Government Programs Committee

Thursday, April 26, 2018
10:10am-11:30am
Robin Affrime, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Robin Affrime	A
II. Approval of Agenda	• Executive Summary	Robin Affrime	A
III. Approval of Minutes	• January Meeting Minutes	Robin Affrime	A
IV. 340B Federal and State	• 340B Memo	Andie Patterson Liz Oseguera	D
V. OSHPD 3 and Licensing	• OSHPD 3 Memo • Licensing Memo	Michael Helmick Emily Shipman	D
VI. Managed Care	• Managed Care Memo	Meaghan McCamman Nenick Vu	D
VII. Behavioral Health	• State BH Update Memo • Federal Opioid Memo • MHSA Memo	Meaghan McCamman Michael Helmick Liz Oseguera	A I I
VIII. 2703 PCHH	• 2703 PCHH memo	Allie Budenz	I
IX. Lifeline Grant Program	• Grant Program Memo	Michael Helmick	D
X. Oral Health	• Oral Health Memo	Beth Malinowski Emili Labass	I
XI. Adjourn		Robin Affrime	A

California Primary Care Association

Executive Summary

Date: April 26, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy

MEMORANDUM

340B

- The Governor's budget proposes an elimination of the 340B program in Medi-Cal
- DHCS has released a draft All Plan Letter (APL) to clarify the role that Medi-Cal managed care organizations (MCOs) are required to have in eliminating duplicate discounts under the 340B program.
- CPCA is leading a multi-pronged effort to ensure that 340B remains in the Medi-Cal program and that a workable solution is developed between providers, plans, and DHCS to identify and remove duplicate discounts.

OSHPD 3 and Licensing

- CPCA has continued to make progress on the licensing and OSHPD 3 multi-pronged strategies approved by the CPCA Board.
- Our work is focused on research, exploring waivers and exemptions, impacting the building code cycle, and pushing CDPH to work with health centers on our licensing priorities.
- CPCA has begun coalition-building with other statewide advocacy organizations frustrated with OSHPD 3 and licensing process.

Managed Care

- CPCA continues work on our three existing managed care priorities: strengthening relationships between CCHCs and their managed care partners, increasing managed care plan investment in quality improvement, and increased state oversight of beneficiary access and network adequacy.
- While our work in these areas will not stop, under the new RAC managed care plan, state and local RAC will work together to forward new, state and regional collaborative priorities.
- The four RAC/CPCA priorities include promoting the role of CCHCs to the new Administration and leadership at DHCS, Leveraging the commercial plan procurement, working with plans on P4P, HEDIS, and quality alignment, and increasing enrollment efficiency and default assignment to CCHCs

Behavioral Health

- CPCA has been making progress on our BH goals, which expand the ability of CCHCs to provide behavioral health care within the current trifurcated system.
- In advance of the 2020 Waiver negotiations, we propose a bigger goal-setting conversation to

vision a better coordinated and more thoughtful BH delivery system in CA.

Federal Opioid

- The opioid epidemic has been receiving heightened attention at the Federal level from Congress and the Administration.
- Staff has continued to keep abreast of the federal actions and how they may affect health centers, including providing written comments to the White House Opioid Epidemic Commission.
- There are two streams of funds which will affect health centers:
    1. SAMHSA- The omnibus, among other priorities, included an additional $1 billion to support treatment and prevention of opioid abuse.
    2. HRSA- As part of the CR reallocation of the 330 grants, Health Centers received an additional $200 million to specifically address the opioid epidemic.

MHSA

- Mental Health Services Act (MHSA) has come under increased scrutiny in light of the Department of Health Care Services (DHCS) and the Mental Health Oversight and Accountability Commission (MHSOAC) inability or unwillingness to effectively regulate the program, either programmatically or through fiscal oversight.
- CPCA is prepared to capitalize on the new changes to the program management within the state agencies in order to ensure that counties are leveraging the expertise and extensive reach of community-based providers, especially in their outreach to underserved populations.

2703 PCHH

- DHCS has modified the HHP implementation schedule; several plans, including Partnership, have moved to Group 3. Only San Francisco, Riverside, and San Bernardino are going live in group 1 and 2.
- DHCS released a program guide intended to serve as a resource for the MCPs n the development, implementation, and operation of the HHP.
- John Snow, Inc. released a free tool for CB-CME health centers to identify the costs, staffing, and infrastructure needs associated with implementing a care management program and identify the ROI.

Lifeline Grant Program

- The Lifeline Grant applications were due on March 26, 2018.
- The Treasurer's office is currently in a 45 day application review process which will end on May 10, 2018
- CPCA will continue to engage the Treasurer's office and if any funds remain Staff will work with them to determine the most effective strategy moving forward.

Oral Health

- Many providers, including community health centers, may have received overpayment for Program Year January and July incentive payments in the Dental Transformation Initiative. Approximately 76 individual clinics were identified and sent a letter that specified the

overpayment amount and provided instructions to repay and/or appeal. CPCA reached out to impacted community health centers on Monday, April 2, 2018 to alert them of this recoupment effort and to provide more detailed information on how to appeal.

- On Thursday, March 22, 2018 the Little Hoover Commission conducted a public hearing to examine the progress the Department of Health Care Services (DHCS) has made in addressing recommendations from the Commission's April 2016 Report entitled, Fixing Denti-Cal.
- In January, 2018 the DentaQuest Foundation selected CPCA to for the DentaQuest Foundation State Representative position. The role of the State Rep is to carry the voice and represent the Oral Health 2020 Network in California, by building relationships, coordinating efforts, and weaving the various DentaQuest Foundation grantees in California into a statewide Oral Health 2020 Network.
- Continuing our work as a member of the Core Group of the California Oral Health Network, CPCA has continued to assist CPEHN with the foundational development of the Network.

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
January 18, 2018
10:00am – 11:30am

Members: Robin Affrime – Chair, Alex Armstrong, Linda Costa, Doreen Bradshaw, Eddie Chan, Jill Damian, Lynn Dorroh-Watson, Reymundo Espinoza, Deb Farmer, Rachel Farrell, Ben Flores, Susie Foster, Timothy Fraser, Cathy Frey, Naomi Fuchs, Alvaro Fuentes, Greg Garrett, Dean Germano, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Alicia Hardy, Virginia Hedrick, Kerry Hydash, Tina Jagtiani, Daniel Kazakos, Constance Kirk, David Lavine, Marty Lynch, Jyl Marden, Kevin Mattson, Louise McCarthy, Scott McFarland, Leslie McGowan, Nichole Mosqueda, Danielle Myers, Christine Noguera, Rakesh Patel, Carole Press, Tim Pusateri, Tim Rine, Jacqueline Ritacco, Michael Schaub, Laura Sheckler, Paulo Soares, Mary Szecsey, Sabine Talaugon, Christina Velasco, Richard Veloz, David Vliet,

Guests: Raphael Irving, Anitha Mullangi, John Price, Lucresha Renteria, Melissa Eidman, Meryl Schlingheyde, Tabiola Cornejo, Chloe Guazzone, Diana Kawasaki-Yee, Mary Renner, Anthony White, Angie Melton, Sergio Bautista, Paula Zandi, Harpreet Johlmd, Esen Sainz

Staff: Carmela Castellano-Garcia, Andie Patterson, Meaghan McCamman, Daisy Po'oi, Elizabeth Oseguera, Michael Helmick, Emily Shipman, Nenick Vu, Emili Labass, Allie Budenz, Ginger Smith, Val Sheehan

I. Call to Order
Robin Affrime, Committee Chair, called the meeting to order at 10:13am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (C. Frey, D. Farmer)**

III. Approval of Minutes
A motion was made to approve the minutes of October 10, 2017. **The motion carried. (D. Myers, N. Gupta)**

IV. Year in Review
Meaghan provided an overview of what the committee projected from 2016 and what happened in 2017.

IV. 340B
The state budget proposes to ELIMINATE 340B from the Medi-Cal FFS and Managed Care Programs. The state argues that the current 340B program costs more than it should because providers bill not at acquisition cost but at higher prices, which drives up managed care rates. The state also argues that claims are not being properly identified, which prevents DHCS from receiving rebates and puts the state at risk of double discount liability. A full blown advocacy strategy is underway, including further legal analysis on whether the state can eliminate a federal program such as 340B from the Medicaid program.

V. Lifeline Grant Program
CPCA sent a letter to the Treasurer's office highlighted the feedback that we gleaned from the webinar and offered several recommendations. CPCA has been continually communicating with the Treasurer's staff to push them for an expeditious release of the grant funds and will be attending the upcoming CHFFA meeting on January 25th. An update will go out to members accordingly.

VI. OSHPD3 & Licensing Strategies
CPCA staff continue to build strategies to alleviate some of challenges health centers face in regards to OSHPD and building codes. Staff improved communication and relationships with OSHPD and the Building

Standards Commission. CPCA is in the process of identifying an author for legislation that would improve AB 2053, which was passed in 2016. CPCA staff has had extensive dialogue with Assemblywoman Gonzalez-Fletcher's staff regarding the need for the bill and are optimistic that we will have an author finalized before the deadline to submit legislation in February 2018.

VII. Licensing

CAU is making progress in filling vacant positions and expects to see meaningful progress on the licensing backlog by March, aided by the release of an electronic applications process coming early 2018.
CPCA is working to introduce legislation this year to amend the Welfare & Institutions Code to allow for consolidated licensees to bill under a shared license and PPS rate, should they choose to do so.

VIII. Managed Care

CPCA is launching 2018 with a Managed Care Strategy summit with all of the RAC to examine the changing managed care landscape, including the commercial procurement, new administration, and major market changes. CPCA will continue to work on key existing priorities such as unseen patients, network adequacy, provider directories, and plan relations. Staff will add Unseen Patients to the April Government Programs committee agenda.

IX. Behavioral Health & MHSA

CPCA has key successes under our belt and high hopes for the future in removing regulatory barriers such as billing for MFTs, provider Drug Medi-Cal and Specialty Mental Health Services, and Same day Billing. CPCA continues to work with state mental health and counties to ensure that FQHCs are recognized for their important role in the behavioral health delivery system, and receive behavioral health resources commensurate with that role.

The Mental Health Services Oversight and Accountability Commission (OAC) released its updated amendments to the PEI and Innovation regulations. CPCA is very pleased that the OAC has accepted its recommendations.

X. Emergency Preparedness

CPCA has collected and disseminated a multitude of disaster related resources and has provided daily technical assistance to health center and regional association staff on a variety of topics. We continue to work closely with our national and local partners to quickly find and consolidate existing materials, identify gams and missing elements, and work to create tools to fill the gaps. Resources can be found on the CPCA Emergency Preparedness website.

XI. 2703 PCHH

DHCS notified SPA to implement ACA Section 2703 HHP approved by CMS with minor, non-substantive modifications to language. Draft rates from DHCS to MCPs are in negotiations and expected to be finalized in March 2018. DHCS contracted with Harbage Consulting to provide technical assistance on outreach, education and communications to MCPs, providers, CB-CMEs, eligible Medi-Cal beneficiaries, and other stakeholders through all 3 implementation phases of the Health Homes for Patients (HHP).

XII. Oral Health

CPCA joined CPEHN and other stakeholders as Core Group members in the development of a new California Oral Health Network. CPCA developed four key oral health network goals around maximizing connectivity and engagement, using better data, knowledge and practices to develop community driven policy, engagement on oral health advocacy and provide opportunities for consumer and community engagement to advance oral health.

The Dental Transformation Initiative enters its third Program Year with steadily increasing participation from

FQHCs. CPCA remains a committed partner in the National Oral Health Integration and Innovation Network (NOHIIN) and has successfully completed a new phase of PCA oral health leadership with funding from the DentaQuest Foundation.

XIV. Adjourn

The meeting was adjourned at 11:36am.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care ASSOCIATION

DISCUSSION

Date: April 9, 2018

To: Government Programs

From: Elizabeth Oseguera, Senior Policy Analyst

Re: 340B Update

MEMORANDUM

I. 340B State Budget Battle

The Governor's proposed budget includes language that would eliminate the 340B Drug Discount Program (340B) from Medi-Cal in both Fee-for-Service and Managed Care Programs. In response, CPCA has been working very closely with its partners, the California Association of Public Hospitals, California Hospital Association and others to coordinate strategies and advocacy efforts to help save the 340B program in Medi-Cal.

340B Partner Collaboration

Similar to the FY 2017-2018 budget battle, state associations representing the interest of 340B covered entities are again working closely together on capitol strategy and engagement with the administration. CaliforniaHealth+ Advocates, on behalf of health centers interest, is coordinating closely with other associations on all 340B-related capitol visits. Over a dozen meetings have been held with staff, consultants, and elected officials associated with the budget process. To date, legislative engagement has focused on the Senate Budget Subcommittee 3 on Health and Human Services and the Assembly Budget Subcommittee 1 on Health and Human Services, the two committees that will first hear this budget item.

This year's partner collaboration has grown to include a broader array of stakeholders. Organizations that partner closely with 340B covered entities, consumer and worker advocates, and others are now voicing opposition. This broader opposition can best be seen in a coalition 340B opposition letter that was circulated in the capitol prior to the first hearing of the 340B budget item. With roughly thirty organizations signed-on, this letter sent a strong message to the capitol community that the 340B program matters. This letter can be found in the resource section.

Senate Subcommittee Hearing on 340B

On March 22nd the Senate Subcommittee on Health and Human Services hosted a hearing where the 340B program was discussed. This hearing included a stakeholder panel representative of multiple covered entity interests, including hospitals, community health centers, and Planned Parenthood. Britta Guerrero, CEO, Sacramento Native Health

Centers, represented health centers interests, testified to the critical role 340B savings play in supporting access to care and the commitment of health centers to work with the state to improve the 340B program.

Overall the hearing went well, no vote on the item was taken, and the item was held open for future discussion. Members of the committee had great questions regarding the program, and Senator Pan, the Subcommittee's Chair, provided comments during the hearing that indicated significant concern with the Administration's proposal. In their testimony, the California Department of Health Care Services (DHCS) and Department of Finance indicated that they would have a 'savings estimate' prepared prior to the May revise. However, after being questioned by Senator Pan, the Legislative Analyst's Office (LAO) signaled that this proposal may be cost neutral considering that covered entities would need help from the state to obtain funding that would offset the cost of losing 340B savings.

In their testimony, DHCS continued to state that it is very difficult to provide proper oversight of the 340B program, especially when trying to avoid duplicate discounts, and believes that the best solution is to eliminate the 340B program from Medi-Cal. However, to date, DHCS has not promulgated clear policies to avoid duplicate discounts.

LAO Report on the 340B Program

The Legislative Analyst's Office (LAO) released a report on March 21st regarding DHCS' proposal to eliminate 340B in Medi-Cal. Although we appreciate the LAO looking into this issue, we don't believe the report represents all sides of the argument, and heavily focused on DHCS perspective. To help clarify some of the misleading statements in the report, Advocates created a document that helps to explain the health center perspective and helps to clarify misleading statements made in the LAO report. This can be found in the resource section below along with a copy of LAOs report.

Although improvements could've been made to the report, we were glad to see the LAO acknowledge that under existing federal law, the state is required to create policies and procedures that help prevent duplicate discounts, clearly placing the responsibility on DHCS. The report also recognized that California would likely lose money if the state chose to only collect rebates under Medi-Cal since only a third of the rebate amount stays in the state, while a covered entity is able to maintain close to 100 percent of its savings. CaliforniaHealth+ Advocates met with key LAO staff to educate them on health centers and the importance of the 340B program to the communities we serve.

II. APL

Although the 340B budget battle continues, DHCS has released a draft All Plan Letter (APL) to clarify the role that Medi-Cal managed care organizations (MCOs) are required to have in eliminating duplicate discounts under the 340B program. This is in response to a rule issued in 2016 by CMS, the Medicaid and CHIP Managed Care Final Rule, that required states to either mandate MCOs to identify and exclude 340B claims from the utilizations reports or instead require covered entities to submit 340B claims data directly to the state. This APL is

the state's attempt to implement these requirements, however, DHCS continues to pursue the elimination of the 340B program under Medi-Cal through the budget process.

CPCA appreciates that DHCS has decided to release this APL with the intention to provide both MCOs and covered entities direction on how to submit utilization data to the state in hopes of preventing duplicate discounts, which supports our goal to receive direction and guidance from the state in this process. However, CPCA had some concerns. Working with our hospital partners, we submitted a joint letter to provide DHCS some recommended amendments. You may see the coalition letter under the resource section below.

III. Federal Legislative Update

Congress has introduced two bills, the 340B Pause Act and the Help Act, to help better regulate and oversee the 340B drug program. Currently, none of the bills that have been introduced impact health centers.

IV. Resources

- LAO Report on the 340B Program
- Advocates response to the LAO report
- DHCS Draft APL on 340B
- Coalition Letter - APL
- CA FQHCs Use of 340B Savings
- 340B Coalition Sign On Letter

California Primary Care ASSOCIATION

Discussion

Date: April 26, 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: OSHPD 3 Strategy Update

MEMORANDUM

I. Background

Removing the application of OSHPD3 building standards to licensed CHC facilities is at the top of CPCA's policy agenda. As agreed upon by the Board in October 2017, we have embarked on a multi-pronged effort to examine options for removing the standards as well as easing the burden of OSHPD3 via: A) licensure exemption; B) building standards exemption; C) refinement of building code, and D) expansion of the application of waivers. The strategy and work streams are outlined in the OSHPD 3 options chart in the resources section.

II. OSHPD 3 Strategy Update

A. **Licensure Exemption**
Please see the "Licensing Update" memo in the Government Programs Committee packet for a full overview of CPCA's work around licensure exemptions using the 1206(g) exemption process.

B. **Building Standards Exemption**
As discussed in meetings prior, per CPCA's analysis it is not appropriate at this point in time to pursue a direct legislative strategy to secure exemption from the OSHPD3 building standards. However, staff is committed to working towards that goal by laying the groundwork for a legislative play. Part of that strategy includes external research that justifies to our concerns and solutions.

Ideally, an external entity would do research on the challenges of OSHPD 3, however we believe the best way to ensure external research is to first engage in our own funded study. As such, CPCA staff has crafted a scope of project and is searching for the appropriate research team to complete the project in 2018. The goal is to examine California's licensing and building standards and determine whether there is an associated health and safety need for those standards, specifically for licensed health centers compared to unlicensed health centers or providers. The report shall determine the relative health and safety enhancements provided by OSHPD 3 standards compared to general building standards, and will examine the added cost to licensed providers and the health care access issues that result from building delays related to OSHPD3.

Once conducted, the study will be shared with the Little Hoover Commission, the Legislative Analyst's Office, and other trusted research bodies as a precursor to a larger movement to objectively examine the efficacy of California's building code.

C. Building Standards Commission Composition

The California Building Standards Commission is the group responsible for approving the building standards proposed by OSHPD. The Commission is currently soliciting applications for one vacant position. CPCA Staff have assisted three candidates with the application process for the CBSC. If a CPCA representative is selected to the CBSC, we will be in an unprecedented position to monitor and impact changes to the building code as the part of future three year cycles. There is no set timeframe, but we expect the Governor to select a representative before the end of his final term, at least.

D. Refinement of the Building Code

CPCA staff is also engaging actively in the 2019 'triennial building code cycle,' or the three-year cycle of building code development. Our attendance and comments at these meeting will allow us to shape the continued building standard discussions and advance the health center perspective. The 2019 cycle recently began with the Hospital Building Safety Board (HBSB) holding a hearing on the suggested changes to OSHPD 1-4. There are minimal changes to the OSHPD 3 regulations, with many simply clarifying language. In addition, it is our goal to create opportunities for our member health centers to interface and learn directly from OSHPD building standard and management staff through meetings and educational events and webinars.

E. Waiver Applications

Please see the "Licensing Update" memo in the Government Programs Committee packet for a full overview of CPCA's work around the use of Flexibility Waivers.

III. Relationship Building and Coalition Work

A. Staff has begun scheduling regular meetings with OSHPD leadership. The meetings, similar to those currently in place with CDPH L&C, will focus on creating open dialogue and information sharing between OSHPD, CPCA, and health centers.

B. Staff has identified other organizations similarly challenged by the OSHPD3 standards and is leading the development of a coalition of organizations that share our concerns with licensing and OSHPD regulations. This coalition will share information and strategies utilized by each organization's members and begin working in tandem to reduce the burden of these regulations.

VI. Resources

- OSHPD 3 Options Chart

California Primary Care Association

Discussion

Date: April 26, 2018

To: Government Programs Committee

From: Emily Shipman, Senior Program Coordinator of Health Center Operations

Re: Licensing

MEMORANDUM

I. Background

Beginning in July 2015, the Centralized Applications Unit (CAU) of the Licensing and Certification Division (L&C) of the Department of Public Health (DPH) began consolidating facility licensing functions that were previously handled by District Offices. The effects of this massive change include a backlog in licensure applications that has delayed the processing timeline. Unclear and outdated application guidance from CAU also contributes to incomplete and inaccurate applications, which further compound delays. CPCA has been pursuing strategies to help alleviate the backlog and address process inconsistencies.

II. Licensing Strategy Updates

Staff continue working on multiple strategies to address the licensing issues identified by the Membership:

A. **Work with L&C Team:** CPCA is pursuing an aggressive administrative strategy to push licensing process improvements forward in conjunction with Licensing & Certification's Centralized Applications Unit:
   - **L&C Meetings:** CPCA has been meeting regularly with L&C leadership to escalate challenges and force continuous improvement with the CAU. These meetings have helped to establish relationships and open the lines of communication between CPCA and CAU. Although there remains a need for continued improvement, staff advocacy through these meetings has led to an increased emphasis on the needs of health centers.
   - **Application Checklist:** CPCA offered extensive comment on L&C's draft application checklist, which will result in the issuance of a streamlined and consistent set of application requirements. The comments have been incorporated into the final document which will be released via the CDPH website soon.
   - **Online Application:** CAU has made an online application available for PCC and affiliate applications. Applicants can opt for the traditional paper-based application or use the online system, with CAU projecting that online applications will move more quickly through processing than paper-based.
   - **Backlog:** CAU remains focused on getting through the existing licensing backlog. A team of 30 12-month temporary positions have been added to CAU in order to assist in

processing outstanding changes. This will allow existing analysts to focus on moving applications. To mitigate the effects of the backlog, clinics planning changes in location or new applications should contact CAU during planning stages to ascertain whether partial documents should be submitted in advance, versus waiting for building certification before submitting an application package.

B. **Consolidated Licensing – AB 2428:** Consolidated license legislation [AB 2428 (Gonzalez Fletcher)] seeks to improve the consolidated license process by: allowing the consolidated facility the option to share the PPS rate of the parent facility; allowing the consolidated facility the option to enroll in Medi-Cal through the parent site. AB 2428 was heard in Assembly Health Committee on April 17, 2018. CPCA staff have met with DHCS in addition to Legislative staff, in order to discuss the bill and possible impacts. DHCS expressed interest in understanding the quantity of intermittent and rural health clinics that would qualify for the consolidated license process, a question we believe is to ascertain cost to the state. CaliforniaHealth+ Advocates shared that these entities would likely not put an emphasis on utilizing the consolidated licensure process, due to the administrative benefits that their current licensure status entails.

C. **Evaluating the Use of Flexibility Waivers:** HSC 1231(a) allows L&C flexibility to approve an exception to clinic licensure requirements based on an "alternate concept, method, procedures, techniques, space, equipment, personnel qualifications, or the conducting of pilot projects."
   - Staff has made a Public Records Act request to all CDPH Licensing and Certification Division District Offices requesting all records of primary care clinics utilizing the 1231(a) waiver.
   - Thus far we have received responses from 11 or the 19 total District Offices.
   - Most of the responses we received highlighted an alternate method of complying with CA Code of Regulations 75055(h), which deals with medical records storage. However, CPCA is aware that this waiver has also been successfully used in the past to exempt a clinic from licensure. Staff are researching how/whether it may be feasible to use this waiver on some or all elements of the building requirements (OSHPD 3) enforced via the licensure process.
   - Staff will continue to research applicable uses of the 1231(a) and engage with the DOs in order to figure out how to implement this strategy most effectively. This research will also include engaging architects to best understand the applicability of these methods and conceptualizing the affect it has on a health center.

D. **Evaluating the Use of Licensure Exemptions:** Health and Safety Code (HSC) 1206 lists the situations in which licensure is not required. CPCA has identified the HSC 1206(g) licensure exemption as one possible option for health centers who desire to be out of the challenges of licensure and OSHPD3 building standards. Having health centers that are not licenses and where there is no history of health and safety violations helps to build a case for why the regulations are no longer necessary and are instead a barrier rather than a tool to advance access.

- 1206(g) states "A Clinic operated by, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art."
- Staff interviewed 4 health centers who have volunteered to be part of exemption process.
- Currently, staff is conducting research into how the exemption may affect a health center's ability to participate in various funding streams, including Medi-Cal and Medicare, in order to discern if it's appropriate to seek an exemption.

III. Existing Licensees: Multiple Buildings on Shared License

A. **Summary:** In recent months, CDPH L&C has determined that Welfare and Institutions Code (WIC) 14132.100 prevents clinic sites from billing Medi-Cal under a shared PPS rate with the exception of intermittent sites and mobile units. For some existing clinics, this will require pursuing a separate license for sites previously treated as consolidated locations, in addition to separate Medi-Cal enrollment and PPS rate establishment. The two health centers identified by L&C as being in this situation have taken steps to resolve the licensing scenarios directly with L&C and have received assurance from DHCS that there will be no retroactive financial penalties resulting from the mishandling of these licensing situations by L&C staff.

B. **More Sites Identified:** L&C has communicated to CPCA that they are aware of at least 10 clinics who are in this situation of having multiple addresses/buildings combined under one license, and have begun the process of reaching out to these clinics. L&C was not able to share with us who those clinics are or how they have been identified. Clinics who think they may be in this situation can reach out to Emily Shipman at CPCA (eshipman@cpca.org) to talk further about bringing their sites into compliance.

IV. Additional Strategy

A. **Provisional Licensing in the Case of Processing Delays**: Current Health & Safety Code statute specifies timeframes for CAU's processing and issuing of clinic licenses. Given their current and historical inability to meet these timeframes, there is a need to make provisions available to applicants to allow for a temporary or provisional license in the event that CAU is not able to process an application within the required timeframe. Establishing such a process would require legislation. CA Hospital Association is currently running a bill (AB 2798) which is very similar to this strategy. Staff will track the legislation and work with CHA to determine if this is a viable legislative option moving forward.

DISCUSSION

Date: April 26, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy
Nenick Vu, Associate Director of Managed Care
Re: Medi-Cal Managed Care Update

MEMORANDUM

I. Background

Unlike much of the policy work that we do, which relies on the administration and legislature to drive changes, managed care policy is largely delegated to California's licensed health plans, within broad federal and state parameters. These health plans, in turn, delegate portions of their work to risk-bearing organizations, IPAs and providers. This means that a simple change in law or practice might be implemented hundreds of different ways, and coordination between CPCA, RAC, and individual health centers is necessary in order to implement effective policy change from the state to local level.

In light of the substantial growth in Medi-Cal managed care, CPCA and the regional consortia have begun a process of identifying priority issues and developing a joint work plan that encompasses managed care plan relations as well as state regulatory and contract oversight. Below, we outline our existing managed care policy work, and then describe the newly adopted RAC/CPCA joint managed care prioritization that is in development for 2017/2018.

II. Current Efforts

CPCA's managed care work to this point has fallen under three priority issue areas:

1) Strengthening relationships between CCHCs and their managed care partners

CPCA is *always* available to health centers and RAC, by request, to facilitate relationship development and troubleshooting with managed care plans and IPAs. By member request, we hold bi-annual meetings with several large multi-region health plans and one IPA. These meetings have resulted in changes to prior authorization requirements, changes to P4P incentive programs to conform with our published "Best Practices," and closure of access gaps. One on one troubleshooting has resulted in payment of previously denied claims and expedited credentialing for health center providers.

As a part of our work on strengthening relationships with managed care plans, CPCA has also begun collaborating frequently with the Local Health Plans of California and the California Association of Health Plans at the state level. We have partnered with the state associations to

share information on FQHC P4P, on changes to Medi-Cal enrollment requirements, and on investment in workforce and behavioral health.

2) Increasing managed care plan investment in quality improvement

CPCA's work in this area recently has focused around adoption of the FQHC P4P best practices, which is outlined in the P4P memo in the 330 Committee packet.

We have also begun working closely with Anthem Blue Cross on their recent major quality push. Anthem has increased quality staff from 35 in 2013 to more than 80 in 2018. This has been an enormous opportunity to drive their quality agenda toward greater investment in CCHCs. Anthem has recently announced the development of a quality incentive program for directly contracted safety net providers. Until this time, it's our understanding that Anthem has been unwilling to run their own quality program, and provider incentives have only been available if contracted via delegated organizations. Anthem has also hosted a series of diabetes-related "clinic days" at CCHCs around the state.

Finally, CPCA and member representatives continue to work with IHA in the development and implementation of a standardized statewide P4P program in Medi-Cal. As of right now, five Medi-Cal plans have adopted the IHA core measure set in its entirety, and nine have partially adopted.

3) *Increased state oversight of beneficiary access and network adequacy*

Implementation of the Medicaid Managed Care Mega-Regulation released in 2016 has been a heavy lift for California's Department of Health Care Services. The three-year phased implementation means that we're currently in the midst of standing up extensive new quality monitoring programs, revising state/plan contracts, and making major changes to plan oversight. Changes are especially significant in the specialty behavioral health field. CPCA has been tracking these changes closely at DHCS and DMHC, was appointed to serve on the EQRO Access Assessment Advisory Committee, and has engaged in the DHCS quality strategic planning process.

III. RAC Managed Care Prioritization

Up to this point, CPCA managed care policy priorities have included 1) strengthening relationships between CCHCs and their managed care partners, 2) increasing managed care plan investment in quality improvement, and 3) increased state oversight of beneficiary access and network adequacy. While our work in these areas will not stop, under the new RAC managed care plan, state and local RAC will work together to forward the following four newly identified priorities:

1) Promote the role of CCHCs to the new Administration and leadership at DHCS

The purpose of this priority is to ensure the preservation of the Medi-Cal expansion under the ACA and preserve Medi-Cal benefits and coverage, ensure that Medi-Cal and health care is a priority for the new administration, and promote the health center role in the overall health care system by highlighting the quality, cost savings, cultural competency, and integration of care rendered within CCHCs.

2) Leverage the Commercial Plan Procurement

DHCS has announced that all commercial plan Medi-Cal contracts in the state will be re-procured between 2021 and 2024, and that health plan quality indicators will be a central factor in determining which plans are selected to serve Medi-Cal beneficiaries. This provides an opportunity for CCHCs and Consortia to partner with Medi-Cal managed care plans and leverage their contribution to high quality care and patient satisfaction. Medi-Cal managed care plans angling to procure a Medi-Cal contract are strongly incentivized to increase partnership and invest in CCHC quality infrastructure during this process.

3) P4P, HEDIS, and Quality Alignment

This priority is about understanding managed care plan quality and data priorities, and seeking to align their priorities and ours through standardization. Beyond identifying and defining data priorities, this priority also encompasses work to improve the quality of data exchanged between plans and CCHCs and enhance consortia capacity to support CCHCs and plans in this area.

Finally, under this priority we will continue to work on disseminating best practices related to FQHC P4P incentive programs. A full memo on the subject is available in the 330 Committee packet.

4) Increasing Enrollment Efficiency and Default Assignment

Working together, RAC at the county level and CPCA at the state will seek ways to modernize and streamline the Medi-Cal enrollment system and better define patient assignment processes to incentivize default assignment to CCHCs. In line with our work in the P4P, HEDIS, and Quality Alignment priority, this goal seeks to improve and standardize how health centers receive information on assigned members from plans. It's our hope that our work in this area will impact several ongoing and timely managed care policy issues, including addressing the HEDIS and capitation impact of unseen patients, streamlining the statewide standardized provider directory development process, and ensuring that the DMHC's timely access methodology accounts for the unique role of FQHCs in the Medi-Cal delivery system.

California Primary Care Association

ACTION

Date: April 26, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy, Allie Budenz, Associate Director of Quality Improvement, Liz Oseguera, Senior Policy Analyst, Michael Helmick, Senior Policy Analyst
Re: Behavioral Health Update

MEMORANDUM

I. Overview

Although we have seen some recent advances through policy changes under the ACA and federal and state rulemaking, California's safety net behavioral health delivery system remains fractured, uncoordinated, and inefficient. This fragmented system of delivering care has evolved over decades and is now deeply entrenched in law, policy, and financing structure. While we all recognize the challenges associated with the current disjointed system, a fundamental structural change is a herculean lift. One opportunity for major change is forthcoming in the renegotiation of California's 1915(b) Specialty Mental Health Services Waiver in 2020.

II. Current Efforts

CPCA's small-but-mighty behavioral health team has been working diligently to support CCHCs in expanding the breadth and depth of their behavioral health services within the existing delivery structure. Our work has focused on three priorities: removing regulatory barriers to FQHC participation in the full spectrum of care; expanding access to resources and additional behavioral health funding streams; and ensuring health centers are included in all behavioral health policy discussions.

We have been successful in advancing key policy items within each of the three priorities. A few of our biggest wins within the past year include the passage of SB 323 which clarifies the process by which FQHCs can contract as Drug Medi-Cal and Specialty Mental Health Services providers; the ability of FQHCs to bill Vivitrol outside of the PPS rate; language within the SB 82 Triage grant guidance that awards extra points to counties who partner with community entities, calling out CCHCs specifically, and a requirement that CCHCs must be represented on the Advisory Board for a newly created fund at the Mental Health Services Oversight and Accountability Commission. Each of these efforts expands the reach of CCHCs in both behavioral health service delivery and in behavioral health policy making, but has assumed the continuation, albeit having found work-arounds, to the existing fractured delivery system.

One of the most important elements of our current work is our concerted effort to open collaborative dialogue with counties, community based mental health agencies, residential

treatment facilities, hospitals, and substance use and alcohol treatment providers about how to create bridges between fractured funding streams and delivery systems in order to create an efficient and seamless feeling for our mutual patients. As with all resource-scarce communities, stakeholders tend to guard their territories. It takes thoughtful relationship-building and growing trust to begin thinking together about how to de-duplicate and de-complicate a challenging infrastructure.

California's behavioral health delivery system is divided into at least three very separate, very complicated structures at the state level. In order to coordinate care, local providers and counties must work around and surmount challenges put in place through state policy. It seems backwards for behavioral health policymaking to *get in the way* of a seamless and coordinated delivery system. Arguably, the state would be better served if we were to spend our time building a straightforward and supportive system, rather than trying to work around ineffective policy barriers from the past.

III. Looking Ahead

We can continue to build upon our three priorities and expand the CCHC role in behavioral health within the existing delivery system. However, in advance of the 2020 Specialty Mental Health Waiver negotiations, we can also begin a dialogue about visioning a behavioral health delivery system for the future – one in which patients come first, and funding and programmatic silos work seamlessly to support California's low income communities.

Making major changes to how the Medi-Cal managed care delivery system interfaces with the county specialty mental health system is a fraught proposition. In California, counties pay the non-federal share for these services and DHCS has no authority over how those funds are spent. However, the shocking patient outcomes and high cost burden of untreated mental illness means that a concerted effort to address these issues are needed. Achieving complete integration for people with serious mental illness would require a change to the state's Constitution, but there are opportunities short of a constitutional change using the 2020 Waiver which may improve care for this population. CCHCs must be actively engaged not just to inform the conversation but to push the conversation forward among those with a vested interest in keeping the same, ineffective structure. We must work together, across the aisle, to develop a clear and public set of metrics for achieving care integration and improving outcomes for people with behavioral health needs.

IV. Action Steps

CPCA staff proposes to establish a Behavioral Health Visioning Workgroup that will begin a concerted effort to:

- Understand California's existing behavioral health delivery system, and why it is the way it is (including financing, legal, and delivery system)
- Understand what is working and what is not working about the current system, including geographic and regional variations
- Understand the political landscape, and how that puts parameters around what we can and cannot do in changing behavioral health policy.

- Understand what we, as CCHCs and advocates with friends in high places, do to improve the delivery system for a healthier California?

Both the BHWG and the BHPN will be invited, as well as all interested health center CEOs. The goal of the BH Visioning Workgroup will be to develop the community health center vision of a preferred behavioral health delivery system, which will help CPCA and CaliforniaHealth+ Advocates to position and drive the necessary policy changes for the 2020 Specialty Mental Health Services Waiver.

The California Behavioral Health Directors Association (CBHDA) is the lead stakeholder in designing the 2020 Specialty Mental Health Services Waiver. They are in the midst of a similar visioning process with their Board of Directors. It's our hope, by the end of 2018, that CPCA will be able to share our guiding principles and suggestions for delivery system redesign with CBHDA and DHCS, in time to be considered thoughtfully in drafting the new waiver.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: April 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: Federal Opioid Update

MEMORANDUM

I. Recap

At the end of 2016, Congress passed two significant pieces of behavioral health legislation with the aim of infusingthe delivery system with the infrastructure and funding it needs to augment mental health prevention, early intervention, and treatment and combat the opioid epidemic through Medication Assisted Treatment. The first is the Comprehensive Addiction and Recovery Act (CARA) which authorizes over $181 million each year in new funding to fight the opioid epidemic. The second is the 21st Century Cures Act, which among other provisions, provided funding for State-Targeted Response grants to increase access to addiction treatment services. In California these funds were used to create and develop the $90 MAT expansion project known as Hub and Spokes system (H&SS).

The President, in order to address a key campaign promise, created a blue ribbon commission to examine and make recommendations for how to respond to the opioid epidemic. Following the Commission's report, in early 2018, the President held a White House opioid summit to lay out the Administration's plan to address the opioid epidemic. However, many of the efforts that the President championed at the Summit were inconsistent with the policies recommended by the Commission. The efforts include increased drug enforcement and punishment, anti-stigma and abstinence campaigns, and treatment and prevention.

II. Moving forward

In the last 6 months of FY 18 and into FY 19, we foresee a fairly significant increase in funds available to address the opioid epidemic. On March 23, Congress passed a FY 18 Omnibus bill which funds the federal government through September 2018 and included $4 billion in funding to address the opioid epidemic. A significant portion of these funds are to be used to improve law enforcement efforts (such as drug monitoring, enforcement, and prosecution) and stemming the flow of opioids (port/border detection and USPS drug detection). The omnibus appropriated approximately $1 billion in new funding to support the treatment and prevention of opioid abuse. These funds will be made available to States and American Indian/Alaskan Native tribal governments to address the opioid epidemic. In California, these funds will likely be used to sustain and expand the H&SS project.

Congress has continued engagement in the opioid response efforts, which is evident by the amount of legislation proposed, over 30 bills to date. There have been numerous hearings in both Senate and House and it is likely that these discussions will continue through FY 18, but no legislation is likely to proceed until post-election and post a formal appropriations committee process. Additionally, much of

the legislation is only policy-oriented and is meant to inform the appropriations discussions, without any associated programmatic costs. As of today, most of the legislation is still fairly fluid, however, it should be noted that the author of the CARA bill has proposed additional legislation which includes programmatic and funding increases titled CARA 2.0.

III. Impact on health centers

As we have seen from the H&SS project, health centers have been, and will continue to be, a key State and Federal partner in addressing the opioid epidemic. While the H&SS project was initially only a 2-year pilot, there are two potential grant opportunities that will likely impact the H&SS entities and health centers overall.

First, in the Continuing Resolution, signed on February 8, Congress included a two year extension to the Community Health Center Fund. In addition to this extension, the CR included $200 million for supplemental 330d HRSA grants. The 330d HRSA grants are to be used to implement evidence-based models for increasing access to primary care services, including addressing emerging public health issues, such as the opioid epidemic. 330d grants are available to health centers for FY 18 and pending Congressional approval will be available for FY 19.

Resources:

- Advocates comments on the Federal Opioid Commission Recommendations
- List of Opioid-related programs and TA opportunities in CA

California Primary Care ASSOCIATION

INFORMATIONAL

Date: April 16, 2018

To: Government Programs Committee

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Mental Health Services Oversight and Accountability Commission

MEMORANDUM

I. Overview

The Mental Health Services Act (MHSA), a program passed in 2004 by voters as Proposition 63, provides for a 1 percent income tax on individuals earning more than $1 million per year in order to expand existing mental health programs and services, address the stigma and discrimination associated with seeking mental health services, and improve access to underserved groups. The funds are distributed to county local mental health agencies and are ostensibly overseen by the Department of Health Care Services (DHCS) and the Mental Health Oversight and Accountability Commission (MHSOAC).

MHSA has come under increased scrutiny in light of DHCS' and the MHSOAC's inability or unwillingness to effectively regulate the program, either programmatically or through fiscal oversight. A State Auditor's report has sparked some movement at the two agencies, as well as a host of MHSA-related legislation. CPCA is prepared to capitalize on the new changes to the program management within the state agencies in order to ensure that counties are leveraging the expertise and extensive reach of community-based providers, especially in their outreach to underserved populations.

II. Oversight Efforts

In response to a request from the legislature, the State Auditor released a report in late February that offered recommendations on improving oversight and funding allocations in MHSA. The report concluded that the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (OAC) have been remiss in their oversight of MHSA, resulting in counties accumulating $81 million in unspent interest and $535 million in reserves, contrary to requirements of the Act which require funds be expended. In addition, DHCS was found to have $225 million in unspent funds.

The state Auditor's report has sparked DHCS to begin the process of – for the first time – building a regulatory package for the oversight and management of MHSA funds. Though the first draft of the package is not due until 2019, CPCA has already begun advocacy with DHCS to build standards into the MHSA rules that require counties to partner with local community-based organizations, such as CCHCs.

Under Proposition 63, counties who do not spend portions of their MHSA funding within three years are required to revert those funds back to the state. Unfortunately, as the State Auditors report mentions, DHCS has not created a clear system to collect these funds, causing in many cases for these funds to go unused. The State Auditors report recommends DHCS create and implement a fiscal reversion process to reallocate to other local mental health agencies any MHSA funds that are unspent within the statutory reversion time frames.

Last year AB 114, a budget trailer bill, officially reverted unspent MHSA funds from the counties to the state, and back to the counties. However, the bill required counties to submit a plan by July 2018 outlining how they will expend their reverted funds by July 2020. CPCA sees the forthcoming guidance to plans on how they must spend their reverted funds as an additional opportunity to push for standards in community-based organization engagement.

III. MHSA Legislation

In response to the State Auditors report, and stakeholder concerns, there have been a number of MHSA related pieces of legislation introduced, including SB 1004 (Weiner). This bill would place parameters on how counties can expend prevention and early intervention (PEI) funding under MHSA by creating specific funding priorities. CPCA has requested, and the bill sponsor has committed, to include CPCA's suggested amendments to the bill that would highlight the importance of integrating mental health and primary care services to effectively deliver PEI services under MHSA.

CPCA will continue to track MHSA legislation and engage with bill sponsors and authors to suggest amendments that will open the door to greater partnership between counties and health centers under MHSA.

IV. Resources

- DHCS December Guidance – Fund Reversion
- State Auditors Report – MHSA
- CPCA's MHSA Bill Sheet

California Primary Care ASSOCIATION

INFORMATIONAL

Date: April 17, 2018

To: Government Programs Committee

From: Allie Budenz, Associate Director of Quality Improvement

Re: Section 2703/Health Home Program Update

MEMORANDUM

HHP Status Update

In December 2017, CMS approved amendments to the California Medicaid State Plan to authorize DHCS to implement an ACA Section 2703 Health Homes Program (HHP) through the Medi-Cal Managed Care delivery system. DHCS and managed care plans (MCP) are currently negotiating draft rates; final rates are expected soon but have not been released.

DHCS has modified the HHP implementation schedule significantly based on feedback they received from MCPs. Several plans, including Partnership Health plan of California (PHC) which was expected to go live in group 1, indicated a preference to move to Group 3 in order to become more prepared. The revised implementation plan is:

Group 1 July 1, 2018 (Physical/SUD) January 1, 2019 (SMI)	Group 2 January 1, 2019 (Physical/SUD) July 1, 2019 (SMI)	Group 3 July 1, 2019 (Physical/SUD) January 1, 2020 (SMI)		
San Francisco	Riverside	Alameda	*Humboldt	*Napa
	San Bernardino	Fresno	*Imperial	*Orange
		Kern	*Lake	*Shasta
		Los Angeles	*Lassen	*Solano
		Sacramento	*Merced	*Sonoma
		San Diego	*Monterey	*San Mateo
		Tulare	*Marin	*Santa Clara
		*Del Norte	*Mendocino	*Santa Cruz

*Counties that moved to Group 3

DHCS released a program guide intended to be a resource for MCPs in the development, implementation, and operation of the HHP. The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The state has been very clear that the pilot will only continue as a permanent benefit if there are savings across the entire program. Per AB 361, the legislation authorizing the state to pursue ACA section 2703, the program must be evaluated for fiscal neutrality at some point, but no specific timeline is noted. At present the state has not identified the methodology and has flexibility in the design. It is critical that Group 3 counties have the full 2 years of implementation prior to evaluation because according to PHC data from the intensive outpatient care management program, it takes a minimum of 18 months to show a bend in the cost curve.

CPCA staff have fielded a number of questions about the potential for DHCS to recoup HHP supplemental payments paid to FQHCs participating as CB-CMEs. CPCA successfully lobbied to include language in the SPA that protects HHP payments. The FQHC reconciliation language is on page 28 of 53 of the SPA, under "Indicate which payment methodology the state will use to pay its plans." As written, "HHP services when provided by an FQHC or RHC, shall be compensated separately from, and in addition to, the prospective payment rate received by an FQHC or RHC. This additional rate shall be deemed a supplemental rate for services not already included in the PPS rate calculation and shall therefore not be subject to a reconciliation or other reductions."

Technical Assistance Update

DHCS contracted with Harbage Consulting to provide technical assistance on outreach, education, and communications to MCPs, providers, CB-CMEs, eligible Medi-Cal beneficiaries, and other stakeholders through all 3 implementation phases of the HHP. CB-CME required training will be offered as live and recorded webinars. Topics include: "Overview of the HHP", a three part webinar series entitled, "Topics in Care Management" and "Community Resources and Referrals". MCPs will still need to develop a training plan for their CB-CMEs with information unique to their plan and their care management approach.

John Snow, Inc. has developed a tool for CB-CME health centers designed to support health center leaders in considering the costs, staffing, and infrastructure needs associated with implementing Health Homes or other care management/coordination initiatives. The tool uses Partnership Health Plan assumptions on program costs and users also have the option to customize the staffing needs and population distribution based on their own experiences. The tool is free and may be used to identify a minimum per member per month rate for HHP activities in year 1 and 2 that can support rate negotiation with plans. CPCA produced a webinar with JSI to explain the tool; a link to the recorded webinar and the free tool are in the resource section.

The state has been very clear that the pilot will only continue as a permanent benefit if there are savings across the entire program. CPCA's efforts to convene the health plans and health centers to coordinate the execution and delivery of a successful pilot were stalled over concerns about duplicative work between our efforts and Harbage's. The workgroup decided to hold off on meeting until more details were known about the state's approach, which is developing slowly.

Resources

- Medi-Cal HHP Program Guide: http://www.dhcs.ca.gov/services/Documents/MCQMD/HHPProgramGuide_3-8-18_Clean.pdf
- HHP Implementation Schedule: http://www.dhcs.ca.gov/services/Documents/HHP_Revise_Implement_Sch_4.4.18.pdf

- State Plan Amendment (SPA 16-007) authorizing Health Homes. The FQHC reconciliation language is on page 28 of 53, under "Indicate which payment methodology the state will use to pay its plans": http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA16-007%20Apv%20Pkg.pdf
- Recorded Webinar, "Rate Setting Tool for CB-CME Health Centers": https://www.cpca.org/cpca/Reg/Event_Display.aspx?EventKey=3PSQ022118
- Rate Setting Tool: http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=19343&thisSection=Resources

California Primary Care Association

Discussion

Date: April 26, 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: Clinic Lifeline Grant Program

MEMORANDUM

I. Background

The Clinic Lifeline Act of 2017 was signed into law by the Governor on July 10th, 2017 and established the Clinic Lifeline Program within the State Treasurer's Health Facilities Financing Authority (CHFFA). The Lifeline Program appropriated $20 million from the Health Expansion Loan Program (HELP) in order to create a grant program with the goal of assisting small health center locations (sites with a budget under $10 million) and rural health facilities that are adversely financially affected by a reduction or elimination of federal government assistance.

II. Update

Applications for grants available under the program were due on March 26th, 2018. The purpose of this Lifeline Grant was to respond to the threat of the health center fiscal cliff, the defunding of Planned Parenthood, and other federal actions that might destabilize California's safety-net. Staff successfully advocated for broad triggering language in order to increase the likelihood of health centers qualifying and in addition, we were successful in getting additional application points for FQHCs and look-alikes. However, since the fiscal cliff and other federal defunding which could have detrimentally affected health centers did not materialize, there is not a clear event, action, or inaction by the federal government that could be utilized by health center applicants under the grant application process. Applications were submitted however, and it's our understanding that submitted applications provided nuanced arguments around changes in patient insurance status or drops in visits due to uncertainty at the federal level.

Currently, CHFFA is in their 45 day application review process until May 10th, 2018 and will be announcing the grant awardees, should there be any, at the June CHFFA meeting.

III. Next Steps

Staff will continue to track the Grant updates and will determine whether any health centers have been selected to receive the grant. Additionally, if any funds are unexpended by CHFFA, staff will work with CHFFA to determine any additional application processes and triggering events. CHFFA is not currently able to provide any information on their future plans while the application process is

ongoing. Staff requests Board input on the position that CPCA should take on unspent grant funds moving forward.

IV. Options

- Advocate for another, expeditious process?
- Advocate for no action to be taken until a clear federal action occurs?

California Primary Care ASSOCIATION

INFORMATIONAL

Date: April 12th, 2018

To: Government Programs Committee

From: Emili LaBass, Senior Program Coordinator of Health Center Operations

Re: Oral Health Update

MEMORANDUM

Dental Transformation Initiative (DTI): Potential Overpayment

CPCA was recently notified by the Department of Healthcare Services (DHCS) that a number of providers participating in the Dental Transformation Initiative - Domain 1, including community health centers, may have received overpayment for Program Year January and July incentive payment. Approximately 76 individual clinics were identified and sent a letter (see attached template) that specified the overpayment amount and provided instructions to repay and/or appeal. CPCA reached out to impacted community health centers on Monday, April 2, 2018 to alert them of this recoupment effort and to provide more detailed information on how to appeal.

As stated in the letter, DHCS found that overpayment was due to one of the following reason(s):

- Your clinic submitted data via excel spreadsheet but did not submit the required encounter data for PY 1 via the formal encounter data submission process through the Electronic Data Interchange (EDI) or the Proprietary Paper Claim forms;
- Your clinic submitted self-attested preventive rendered services data for PY1 that did not match the encounter data you provided to the Department via the formal encounter data submission process.

If you believe this decision was made in error, you must:

1. Submit or resubmit your PY 1 formal encounter data via Electronic Data Interchange (EDI) or the Proprietary Paper Claim forms. To assist you in your formal encounter data submission, an informational guide on the EDI submission system can be found at: https://www.denti-cal.ca.gov/DC_documents/providers/Denti-Cal_EDI_How_To_Guide.pdf. Also see the encounter data submission process guide for safety net clinics: http://www.dhcs.ca.gov/provgovpart/Documents/DTI/DTIEncounterDataSubmissionforSNC5-22-17.pdf

AND

2. Notify the Chief of the Medi-Cal Dental Services Division at DTI@dhcs.ca.gov within 30 days of the date of this letter.

After additional review by DHCS, the overpayment may be adjusted to reflect incentives earned based on the additional data submitted. Please note that this review process does not toll the 60 day response period outlined in the previous paragraph. If the clinic does not believe this decision was made in error they have 60 days from the date of this letter to pay the overpayment amount in full to DHCS, or obtain an executed repayment agreement with the DHCS.

CPCA remains in close communication with DHCS and will be resuming monthly meetings with the Medi-Cal Dental staff until this matter is resolved. If you have additional questions and/or concerns, please contact Emili LaBass at elabass@cpca.org.

Little Hoover Commission Report: Fixing Denti-Cal Hearing

On Thursday, March 22, 2018 the Little Hoover Commission conducted a public hearing to examine the progress the Department of Health Care Services (DHCS) has made in addressing recommendations from the Commission's April 2016 Report entitled, *Fixing Denti-Cal*. The Commission heard from a panel of two families who are Denti-Cal patients, a Denti-Cal dental provider from Golden State Dental Group, the Chief Dental Officer from Western Dental, the CEO & Dental Director from PDI Surgery Center, and the CEO & Dental Director from Wellspace Health. Representing the Department of Healthcare Services were Jennifer Kent, Director, and Alani Jackson, Chief, Medi-Cal Dental Division. Representing the Department of Public Health was Dr. Jayanth Kumar, State Dental Director.

All parties acknowledged the progress the Department of Healthcare Services has made since the release of the original April 2016 report, such as the streamlined Denti-Cal Provider application and increased reimbursement rates, however the Commission expressed continued disappointment in the department's progress. This was exemplified by the testimony from the Denti-Cal patients who continue to face enormous challenges seeking care for both their adult and child family members. It was also illustrated in the public comment forum

One area of optimism was displayed in the testimony of Jonathan Porteus, Chief Executive Officer and Dr. Elizabeth Johnson, Dental Director of Wellspace Health. Again, as we saw in the original *Fixing Denti-Cal* report, the FQCH model was highlighted as an ideal mode of providing care to patients. The Commission was encouraged to hear that Wellspace patients who received oral health care also are able to receive a suite of other integrated services.

The Commission closed the hearing with testimony from the State Dental Director, Dr. Jayanth Kumar giving an overview of the new funding opportunity to increase capacity within local health departments and jurisdictions to address oral health made possible by the passage of California Healthcare, Research and Prevention Tobacco Tax Act of 2016, Proposition 56 *(community health centers are not eligible for this funding.)* There was no future action identified at the conclusion of the hearing and no next steps at the time this memo was written.

DentaQuest Foundation New Funding and Role: State Representative

In January, 2018 the DentaQuest Foundation invited CPCA to apply for the DentaQuest Foundation State Representative position and we were selected. The role of the State Rep is to carry the voice and represent the Oral Health 2020 Network in California, by building relationships, coordinating efforts, and weaving the various DentaQuest Foundation grantees in California into a statewide Oral Health 2020 Network. The new role's responsibilities overlaps with activities CPCA already engages in such as identifying new oral health stakeholders, including non-traditional partners to involve in regional network activities each year. We are also tasked with working in partnership with the State Grassroots Representatives to share information with the regional and national network about what is going on in their state, as well as share best practices from the network with stakeholders within the state.

This new funding is in addition to the funding CPCA receives to participate in the National Oral Health Integration and Innovation Network initiative. This program focuses on increasing the visibility of oral health on the national and local stage by strengthening ties with and among PCAs, CHCs and community partners/stakeholders, and leverage that power for change, while continuing to support oral health in the health care safety net.

California Oral Health Network

Continuing our work as a member of the Core Group of the California Oral Health Network, CPCA has continued to assist CPEHN with the foundational development of the Network. The Core Group is a cohort of network members from different organizations and affiliations across the state who are guiding the planning process to develop the infrastructure and priorities for the California State Oral Health Network. Core Group members are responsible for providing leadership and content expertise to ensure the network Goals of strengthening existing relationships and create new connections, providing timely information and sharing best practices, aligning state and local oral health efforts, and providing opportunities for engagement in advocacy and advance equitable oral health policies to best meet community needs.

The Core Group meets every month to facilitate, coordinate, weave, implement, and strategize the work of the network support infrastructure and the building of the network as a whole. The Core Group act as a sounding board and thought leader in the network development process and will ultimately be responsible for the successful launch of the California State Oral Health Network in 2019.

Beginning in January through March, the Network hosted regional convening's to provide updates on the state oral health opportunities and offer opportunities for partners to connect. Convening's were co-hosted by CPEHN and member(s) of the Core Group in Los Angeles, San Diego, Oakland, Fresno, and Sacramento. CPCA and the Latino Coalition for a Health California co-hosted the Sacramento convening on March 20th. Speakers included the state dental director Dr. Kumar, DDS, and Chief, Medi-Cal Dental Division Alani Jackson, MPA who gave an overview of the oral health landscape in California including new opportunities for engagement for local stakeholders. Robyn Alongi from Sacramento County Department of Public Health presented on the local oral health activities involving the Dental Transformation Initiative Local Dental Pilot Program and Prop 56 funding. The convening was well attended with over 80 participants from varied backgrounds including community health centers, county oral health programs, providers, consumer groups, and healthcare advocates.

For questions and/or comments on CPCA's oral health activities, please contact Emili LaBass at elabass@cpca.org.

Resources

- DHCS DTI Overpayment Letter