April 3, 2020

Governor Gavin Newsom
1303 10th Street, Suite 1173
Sacramento, CA 95814
Sent via email

Dear Governor Newsom,

First of all, our deepest gratitude to you and your administration for taking the threat of COVID-19 extremely seriously and acting accordingly, particularly when it required making unpopular decisions. We appreciate the round-the-clock nature that many state workers have engaged in the past two weeks and the responsiveness of state agencies and the Legislature to address the severe threat our communities face. On behalf of ACLU of California, California Pan-Ethnic Health Network, Children Now, Disability Rights California, Justice in Aging, Health Access California, Maternal and Child Health Access, National Health Law Program, The Children's Partnership, and Western Center on Law & Poverty, we write this letter to provide information about additional community needs to access the health care and related services they need. We also recognize that many of the communities we serve - older Californians, Californians with disabilities, children, people of color, the uninsured, and low-income Californians are the very groups that will be hit hardest by either the virus itself or the economic fallout that results in our efforts to contain the virus.

A. State legislation/funding needed

1. Health4All Older Californians in Medi-Cal

We strongly support all efforts to continue with and to expedite implementation of the Health4All Elders/Older Californians Medi-Cal eligibility expansion. This proposed expansion was prescient in targeting the most at-risk population currently excluded from full-scope coverage--including COVID-19 treatment to this day. During this pandemic, seniors with restricted-scope Medi-Cal cannot afford to wait until January 1, 2021 for full-scope coverage. By accelerating implementation to mid-summer 2020, the Department can guarantee

comprehensive coverage for thousands of seniors who urgently need it now. While restricted-scope Medi-Cal may cover the initial emergency services that are needed, for this population in particular, management of chronic disease now and follow up treatment later will likely be needed.

2. **Additional help for the uninsured and underinsured**

We know many patients will struggle with medical bills due to lack of insurance or having plans with high deductibles and out-of-pocket cost sharing. We urge the state to explore all options of providing additional assistance to this population regardless of immigration status, including any potentially available federal funds. We also request guidance clarifying that COVID-19 testing and treatment is already covered for undocumented individuals under existing law regarding emergency Medi-Cal services.

We understand DHCS is looking at both treatment and testing coverage options for uninsured persons who would be eligible for the testing-only coverage under H.R. 6201. One option for assistance for the uninsured or underinsured could be provided as additional subsidies for Covered California premiums and out-of-pocket costs, particularly for those who did not receive additional state subsidies. Alternatively, should the state be contemplating direct compensation to hospitals and other providers for uncompensated care, we ask that any such funds be distributed on the condition that patients not be billed. Finally, we urge the state to remind hospitals of their obligations under the Hospital Fair Pricing Act to work with both the uninsured and the underinsured under 350% of the federal poverty level to reduce the cost of hospital bills to what Medicare pays, and to offer payment plans based on what the patient can actually afford. While we know that many hospitals offer far more generous charity care or discount payment plans, many hospitals do not apply this to the underinsured in particular or do not readily offer such plans to immigrants who are undocumented, contrary to state law.

3. **Additional supports for people who are isolated**

We commend the Administration for its efforts to increase access to housing for persons who are unsheltered and for expanding food benefits during this crisis. We also urge the Administration and DHCS to look to how else these supports can be offered by leveraging Medicaid dollars. For example, can current Health Homes or Whole Person Care housing supports be expanded? Can the existing medically tailored meals program be modified and expanded to provide medically supportive meals and nutrition to populations most at risk for COVID-19? Finally, certain populations will need additional outreach to ensure their health & safety including older Californians,

persons with multiple chronic conditions, and pregnant and postpartum individuals, particularly as their access to regular health services is diminished.

4. **End discontinuances for pregnant individuals eligible for the Medi-Cal Access Program whose presumptive eligibility ends**

Now, of course, is the worst possible time for pregnant people to be discontinued from or experience gaps in medical care, but this will continue to happen for a relatively small but important number of Californians without budget action. When an individual starts Medi-Cal under the 213% Presumptive Eligibility (PE) program but is screened in real time as having income in the range for the separate Medi-Cal Access Program (213%-322% of poverty) at the time the follow up application is submitted, she is abruptly dropped from PE Medi-Cal. This disconnect often occurs because the tax and wage databases are at least several months out of date. With more people now unemployed, even more eligible individuals will be abruptly dropped from PE and experience coverage gaps until they can re-apply. This churning will also add to pressure on the enrollment process. A short "mini-bridge" from Medi-Cal PE to MCAP would address the problem. Alternatively, pregnant individuals could be enrolled in Medi-Cal with income to 322%, since MCAP is delivered through Medi-Cal plans anyway.

5. **Additional support for services to Individuals with substance use disorders in non-Drug Medi-Cal Organized Delivery System counties**

DHCS has clarified that all Drug Medi-Cal Organized Delivery System (DMC-ODS) services that may be provided via telehealth or telephone are reimbursable when provided through these mechanisms. However, substance use disorder services in counties that are not participating in the DMC-ODS demonstration are not reimbursable when provided via telehealth. The Department has encouraged non-DMC-ODS counties to use Substance Abuse and Mental Health Services Administration (SAMHSA) grants to fill these gaps. Moreover, SAMHSA has made available emergency grants for states to address substance use disorders during the COVID-19 pandemic. We urge DHCS to request funding from these emergency grants to address gaps in telehealth coverage in counties not participating in the DMC-ODS demonstration.

B. Issues requiring coordination of multiple state departments

1. **Network capacity**

We also urge the Department of Health Care Services, the Department of Managed Health Care (DMHC), and the Department of Insurance (CDI) to

require all health plans, dental managed care plans, and insurance companies to affirmatively reach out to the providers in their network to get regular updates on capacity. Plans should know which providers have closed completely, which are still seeing patients and have available appointments, and which are at capacity.

We appreciate that plans have been directed to offer access to care out-of-network where appropriate and required as the crisis develops. Given the massive shifting of resources that is occurring in our healthcare system right now, in addition to plans updating their own provider networks, we request a uniform provider directory to help Californians with immediate health care needs so they know where they can get care. Patients will still need kidney dialysis, and babies will continue to be born. Patients need to know which providers are still open and how to flag urgent needs.

2. **Medical verification for benefits programs**

While we appreciate the waiving of waiting periods and the strong messaging about unemployment, paid family or medical leave, and other benefits programs, many programs require the certification of a doctor or other medical professional in order to gain access to benefits. Accessing medical providers right now is a significant challenge when providers are not taking non-urgent appointments. For those programs within the control of the state or counties, we recommend temporarily waiving these requirements.

3. **Coordinate with Other State Departments to Ensure Continuing Access to Medi-Cal Home and Community-Based Services and In-Home Supportive Services**

In the midst of this pandemic, older adults and individuals with disabilities must continue to have access to the home and community-based services (HCBS) that keep them healthy. Mitigating disruptions to HCBS helps California flatten the curve by reserving scarce resources to those who most need it. We ask DHCS to coordinate with other departments and agencies to ensure access to HCBS continues. For example, Community-Based Adult Services (CBAS) centers need guidance from the California Department of Education regarding reimbursement of meals provided through the Child & Adult Care Food Program (CACFP). We appreciate DHCS has already granted centers flexibilities around delivering such meals while center services are limited, but the state must coordinate to ensure funding is available so centers can actually provide meals.

In addition, with respect to In-Home Supportive Services (IHSS), we ask that DHCS and the Department of Social Services (CDSS) allow initial assessments for IHSS to be conducted over the phone than in-person. DHCS and CDSS recently

published guidance, ACL 20-26, that continues to require in-home assessments for applicants while allowing for phone re-assessments for current recipients. Given the risk to both applicants and social workers, the state should suspend this requirement immediately.

4. Clarity regarding essential services and limitations on telehealth

We appreciate the DHCS guidance dated March 24, 2020 related to non-urgent, non-essential services, especially, DHCS's emphasis on providers discussing these decisions with their patients collaboratively and based on an individualized clinical determination rather than just blanket policy. We understand that there are significant workforce issues as services are redirected to deal with the public health crisis and we also understand the challenges in providing safe care absent adequate protective equipment. Nonetheless, there are Californians who will have other urgent health care needs and will not be able to use their usual source of care. Further oversight from DHCS and guidance from DMHC and CDI would be helpful to clarify for all providers, including dentists, that providers are expected to continue to make informed clinical choices about urgent and emergency services for their patients and consult with professional associations for clinical best practices during the pandemic.

In addition, state agencies should make clear that plans have an obligation to ensure access to time-sensitive services and to make such services available by telehealth to the extent feasible and clinically appropriate. We have been hearing about beneficiaries experiencing barriers to accessing to urgent and time-sensitive services in the past week including dialysis, applied behavioral analysis therapy, chemotherapy, severe allergic reactions, and urgent dental services (services beyond "life-threatening" conditions as the California Dental Association has stated must be provided, but "conditions that require immediate attention" as state by the American Dental Association). The plans also need to clarify who managed care members can contact on a 24-hour basis at the plan to authorize services.

For Medi-Cal members using fee-for-service, we do need DHCS assistance and oversight when services are cancelled. For example, we have recently been notified that crisis services for youth eligible for wraparound mental health services are being cancelled, resulting in 14-day placement disruption notices from caregivers and calls to the County's mental health crisis line or the police.

5. Notify providers of HIPAA changes

DHCS, DMHC, & CDI should also broaden the ability of providers to engage in, and get reimbursed for, all interactions with patients through all technology enabled modalities, without concern to strictly meeting HIPAA privacy

requirements. Recent HHS OCR guidance states: "During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately." See, also CMS Guidance issued March 24, 2020. DHCS, DMHC, and CDI should instruct all plans that any contract limitations in this regard should be waived or need not be strictly adhered to.

Healthcare providers should only use non-compliant telehealth platforms as a stopgap measure until they can transition to HIPAA-compliant platforms. Similarly, we do want to make sure the medical privacy protections are still adhered to in any other partnerships, including those with commercial entities not currently covered by medical privacy laws to ensure data is not improperly shared.

6. Create a Free State Hotline for Providers to Access Language Assistance Services

Californians speak up to 220 different languages; forty-four percent speak a language other than English at home, and almost one in five speak English "less than very well." With the addition of COVID-19 related mobile testing sites and medical hospitals in California, it is more important than ever that Californians continue to receive state mandated language assistance which includes oral interpretation for screening, testing and treatment. We urge the state to create a free 800 hotline for providers to use at these testing sites and medical locations in order to access telephone or video interpretation in real-time to help reduce bottlenecks while ensuring that Limited English-Proficient (LEP) patients are able to receive equitable treatment and care.

7. Advertise the State of California's new Consumer Hotline and Ensure Staffing in Languages Other than English and Spanish

We are excited about the launch of the state's new COVID-19 hotline (833-544-2374) with consumer oriented public health information on COVID-19. Unfortunately, some non-English speaking communities such as Sacramento's Slavic community report even recently that they were unaware of the state's shelter-in-place order. We urge the state of California to provide appropriate

resources to advertise the existence of this hotline through television, online, digital and print media so more Californians act on state and local public health messages and ensure staffing in languages other than English and Spanish.

8. Creation of a State Hotline to Report COVID-19 Hate Crimes

The pandemic has a unique impact on some particular communities in California. Asian American and Pacific Islander communities have reported a surge in hate crimes in the wake of COVID-19. A website launched on March 19 to track anti-Asian harassment has received more than 1,000 reports from people in 32 states, including acts of violence and physical assaults. These incidents compromise the physical and mental health and well-being of Californians. We ask that the Governor create a state hotline - similar to what has been launched in New York - to report and investigate COVID-19 related hate crimes and incidents. The hotline should be supported by multiple state agencies, including the Attorney General's Office, the Department of Fair Employment and Housing, and others.

9. Collection of Race and Ethnicity Data with Local Health Departments

We ask the California Department of Public Health to monitor and address racial disparities in the provision of COVID-19 testing and treatment statewide. Since the Governor declared a State of Emergency on March 4, testing disparities are emerging across counties showing significantly more positive test results in higher income neighborhoods. For example, in Los Angeles County, the affluent neighborhoods of Melrose and Beverly Hills reported 113 and 45 positive test results, respectively, as of April 2, whereas the working-class neighborhoods of Pacoima and South El Monte reported 8 and 0 positive test results. These results are counterintuitive to what we know about how the virus spreads—among more densely populated areas, those who work lower wage, essential jobs and cannot work from home, and those with underlying health conditions.

To our knowledge, no county so far has reported testing data with racial and ethnic breakdowns. Yet California law, 17 C.C.R. § 2500(d)(1), requires labs to report race and ethnicity data along with their test results to local health departments. The California Department of Public Health can enforce this provision. Members of the U.S. Senate and Congress have made a similar request to the U.S. Department of Health and Human Services to monitor and address racial disparities at a national level. The collection and analysis of this data is critical to prevent the exacerbation of existing health disparities in communities of color, which are already more burdened with chronic conditions, poverty, and implicit bias from medical providers. We urge the state

to take immediate steps to collect and review this data since testing is one of the key tools to containment of the virus.

C. Additional specific DHCS requests.

We greatly appreciate the work that DHCS has done to date on relaxing verification requirements, suspending renewals and terminations, issuing multiple guidances to expand telehealth, and issuing quick guidance on non-essential, non-urgent, and elective care. We also appreciate DHCS's stated intent to offer free COVID-19 testing to uninsured individuals as provided for in the recent federal legislation and intent to broadly expand our existing presumptive eligibility programs. We also thank DHCS for quickly requesting additional flexibilities to administer the Medi-Cal program in a state of emergency to the Centers for Medicare & Medicaid Services via two recent sets of section 1135 waiver requests and an imminent emergency SPA request. We appreciate the input from advocates that was included. As the situation has developed, we have recognized additional needs in the community and attach them as an addendum to this letter to better increase access to health care through the Medi-Cal and Medi-Cal Access Programs.

D. Specific Requests for Covered California

First, we appreciate that Covered California has created a new Open Enrollment period in anticipation that more people will now be looking for coverage and to assure Californians that they can get covered on or off the Exchange if they lose their job-based coverage.

Advocates have already reached out to Covered California regarding messages that should be updated on the Covered California website anticipating an influx of Californians who have lost or suddenly realize they need health coverage. We have also discussed repurposing the marketing arm of Covered California to address these needs, including highlighting the message that all COVID-19 medically necessary screening and testing is free of charge. Finally, we continue to troubleshoot with Covered California as consumers struggle to enroll in Covered California quickly given the newly increased demand as people lose job-based coverage.

E. Specific Requests for DMHC/CDI

Again, we appreciate the quick response from both departments in using emergency authority to require additional consumer protections from health plans and insurance companies, including waiving costs related to waive out-of-pocket costs for COVID-19 testing and extending prescription refills. Given the difficulty in accessing COVID-19 testing, we also request a waiver of out-of-pocket costs related to testing for related ailments, such as flu or pneumonia, as

the average person would not know what they have and these tests are generally done before a COVID-19 test.

F. Community Outreach Messaging from California Department of Public Health

We thank the California Department of Public Health (CDPH) for clarifying that public charge does not count COVID-19 testing and treatment, even if received under Medi-Cal. Fortunately, there are many other reassuring messages that immigrants need to hear. So we also ask for the following clarifications to be added to CDPH's website and covid19.ca.gov:

1. Clarifying that restricted-scope Medi-Cal covers COVID-19 testing and treatment;
2. Echoing (without directly linking to ICE's website) the latest federal guidance on sensitive locations policies applicable during the pandemic;
3. Clarifying that public health services (such as county free testing and vaccines, when they become available) are *not* counted under the public charge rule (8 USCIS-PM G.10(B)(1));
4. Connecting immigrants to care if they are uninsured or underinsured. This should include a statewide list of programs available in each county, such as My Health LA or Healthy San Francisco, so that immigrants know where to go to get coverage when they are ineligible for Medi-Cal.

We also ask for clear messaging to Medi-Cal beneficiaries about access to care during pandemic for other health needs. Consumers need to know about mail order and delivery of prescription drugs, telehealth options, out-of-network access of medically necessary care, relaxation of prior authorizations, what to do if provider cancels medically-necessary services, and how to access their managed care plan and dental provider on a 24-hour basis.

Finally, we are grateful to CDPH for the creation of critical outreach and education materials, but also recognize there is significant language and cultural variation in our diverse communities' understanding of COVID-19. Particularly for indigenous communities, so much of the COVID-19 jargon is high register terminology that is difficult to convey. We urge the Dept. of Public Health to work with community-based organizations to elevate examples of best practices in terms of culturally and linguistically appropriate materials, identify gaps and develop materials and other communications to convey these important public health terms.

Again, we thank all state agencies for their rapid response to the pandemic and recognize the huge shifts in health care coverage and access that are

occurring right now. Should there be any questions about these recommendations, we are happy to discuss further or provide further details.

Sincerely,

ACLU of California
California Pan-Ethnic Health Network
Children Now
Disability Rights California
Justice in Aging
Health Access California
Maternal and Child Health Access
National Health Law Program
The Children's Partnership
Western Center on Law & Poverty

cc: Mark Ghaly, Secretary, California Health and Human Services
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