*: I want everyone to know that as the state submitted the waiver proposal to extend the waiver, we have been working to include federal legislative language that would require CMS approval of the one-year extension of the existing 1115 waiver and have the extension deemed budget neutral.

*Linda Nguy, Western Center on Law and Poverty*: Does the data indicate that when the PHE ends, we could see potential discontinuances of 1-2 million individuals, assuming ten months at a rate of 100,000-200,000 continuances? How did you arrive at this estimate? It would be helpful for counties to be able to forgive 2020 renewals and proceed with 2021 on schedule. We would recommend looking at that option.

*Jacey Cooper, DHCS*: Unfortunately, CMS has not given us permission to do that, so we await guidance on how we unwind this. We do not anticipate immediate discontinuances. Beneficiaries still have protections that allow them to prove whether they have eligibility. We will work with county partners to come up with a plan for California, and we expect it will take 6-12 months. We hope it will be extended beyond January, but we are awaiting CMS' guidance.

*Linda Nguy, Western Center on Law and Poverty*: Does that mean that a discontinuance notice could be mailed out to 1-2 million people at the end of the PHE?

*Jacey Cooper, DHCS*: I do not think they would all be sent at the same time, but there are a significant number of people remaining on Medi-Cal that, based on historical trends of disenrollment, would not normally maintain Medi-Cal eligibility. We will come up with a comprehensive plan with our county partners to do this correctly.

*Anthony Wright, Health Access California*: Is there more data on how people are using the COVID-19 uninsured program? For example, is it more for testing or treatment? Is this program over or under enrolled from expectations?

*Jacey Cooper, DHCS*: Rene will cover that in the next presentation. We have had 38,000 enroll in the uninsured eligibility group. We are running data on testing and treatment services, but do not have that today. Shortly after this was approved, we know that providers began to use a separate Health Resources and Services Administration (HRSA) option for reimbursement and are not using the COVID eligibility category from the state. We are working closely with CMS and HRSA to compare data to ensure providers are not billing both options. I do not think we had any estimates on this, although I can get you more information later.

*Anthony Wright, Health Access California*: On the waiver, can you offer thoughts on what aspects of the waiver you feel more or less confident about? What is your estimate of the timing?

*Jacey Cooper, DHCS*: In the public hearings, we flagged areas that may be challenging. For example, the additional funds for Whole Person Care is a critical transition component to get us to January 2022 where, depending on the state budget, we can implement CalAIM components. This is even more important given the PHE so that we have coordination and services for vulnerable beneficiaries. We requested additional funds for the Dental Transformation Initiative and Special Needs Care Pool, and we expect to have conversations on those topics. We are looking at flexibilities that CMS could provide in light of our request to extend the PHE. We are having good conversations with CMS. It helps that we were working on a vision and transformation under CalAIM prior to the PHE. We will try to finish negotiations by the end of the year, but it will be challenging. We feel confident CMS will provide temporary extensions since our full Medi-Cal program is in the waiver.

*Anne Donnelly, San Francisco AIDS Foundation*: In addition to numbers, do you have demographic data on the COVID uninsured group?

*Jacey Cooper, DHCS*: We do not collect that data. The program was rolled out under Presumptive Eligibility (PE), and we do not collect any data other than gender.

**Enrollment Update and Discussion**
***Rene Mollow*, *DHCS***
Slides: https://www.dhcs.ca.gov/services/Documents/102820-SAC-Presentation.pdf

Rene Mollow provided a presentation that was updated from the last meeting. DHCS is pleased to see good trends in Medi-Cal enrollment, although there are areas where we are not at pre-COVID levels. These data include all application pathways, including online, in-person, phone, mail/fax, and others, such as going through a community-based organization. Ms. Mollow presented data slides for overall enrollment and each application pathway. These data indicate that we are not making up the ground through online applications that we previously met through in-person applications. Phone applications are higher, but also do not make up all the ground. These data are reported at the application level, and a single application may include more than one person, such as a parent and two children.

There are four Medi-Cal PE programs designed to provide immediate, temporary coverage for eligible low-income individuals, pending a formal Medi-Cal application. Enrollment provides between 31 to 60 days of coverage in PE. Then, if the person does not file an application for Medi-Cal, the eligibility ends. If they do file an application for coverage, then coverage continues until the application is adjudicated. Under PHE flexibilities, there is additional time for coverage.

Ms. Mollow reviewed data from each of the PE programs listed below.

Hospital Presumptive Eligibility (HPE)
The HPE Program provides qualified individuals immediate access to temporary, no-cost Medi-Cal. To apply for HPE benefits, an individual must visit a hospital that is a qualified HPE provider. The HPE provider submits the individual's information via the HPE Medi-Cal application online portal, and eligibility is determined in real time.

Child Health and Disability Prevention (CHDP) Gateway
The "CHDP Gateway" is an automated pre-enrollment process for non Medi-Cal, uninsured children used by providers as the entry point for children to enroll in ongoing health care coverage through Medi-Cal, pending a determination of Medi-Cal eligibility.

Presumptive Eligibility for Pregnant Women (PE4PW)
The PE4PW Program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income pregnant patients, pending the Medi-Cal application.

Breast and Cervical Cancer Treatment Program (BCCTP)
The BCCTP provides breast and/or cervical cancer treatment and services for eligible low-income California residents screened by qualified providers, pending the Medi-Cal application.

Ms. Mollow reviewed data for Medi-Cal enrollment that included newly enrolled, re-enrolled individuals (those who experienced a break in coverage and then reapplied to Medi-Cal), and re-enrollment churn (those who reapplied within 12 months of past coverage). Overall enrollment is up to a total 13 million enrollees in September 2020. She then reviewed demographics by age, gender, ethnicity, and primary written language.

To ensure Californians continued to receive Medi-Cal health coverage during the PHE, DHCS issued guidance directing counties to delay the processing of Medi-Cal annual renewals, and to defer discontinuances and negative actions, effective March 16, 2020, through the duration of the PHE. The only allowable exceptions to the moratorium on discontinuances/ negative actions are:

- voluntary requests for discontinuance,
- death of a beneficiary, or
- individuals who move out of state.

DHCS is working with counties to identify individuals who have been inadvertently discontinued and restore their eligibility. Impacted beneficiaries receive a notice informing them of the restoration of their Medi-Cal coverage. As of October 1, 2020, approximately 110,000 individuals have been restored back into coverage since the beginning of the COVID-19 PHE. For the COVID-19 Uninsured Group program, services are limited to medically necessary COVID-19 testing, testing-related, and treatment services for 2 months or until the end of the PHE, whichever comes later. There are approximately 38,000 enrolled in the program. Federal guidance required DHCS to include a question on the application regarding citizenship.

We have had extensive outreach via our Office of Communications and developed a toolkit with vignettes and messages that are rolling out via social media. We asked our advocates for feedback on these messages. The messages are translated into Spanish, and will be available in all of our threshold languages. The Governor and Secretary of CHHS are including messages in their communication channels.

Consumer advocates raised the opportunity to use post enrollment verifications in a process similar to what we do for children who apply through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) automated system. Children are given conditional eligibility, and on the backend, counties verify income to confirm eligibility. We are currently working on this for adult populations to help people get enrolled, which is greatly needed during the PHE.

**Questions and Comments**

*Maya Altman, Health Plan of San Mateo*: Are there things we can do with our local Department of Social Services agencies? The phone and online applications are not making up for the in-person drop in enrollments. It is a challenge that people may only seek enrollment when they need care because they are not as likely to get preventive care.

*Rene Mollow, DHCS*: One aspect of the messaging via social media is to direct people to the online applications. We realize that the local county offices are closed due to the PHE. We are working with community navigators to get the message out to people.

*Kim Lewis, National Health Law Program*: The post enrollment verification DHCS is working on is promising and we are hopeful this will be implemented soon. Do you have information on timing? Will it happen through CalHEERS, in addition to the county, given the low numbers of applications through the county?

*Rene Mollow, DHCS*: I do not have a timeline, although it is very important to us to move forward. We are having discussions about where we can leverage existing policies, pathways, and aid codes.

*Linda Nguy, Western Center on Law and Poverty*: We appreciate state and local efforts on reinstatements and approving the COVID PE program. The total enrollment data is helpful. I do not understand why new enrollment and re-enrollment numbers are lower than 2019, and why racial data is trending toward white men given unemployment data. Does DHCS have data on pending applications or application timeframes or have other explanations about why there is lower new enrollment?

*Jacey Cooper, DHCS*: One thing to emphasize is that a sizable chunk of regular enrollment, if you compare to 2019, is people re-enrolling who were discontinued for longer than 90 days. Therefore, we cannot automatically compare the numbers. If you are looking at new enrollment, it is lower in recent months. We may be hitting a threshold penetration of enrollment. There are so many factors to digest in the data. For example, California had one of the largest rollouts of the Affordable Care Act (ACA), and we may have penetrated the market in ways that other states did not. We do think the PE data is surprising. A

significantly lower number of people are enrolling through PE pathways during the PHE, perhaps because people are underutilizing medical services and may not be enrolling. Also, we cannot see the impact of public charge on Spanish-speaking populations enrolling. However, we do not have explanations from a data perspective.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: It is helpful to see the data. I am hearing that a lot of the reason we do not see new enrollment is because it is captured in those retained that otherwise would have been enrolled at redetermination. I am still wondering why we are at the bottom of the heap compared to other states. I hear you say we were more aggressive with ACA enrollment, but I am not confident we would be at the bottom based on that. One question is that it would be helpful to see the data breakout for children and also for communities of color compared to 2019. On the COVID Uninsured Group Program enrollment, can we get that data by demographic? We have asked about adding a race question, and now that you have to open up the application based on the federal requirement, can we revisit that issue?

*Jacey Cooper, DHCS*: CMS provided a standard application, and for the most part, we are using that. It does not include demographic information. I do not think we will have that data, although we can look at it for the future. When I think about California penetrating the market more than other states, it is because we had a comprehensive rollout with the Low Income Health Program prior to the ACA. Other states rolled out later, and that is a factor is in this data. We will continue to look at children. For PE, we see significant decreases for children through standard pathways, and this matches the underutilization of kids in services post-PHE. We are working with managed care plans and CDPH on messaging for getting children back into regular care, and we think there is potential for reengaging families in health care.

*Anthony Wright, Health Access California*: I am curious about whether saturation would be an explanation. Some researchers at UC Berkeley did an analysis using Kaiser Family Foundation data on parental ACA enrollment. There does not seem to be a correlation between those figures and enrollment in this COVID-19 period. In your analysis, was there any comparison to other states that you can share? I am happy to share with you the data from the researchers at UC Berkeley.

*Jacey Cooper, DHCS*: We do not have comparative data with other states. It is just our analysis trying to figure out what may be going on in California. Many states have not shut down due to COVID-19 to the extent California has, and that impacts a number of things.

**Managed Care Procurement Process/Timeline**
***Michelle Retke, DHCS***
Slides: https://www.dhcs.ca.gov/services/Documents/102820-SAC-Presentation.pdf

Michelle Retke provided an update on the procurement for managed care plan (MCP) contracts. She reported why DHCS is conducting this procurement. The procurement provides opportunities for new health plans to enter the managed care market in California. Procurement offers an opportunity to update and align MCP contract requirements with DHCS goals related to topics like health disparities, community engagement, CalAIM, and

value based payments. Procurement will also ensure consistency across all plan model types and offer increased compliance and improved contract oversight. This is the first time DHCS will procure through a competitive bid process in all counties at the same time where Commercial Plans operate. The County Organized Health System (COHS) and the Local Initiative (LI) plans are not being procured. She reviewed a state map of current plan models and the counties where those plan models operate. Five plan models are included in this MCP procurement, including the Two-Plan commercial model, Geographic Managed Care (GMC), the Imperial model, Regional model, and the San Benito model.

Procurement will include a Request for Information (RFI) and a Request for Proposal (RFP). The RFI was released in September 2020 to gather high-level information and help develop the RFP. DHCS is developing the Final RFP, which will include qualifications requirements for the proposal submission and evaluation criteria. There is also a sample contract that is part of the RFP. The qualifications review for Stage 1 of the RFP is Pass/Fail, and the applicant must pass all qualifications to move on to Stage 2. Stage 2 is the scored evaluation of narrative proposals based upon RFP requirements.

DHCS is seeking MCPs that demonstrate the ability to deliver services aligned with DHCS' priorities, including reducing health disparities, value-based purchasing, increased oversight of delegated entities, continuum of care, coordinated care, quality, children's services, behavioral health services, social determinants of health, local presence and engagement, emergency preparedness, CalAIM, and administrative efficiency. The process will also update MCP contracts on a range of items, including new statutes and regulations, audit findings, strengthened language on network adequacy, and consistent terminology. The draft RFP is targeted for release in early 2021, and the final RFP is targeted for release in late 2021. Implementation is planned for January 2024.

**Questions and Comments**

*Kim Lewis, National Health Law Program*: How do you see policy decisions in CalAIM being incorporated or impacting procurement given the delay in the final CalAIM proposal?

*Jacey Cooper, DHCS*: We are having conversations within the administration now on CalAIM and hope to have many decisions made with the January budget ahead of issuing the draft RFP. We hope to offer a comprehensive update in January, and then we may need to incorporate changes as CalAIM will be iterative. To the degree we can, we will incorporate the language before plans go live in 2024. We will have mental health plans going live in 2022, and that will require us to incorporate changes.

*Doreen Bradshaw, Health Alliance of Northern California*: There were studies and audits on the regional model that listed challenges related to network adequacy and quality scores. Can you comment on the opportunity for communities to look at different models of managed care or to change their model?

*Jacey Cooper, DHCS*: DHCS has been providing technical assistance to counties that are contemplating changes, with a deadline of March 2021 to make those local decisions. Any decisions that require state statute would have to be in state law and/or county ordinance

by the end of the legislative cycle next year in anticipation of the final RFP. We are working closely with plans and other key stakeholders on this. Changing models is not a small decision to make so we have provided technical assistance and guidance to counties considering those decisions. We want to emphasize that this procurement is upping the game on quality and access to care so that beneficiaries have adequate access to services and high-quality care.

*Doreen Bradshaw, Health Alliance of Northern California*: Providers would need to work with plans and counties? Sometimes there is a disconnect between counties and providers.

*Jacey Cooper, DHCS*: Yes, the state is not making those decisions. It is the responsibility of the counties to work with the health care community if they want to change the model. We are educating people on the decision points depending on the model change and working with the MCP that must be willing and capable of serving a new county.

**Structural Racism in Health Care Delivery System and Outcomes**
**Discussion Facilitated by DHCS and California Pan-Ethnic Health Network**
Slides: https://www.dhcs.ca.gov/services/Documents/102820-SAC-Presentation.pdf

Director Lightbourne framed the discussion of this agenda item and thanked Kiran Savage-Sangwan from California Pan-Ethnic Health Network for her help in designing and facilitating the session. The agenda item began a discussion that will continue in the future. As DHCS looks to reengineer our system as a purchaser and, to some extent, a regulator and evaluator, a driving piece must be disparities related to race and place, both in procurement and CalAIM. COVID-19 has made disparities very visible. Population data obscures some of the impact, however, when we review the mortality rates per 100,000 from COVID-19 by race/ethnicity, it shows a stark picture. He reported that, for Whites, the rate is 27 per 100,000; for Latinos, it is 42 per 100,000; for Asians, it is 27 per 100,000; for African-Americans, it is 48 per 100,000; for multi race, it is 7 per 100,000; for American Indian/Alaska native, it is 28 per 100,000; and for Native Hawaiian and other Pacific Islander, it is 41 per 100,000. Clearly, the mortality rate, which is linked to circumstances where people live and get care, is very racially imbalanced. Disparity data from MCPs in 2018 show health outcomes compared to Whites are significantly worse for American Indian/Alaska Native, African American, and Native Hawaiian/Pacific Islander. For Asians and Latinos, the outcomes are somewhat worse compared to Whites. He also reviewed data specifics from these outcomes, including postpartum care and life expectancy, as examples of significant disparities.

Sometimes these conversations can be sidetracked into underlying policies that fall outside the health care system. We know there is unequal schooling, violent policing, mass incarceration, historic redlining, under-investment in affordable housing and transportation, racialized capitalism, immigration policies and lack of access to high-paying jobs, lack of access to capital, substandard housing, food deserts, high levels of stress and exposure to violence, isolation from needed services and supports, and unsafe and un-walkable neighborhoods. Some of this is potentially within reach of health systems. Some of this we need to take on in conjunction with other partners through government, public policy, and private policy. We want to focus this conversation on what it is that DHCS and you as

partners and stakeholders can do, via things like CalAIM and re-procurement, to not make things worse and to use every possible tool to make conditions better and to reduce disparities. Below we have listed ongoing and potential opportunities and tools. We want to hear from SAC members about where we should focus and what you see as opportunities.

For example:

- Data, reporting, and goal development
- Public hospital quality incentives
- ACEs Aware initiative
- Value-Based Payment Program
- MCPs and county behavioral health monitoring, training, and technical assistance
- Managed care performance improvement projects and population needs assessments
- Managed care contract revisions and procurement
- CalAIM
- Improve beneficiary contact information
- Incentivize improvement

Kiran Savage-Sangwan offered introductory remarks. This conversation about how we center race equity and racial justice is critical as we consider the Medi-Cal program for the future because the program itself can be a tool for equity. Ms. Savage-Sangwan emphasized that this discussion is about structural racism, structured systems, policies, and institutions, including health care systems, that are built upon racism. We want to figure out how we dismantle that. We are not necessarily talking about individual actions or behaviors within health care systems or on the part of consumers. The purpose is to identify policy and systems changes that can disrupt or dismantle structural racism within Medi-Cal. She also noted that there are significant gaps in the data and acknowledged that what we decide to measure and who decides what we measure are also manifestations of structural racism. Although there are gaps, we know that we have to do better. For consideration in this discussion, data is an important tool in dismantling structural racism. Also, the health care system is siloed and fragmented and does not meet communities where they might prefer to receive care, with the type of care they might prefer to receive. We have a hierarchy that has been created where consumers have to figure out how to utilize the system. How can we have different ways of sharing decision-making with consumers and communities (sharing power)? How might payment reform and what we pay for drive change, and how could it drive equity? How will we hold ourselves accountable to these changes?

**Questions and Comments**

*Michelle Gibbons, County Health Executives Association of California*: It is exciting to have this conversation. One thing to emphasize is that Medi-Cal serves a disproportionate population, and this increases the responsibility for DHCS to look deeper at the disparities and the structural and systemic challenges that beneficiaries have experienced and that have led to poor health outcomes. We need to look at what the data is showing us and make changes. I believe one of the easiest ones to change is maternal and child health outcomes. There is no reason other than structural racism for the disparities. The only difference that causes an African-American woman to be three to four times more likely to

die during childbirth than their White counterparts is racism; it's not education or anything else. Are we stratifying the data correctly? Are we looking at access and what supports can be wrapped around them or help increase trust in the health system? If not, why not? What structural issues result in less trust? I would like to talk about how to increase the partnership with public health at the state and local levels as well as how public health and health care can partner to address disparities. And there are other areas to work on, including AIDS, sexually transmitted diseases, cancer, and behavioral health utilization.

*LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies*: I commend DHCS for this discussion. Structural and institutional racism is real, and we have to look at how the structures are set up, including the state level structures, agencies, and DHCS. I encourage us to continue to use this lens of race and equity in every conversation because that is how we will understand what is happening. That means a focus on true integration within our health care system and across state government. Any opportunity to model integration to impact the population will trickle down. For example, how do we get behavioral health and physical health better integrated? DHCS can be a leader in this.

*Linda Nguy, Western Center on Law and Poverty*: I echo the need to collect and use data more equitably. How do we hold plans accountable for outcomes; ensure an equitable provider network; provide care with cultural humility; and address the known disparities? We know there are disparate outcomes for black maternal mortality and eligibility programs for specific medical conditions, such as hypertension and diabetes.

*Maya Altman, Health Plan of San Mateo*: Data is extremely important, and I want to commend DHCS for requiring all plans to complete the population needs assessment health plan due in July. We are reviewing this internally, particularly around disparities. Disparities and racism should be a major initiative for every single plan in the state. We need to have this discussion every time MCPs and the state meet to address this in a diligent way.

*Cathy Senderling, County Welfare Directors Association*: I think about how the disparities in health are also apparent in social services. How are we at CWDA promoting policy and making changes to track and address disparities to eliminate them across the spectrum? How can we do this work together since so many families are common to multiple systems?

*Bill Walker, MD, Contra Costa Health Services*: In Contra Costa, we realized we have to look across the full array of services and systems in the county and its cities. Perhaps the one positive thing about the pandemic is to focus us on the life and death disparities driving our state's ability to reopen. It has gotten community interest, and we are having a crucial conversation within the Living Well Initiative. The effort was underway before the pandemic and now is being integrated with efforts community-wide to bring together partners. I would say that starting with a discussion of the health system is necessary, but not sufficient to address disparities.

*Andie Patterson, California Primary Care Association*: CPCA and health centers are working on a 10-year strategic plan. We are using a structural racism lens with a goal of making improvements in justice and equity. We are heartened to see all of us are hearing the call

and want to work together on this. Health centers want to be engaged and want to do it in partnership with others.

*Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers*: I would love to see smaller workgroups focus on specific areas of the system, such as primary care, mental health, and substance use. Over the years, we have created policies and regulations that create barriers and lead to disparities. It would be good to build a list those policies and regulations and drill down on how they might be modified.

*Erica Murray, California Association of Public Hospitals and Health Systems*: We are starting an important conversation with great potential for collaboration at all levels. I recommend and encourage us to think about some potential forums and opportunities for us to have these conversations.

*Barsam Kasravi, Anthem Blue Cross*: Anthem is also here to partner on this, and we take this seriously. We rolled out a doula program in California and are partnering with DHCS to work on data collection based on race and ethnicity and the opportunity related to quality.

*Chris Perrone, California HealthCare Foundation*: CHCF stands ready to help gather input and ideas on this. I would encourage the effort to address network adequacy and payment because that drives so much. We are letting past utilization drive future payment and that solidifies disparities. I am an advocate for holding managed care partners accountable, and I urge DHCS not to stop at accountability within Medi-Cal provider and plans. DHCS needs to work with CalPERS and Covered California to think about what investment, at what level, is needed to solve this, rather than just delegating solutions down to the plans.

*Anthony Wright, Health Access California*: I have three points to add. I would appreciate additional data breakdown to get to the level of intersectionality so we know differences by age and understand how LGBTQ populations are faring as well as others. Medi-Cal is a powerful tool for accountability of plans and providers. We need to tie payments to real progress on disparities. Procurement is important to tie payments to demonstrated progress on disparities. I appreciate your framing that we need to focus on DHCS, but we do not want to miss the opportunity to partner with others because these structural issues are big and need to be addressed broadly. There is a lot we can do.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: I am thrilled we are starting this discussion. We need to discuss reframing our culture on enrollment to one of getting as many people enrolled as possible, rather than keeping ineligible people out. We can make the measure of success our work to find and eliminate barriers to enrollment, rather than assuming people do not want to enroll. It is a more difficult responsibility for DHCS to proactively find and eliminate barriers to enrollment. Also, many of the requests of health plans for data, such as health disparities, lacks the analysis that is a helpful next step to point to how to address disparities. I think more DHCS community engagement with families would be helpful. In our comments on procurement, we suggested health plans be encouraged or required to work with community health workers to engage families. My question is, what is next?

*Will Lightbourne, DHCS*: There has been a lot of planning and discussion within DHCS, at the Agency level, and across departments about what we need to do. This is a starting point of our conversation because we want to engage the best thinking to make sure we are casting our own thinking in a way that we can accomplish something. We do not want to boil the ocean nor create overly circumscribed boundaries. In the discussion at BH-SAC, a comment was made to bring forward the rules and regulations to the community to allow a structured place for conversation where participants can say, "This is what and where and how I want care." We want to shine a light in all the corners. As Al and Chris mentioned, we have created systems that make disparities worse. All of this will be in the mix of CalAIM, reprocurement, and other innovations in contracting.

*Kim Lewis, National Health Law Program*: On data, are there questions to examine on what we collect and what we measure? Aside from data, the collaboration of agencies is essential. Families do not come in siloes, according to agencies, or divided by health condition. How do we center services around the needs of a family working in concert, especially for children? They need unified approaches that knit together services for them. We need to unify the service delivery system for this population to meet the needs of families.

*Anne Donnelly, San Francisco AIDS Foundation*: As our organizations and coalitions move to center racial justice, we are realizing it needs to be part of the overall organizational strategic plan. I hope that is the way you are moving. I agree with Kim, and we have advocated for better integration through the system to end HIV, Hepatitis B, and STDs. We need to include public health, corrections, and other relevant agencies. And we need relationships with patients, families, and communities. It is essential that beneficiaries have a role in the decisions about health care services delivered to them. When we collect data, we need to include much more on the beneficiary experience and ask about what impedes access and what is quality for them.

*Michelle Gibbons, County Health Executives Association of California*: We need to ensure that access to Medi-Cal is easy to navigate. For some, it is not the challenge of navigating, it is that the systems have failed them, and they no longer seek care. We could be well served understanding perspectives about why they are not seeking the care available.

*Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: Yes, we hear a lot about the history of distrust and stigma in the health care system and Medi-Cal.

*Anne Donnelly, San Francisco AIDS Foundation*: We work with many who use drugs and have high trauma from experiences in the system that are a barrier.

*Barsam Kasravi, Anthem Blue Cross*: When we look at our health disparities initiative, the percent of African Americans in Medi-Cal is low compared to the other races and ethnicities that make up our membership, and I think statewide as well. Do we want to look at the enrollment process to ensure we have adequate engagement in the community for enrollment of African Americans into the program as potentially an opportunity?

*Michelle Gibbons, County Health Executives Association of California*: I would like to explore

how behavioral health services for the mild to moderate category can keep pace with the external climate related to increased trauma because of police shootings, COVID, and other context. It is difficult to get African Americans in my community to access services for mental health support in the current environment.

*Will Lightbourne, DHCS*: Thank you for your openness and frankness for this important beginning to our discussion.

Ms. Savage-Sangwan commented in summary on a few points. I heard themes of data, enrollment, payment, accountability, understanding the consumer experience, and the trauma that creates barriers to services. I heard a lot of commitment to the conversation here and in our own entities. Specific themes include going deeper on data, issues of fragmentation, and partnerships. We also talked about the specific rules and policies we need to dig into and change or undo.

*Chris Perrone, California HealthCare Foundation*: The drug carveout is coming up quickly. Does DHCS have any plans to evaluate the carveout and its impact on consumers? For example, when consumers are asked to change the way they get their care, they may find that some things are better and some are not. Do we see changes in quality of care, access or utilization of medications, or timely refills? Do we see management of chronic conditions getting more difficult? What are the related issues, such as cost?

*Rene Mollow, DHCS*: Yes, we have been putting policy in place to mitigate that. We are continuing to work with stakeholders to look at the impact of the carveout. We have been doing outreach to providers and beneficiaries. I will also put this on the radar of the team to see if these types of questions have come up in other venues where they are working with stakeholders. We have gathered input to inform the policies and will continue to work with MCPs on the impact. We will continue to assess and think through what tools or information we can gather for an assessment of how the carveout is working.

**Public Comment**

*Lisa Matsubara Planned Parenthood Affiliates of California*: I want to thank DHCS for addressing systemic racism and disparities in the health care system. As a society, we have historically underinvested and under-resourced our public health system in a way that has led to limited access to care and dramatic health disparities, as the data you presented showed us. While we are thankful for the continued investments that the state has made to sexual reproductive health, we are hopeful that these conversations will encourage the state to really invest in equity and justice and the Medi-Cal system, and make changes that are driven by ensuring access to quality patient-centered care. As a safety net provider and the largest single provider of family planning services, Planned Parenthood is looking forward to working with DHCS to be a part of identifying the solutions to address this important issue.

*Ciara Keegan, BluePath Health*: I appreciate the efforts on structural racism. My question is related to procurement. For those of us who submitted comments to the RFI, are you planning to release feedback to those comments? If so, what is the timing for that?

*Will Lightbourne, DHCS*: There is a plan to summarize and post the comments, although I am not sure when that is scheduled to occur.

*Katie Heidorn, Insure the Uninsured Project (ITUP):* Thank you for the important discussion today about racial justice, health equity, and social determinants of health. ITUP is focusing on it and trying to include it in all of our work every day. I am excited about this conversation and connecting it to the RFI conversation about procurement. It is critical to embed this in the delivery system so that it becomes part of everyday business.

**Next Steps and Final Comments; Adjourn**
***Will Lightbourne, DHCS***

Director Lightbourne thanked participants for attending and sharing their thoughts. He reminded members of the quarterly meeting dates for 2021 and particularly thanked Kiran Savage-Sangwan for shaping the conversation on racial disparities.

**2021 DHCS Stakeholder Advisory Committee Dates**

- February 11, 2021 – 9:30 a.m. – 12:30 p.m.
- April 29, 2021 – 1:30 p.m. – 4:30 p.m.
- July 29, 2021 – 9:30 a.m. – 12:30 p.m.
- October 21, 2021 – 1:30 p.m. – 4:30 p.m.