Government Programs Committee

Thursday, July 12, 2018
11:10am-12:30pm
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	• April 26, 2018 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 I
VI. Managed Care	• Managed Care Memo	Meaghan McCamman Nenick Vu	D
VII. Behavioral Health	• State BH Memo	Meaghan McCamman Allie Budenz Liz Oseguera Michael Helmick	D
VIII. 2703 PCHH	• 2703 PCHH memo	Allie Budenz	I
IX. Lifeline Grant Program	• Grant Program Memo	Michael Helmick	I
X. Adjourn		Robin Affrime	A

California Primary Care Association

Executive Summary

Date: July 12, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy

MEMORANDUM

340B Federal and State Update

- CPCA's advocacy efforts have paid off - the enacted budget reflects no changes to the 340B program.
- CPCA will continue to work with DHCS, the health plans and our partners to develop legislative language to address duplicate discounts and avoid having the administration attempt to remove the 340B program from managed care again next year.
- The Senate health committee has been holding oversight hearings over the 340B program that may lead to changes around how covered entities can use their saving and how to properly calculate the savings received.

OSHPD 3 and Licensing

- CPCA has selected a consultant to complete the research project which will examine the Licensing process for Primary Care Clinics, including the OSHPD 3 building standards.
- Staff have continued to move forward with the additional, board-approved, multi-pronged strategy to addressing OSHPD 3.
- CPCA's bill to allow for consolidated billing in conjunction with a consolidated license is advancing through the legislature.
- Staff are tracking bill that would allow for provisional licensing to mitigate effects of processing delays in CAU. Metrics are now available to track licensing applications online, though backlog is still causing delays.

Managed Care

- CPCA's Managed Care Work has been defined by 4 overarching priorities, developed by the Regional Consortia.
- CPCA and other RAC have begun developing materials to forward our mutual goals in the 4 priority areas – the new administration; commercial plan procurement; P4P and quality alignment; enrollment efficiency and default assignment

Behavioral Health

- CPCA has developed a draft 'action plan' to prepare CCHCs for a conversation around envisioning a better and less fragmented BH system in the 2020 waiver
- We also continue our work to support CCHCs in the current delivery system by removing regulatory barriers to FQHC participation in the full spectrum of care; expanding access to

resources; and ensuring health centers are included in all behavioral health policy discussions

2703 PCHH

- Plans are currently developing their HHP business plans with program guidance from DHCS. Health centers interested in being a HHP CB-CME should reach out to their managed care plan with contract inquiries.
- CPCA's impression of the Harbage training materials is that it outlines the HHP requirements but it falls short of explaining how to be successful in care coordinating HHP patients. MCPs may train on care management best practices; but CPCA is also considering a webinar series to get care management trainings to CB-CME health centers.

Lifeline Grant Program

- On June 28th, 2018 the CA Health Facility Financing Authority announced over $8 million in grants for the Clinic Lifeline Grant Program.
- 42 grant awards were made and 26 of the awards were made to FQHCs. The additional 16 grants were made to Planned Parenthood Affiliates.
- $11,723,690 remains in the Clinic Lifeline Grant fund.

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
April 26, 2018
10:10am – 11:30am

Members: Robin Affrime – Chair, Lucinda Bazile, David Becerra, Doreen Bradshaw, Edgar Chavez, Carl Coan, Deb Farmer, Rachel Farrell, Ben Flores, Tim Fraser, Alvaro Fuentes, Britta Guerrero, Nik Gupta, Alicia Hardy, Haleh Hatami, Kerry Hydash, Tina Jagtiani, Deborah Lerner, Marty Lynch, Louise McCarthy, Danielle Myers, Christine Noguera, Rakesh Patel, Tim Pusateri, Tim Rine, Sarah Ross, Gary Rotto, Laura Sheckler, Suzie Shupe, Graciela Soto-Perez, Deanna Stover, Vernita Todd, Chad Vargas, Richard Veloz, Christy Ward, Anthony White

Guests: Raphael Irving, Jennifer Hunter, Paula Zandi, Sabra Matovsky, Ticey Brown, Esen Sainz, Mary Renner, Phil Curtis

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

I. Call to Order
Robin Affrime, Committee Chair, called the meeting to order at 10:12am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (L. McCarthy, D. Myers)**

III. Approval of Minutes
A motion was made to approve the minutes of January 18, 2018. **The motion carried. (T. Rine, D. Bradshaw)**

IV. 340B Federal and State
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. CPCA staff submitted a coalition letter to DHCS with recommended amendments on April 2nd.

IV. OSHPD3 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. Staff have 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.

V. 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

VI. 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. CPCA staff will use the BHWG, BHPN and interested CEO's to conduct a visioning session. The goal 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 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 will receive an additional $200 million to specifically address the opioid epidemic. The exact mechanism or timing for the funds to be distributed is unknown.

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.

VII. 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 in 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.

VIII. Lifeline Grant Program

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.

Currently, the Clinic Lifeline Program within the State Treasurer's Health Facilities Financing Authority (CHFFA) is in their 45 day application review process until May 10th and will be announcing the grant awardees, should there be any, at the June CHFFA meeting.

IX. 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. 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.

XIV. Adjourn

The meeting was adjourned at 11:28am.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care ASSOCIATION

DISCUSSION

Date: July 1, 2018

To: Government Programs

From: Elizabeth Oseguera, Senior Policy Analyst

Re: 340B Update

MEMORANDUM

I. 340B State Budget Battle

The Governor's proposed budget from January included language that would've eliminated the 340B Drug Discount Program (340B) from Medi-Cal in both Fee-for-Service and Managed Care Programs. However, we are excited to share that our advocacy efforts have paid off, since the enacted budget reflects no changes to the 340B program.

CaliforniaHealth+ Advocates (Advocates) fought the Governor's proposal on behalf of health centers and continues to work with Department of Health Care Services (DHCS), plans, and covered entity stakeholders to find a solution to the duplicate discount concerns.

In June DHCS presented the stakeholders (health centers and hospitals) with updated language from January budget. The language had all of the elements important to ensure the 340B program was protected, including eliminating the duplicate discount issue with assistance from the managed care plans. Newly added to the conversation was transparency language requiring covered entities to reveal to the state how much they are saving through 340B and what they are doing with the savings. In response to this language the stakeholders – health centers and hospitals- updated it to ensure a program that would best meet our needs, and in so doing eliminated the language about the transparency. At this point in time we are still awaiting a response by DHCS.

II. Federal Legislative Update

Several 340B bills have been introduced in both Houses of Congress this year. Most of those bills focus on hospital access to 340B and include some transparency provisions and reporting requirements.

Congresswoman Matsui recently introduced H.R. 6071, the Stretching Entity Resources for Vulnerable (SERV) Communities Act. This bill highlights how covered entities are achieving the original intent of the 340B program by using their savings to stretch scarce Federal resources as far as possible to ensure comprehensive services reach more eligible patients. It is a positive bill to counter the negative narrative that is being spread by some Members of Congress and the pharmaceutical industry. CPCA was an original supporter of the bill.

340B Committee Hearings

The House Energy and Commerce Committee has tentatively scheduled a hearing on 340B for mid-July, and Congresswoman Matsui hopes that her bill will be part of that conversation.

Additionally, the Senate HELP committee has held several oversight hearings about the 340B program where they've invited industry and the administration to testify. The last hearing focused on the Health Resources and Services Administration's (HRSA) oversight of the program. HRSA, the Government Accounting Office (GAO), the Health and Human Services (HHS), and Office of the Inspector General (OIG) have all used these hearings to explain the limitations of the current laws and regulations with regard to 340B oversight. Senators, including Senate HELP Committee Chairman Alexander, expressed interest in crafting legislation to provide HRSA more comprehensive oversight. These hearings have not yet led to legislation, and it is unlikely that the Senate will act of 340B legislation before the end of the session.

CaliforniaHealth+ Advocates will continue to track these developments and seek advocacy from members when appropriate.

III. Utilization of 340B Savings

In anticipation of the federal government or perhaps the state trying again to dismantle the 340B program, staff recommend the board and members consider coming to consensus on a process for how savings is calculated and what is done with it.

The first step to this strategy is first to ensure that all health centers are appropriately tracking their savings. In the resources section we have linked to tools that can help health centers properly monitor and report their savings.

Below we provide a few areas to consider investing 340B savings. These "buckets" are by no means required for 340B, but are a strategy to help protect the program. If all health centers can say, for example, that 340B is spent on workforce to retain providers we could more easily translate the figures to an economic impact on the state of California. When every health center approaches the savings differently it makes it harder to defend. While we have prevailed two years in a row, we are concerned that in an economic recession we may have a harder time preserving the program as it is today.

Discussion:

1. Should we task ourselves with defining the areas for where 340B savings are invested?
2. If yes what areas should we focus on?

Ideas for consideration:

- Workforce
    - Retaining providers
    - Expanding provider skills through trainings
    - Hiring new staff

- Drug Management Programs
    - Expanding and refining drug management programs
    - Covering costs of drugs for low income patients
    - Open new service delivery sites in underserved or unserved areas, including rural locations.

- Care Coordination and Wrap around care
    - Support the Patient Centered Medical Home Initiative, which includes case management and care coordination, nurse triage and specialty referral support.
    - Provide robust care coordination for HIV and Hepatitis C patients, as well as STI prevention (PrEP and PEP).
    - Create Charity Care Programs, including Diabetes education and nutrition classes, legal advocacy, food pantries, transportation services, transitional housing and other enabling services.

IV. Resources

- 340B Coalition Sign On Letter
- DHCS Trailer Bill Language with our recommended edits
- CA FQHCs Use of 340B Savings
- Use of 340B Savings University Tool 1
- Benefits and Use of 340B savings, University Tool 2

California Primary Care ASSOCIATION

DISCUSSION

Date: July 12, 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: OSHPD 3 Strategy Update

MEMORANDUM

I. Background

In October of 2017, CPCA presented to the Board an extensive, multi-pronged strategy to address member concerns with OSHPD 3 building standards. The strategy that was approved by the Board included several options for removing the standards and for reducing the burden from OSHPD 3.

II. OSHPD 3 Strategy Update

A. Research into Licensing and OSHPD 3

The Licensing process in California is a cumbersome process which causes inexplicable delays for health centers, including adherence with the overly cumbersome OSHPD 3 building standards.

Staff determined that an in-depth examination of the Licensing process for California's Primary Care Clinics was needed in order to most effectively advocate for health centers and educate elected officials. In addition to our advocacy efforts, we plan on utilizing the findings of the research to engage an external entity to conduct a non-biased study which will provide us with a powerful tool in our efforts to reduce or eliminate the burden of OSHPD 3.

Staff finalized the research RFP process on June 19th. Four proposals were received which offer varying degrees of complexity, experience, and cost. Staff reviewed the proposals in early July and a contractor will be selected by the time of the Government Programs Committee meeting.

B. CPCA OSHPD Survey

In July of 2017, CPCA conducted a survey to better understand the health center experience with OSHPD 3. This survey requested information on the overall experiences with OSHPD, OSHPD 3 project timelines and costs, and building codes which cause the most difficulty.

We have finalized a summary of the survey which we feel could assist members in their advocacy efforts and conceptualize particular pain points, although there are clear limitations to the data. A copy of the survey is available in the "resources" section of the memo.

C. Building Standards Flexibility Waivers

HSC 1231(a) provides CDPH flexibility to approve alternate methods of compliance with the clinic licensure requirements, including OSHPD 3 building standards. CPCA made a public records

act (PRA) request to CDPH for information on the usage of the flexibility waivers. It was determined that the waiver was not used as expansively as we first imagined, and was primarily used for off-site medical records storage.

Staff is in the process of working with one health center who has used the flexibility waiver to centralize their medical records storage for numerous clinic sites in order to develop a webinar for the Licensing and OSHPD 3 workgroup. This webinar will highlight how the health center determined this particular code and the process that they underwent to centralize their records storage. The goal is to create a framework for additional health centers to utilize the waiver in a similar manner to free up additional clinic space for patient services.

Staff has met with OSHPD staff and several architects to determine if there are additional code sections, methods, or techniques that health centers could utilize to make further usage of the waiver process. Staff will work with the Licensing and OSHPD 3 workgroup to develop webinars on the additional options for flexibility waiver usage.

D. Licensure Exemption

Health and Safety Code 1206 lists all licensure-exemptions available. Staff has reviewed all of these exemptions and has determined that health centers would only qualify for the 1206(g) exemption. The 1206(g) exemption states "A clinic operated, 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 has interviewed and reviewed several health centers and have determined that they would likely qualify for the exemption. Staff is currently in the process of working with the State to develop a clear path, and ensure that there will not be any negative repercussions caused by DHCS or CDPH.

At this time, Staff has met with CDPH and DHCS Provider Enrollment Division (PED), and have been encouraged with those discussions. Our last step is working with DHCS Audits & Investigations to ensure that the department does not take any negative actions on a health center utilizing the licensure-exemption. CPCA has inquired as to how DHCS would treat a facility utilizing this licensure-exemption.

E. Building Standards Commission Composition

The California Building Standards Commission (CBSC) is authorized to administer the processes related to the development, adoption, approval, publication, and implementation of California's building codes, including OSHPD 3. The 11 members of the CBSC are appointed by the Governor and confirmed by the State Senate. Currently there are two available Public Member seats available.

CPCA has nominated three health center friendly candidates for the CBSC. At this time, the Governor's office is still deliberating the candidates, but we do expect the Governor to make a selection before the end of his term in November.

F. Triennial Building Codes Cycle

Staff continues to engage with in the Triennial Building Code cycle. At this time, the Code Advisory Committees have minimally focused on OSHPD 3, and have spent a majority of their

time in the development of OSHPD 5 (Acute Psychiatric Hospitals). Staff will continue to engage with the OSHPD staff throughout the building code cycle.

G. Additional efforts

In addition to our Board approved strategies, CPCA is participating in additional efforts that have been undertaken by some Consortia leaders and being led by Health Center Partners of Southern California. This effort is seeking to more definitively outline the costs of OSHPD 3 for health centers in order to improve health centers ability to advocate effectively on this topic. The group plans to meet throughout the summer, gathering information, to be shared once sponsored bill advocacy has been completed. We are excited to partner in these efforts and look forward to them assisting CPCA in our efforts moving forward.

VI. Resources

- OSHPD 3 Options Chart
- OSHPD 3 Survey Summary

California Primary Care ASSOCIATION

INFORMATIONAL

Date: July 12, 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. Health centers have continued to express their frustration with the new centralized process, so CPCA has been pursuing strategies to help alleviate the backlog and assist health centers with licensing issues.

II. Current Status

CAU has made modest progress towards reducing their existing backlog and has released an updated and improved applications checklist; online licensing applications for clinics; and is also posting current processing metrics here: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Centralized-Applications-Unit-Licensure-and-Reports-of-Change-Applications.aspx.

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.

III. Licensing Improvement Strategies

A. **Consolidated Licensing – AB 2428 (Gonzalez Fletcher):** The consolidated license legislation 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 passed out of Senate Appropriations Committee on July 2.

   CPCA staff have recently received suggested amendments from DHCS and, as of writing, are working to determine the effects of these amendments.

B. **Intermittent Clinics- AB 2204 (Gray):** This bill, which is sponsored by Central California Partnership for Health would expand the intermittent clinic hours from 30 to 40 hours per week. AB 2204 passed through Senate Appropriations and is now to be voted on in the Senate Floor. Following the Senate Floor vote, AB 2204 then moves on to the Governor's desk for signature.

C. **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 available to applicants 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, however, would require legislation.

   The California Hospital Association is currently sponsoring AB 2798 which is very similar to this strategy. Staff attempted to get health centers amended into the bill, but CHA decided against such an amendment. CPCA will continue to track this legislation and if it is a viable option we plan on sponsoring similar legislation in the next legislative cycle, with Board consent.

D. **Research into Licensing and OSHPD 3:** *See OSHPD 3 Memo*

E. **Licensure Exemption:** *See OSHPD 3 Memo*

IV. Existing Licensees: License Conversions

CDPH has determined that prior to the centralization of licensing processes, several district Offices had incorrectly licensed some health center sites. In order to bring these clinics into conformity with law, CDPH has commenced actively searching for and identifying clinics with multiple full-time clinics under a shared license and has been reaching out to them to request a conversion of the licenses. At this point, CPCA is aware of 9 clinics who are affected.

CPCA met with L&C on June 26th to better understand their motivation and process for addressing these issues, as well as to request a pause in any efforts to modify these licenses, until which time the success of AB 2428 can be determined. AB 2428 would allow for sites to leave their PPS rate as is which would be the preferred option by many. Additionally, CPCA requested that CDPH provide written assurance that the changes being requested are a technical clean-up, and shouldn't be interpreted to mean that the clinics were not previously licensed.

We will have a follow-up meeting with L&C on July 18th where we expect to receive a response to our request for a pause and written assurance that the clinic was not in violation of their license.

California Primary Care ASSOCIATION

DISCUSSION

Date: July 12, 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. Four Priorities Update

CPCA's Managed Care Work has been defined by 4 overarching priorities, developed by the Regional Consortia. Updates on our work in each priority is available below.

Priority 1: Educating the New Administration and Leadership
CPCA has begun collecting data points that can be used to educate the new Administration and Leadership at DHCS about the important role that CCHCs play in the delivery system. CPCA is in the process of readying the information and stands ready to engage the next administration.

Priority 2: Commercial Plan Procurement
The procurement of new commercial Managed Care contracts is currently set to start in late 2019 according to the DHCS website. We note that the timeline is after the start of the new administration, so it may be updated in the future. To our knowledge t DHCS has not begun the process of developing a new RFP.

CPCA has developed a long list of all of the elements that a CCHC and/or regional consortia could look at to evaluate a health plan's ability to be a good partner. After vetting this list, we hope to create a checklist that CCHCs and consortia can use as they work with the health plans that have expressed interest in their region.

United Health Care has approached CPCA and expressed an interest in contracting with FQHCs in order to grow their networks and become competitive in the procurement. Molina has also indicated an interest in maintaining their existing Medi-Cal managed care counties and potentially growing their footprint. CPCA is referring commercial health plans to regional consortia for local conversations about priorities and partnership.

Priority 3: P4P, HEDIS, and Quality Alignment
Much of the work in this priority is driven by conversations with DHCS about the potential inclusion of P4P incentive payments in the annual reconciliation. As we come to an agreement around P4P incentive guidelines with DHCS, it is our intention to push the industry toward the adoption of best practice measures that have been shown to drive providers toward value-

based quality in the commercial market by endorsing IHA's value-based P4P measure set. This set is widely used in the commercial space but has been adopted in full by only one Medi-Cal managed care plan. There are a wide variety of slightly varying P4P measures in use around the state. In the resources section we have included a crosswalk of measures that we know are currently being used.

CPCA reported in April that we began working closely with Anthem Blue Cross on their recent major quality push. In fact, CPCA worked with Anthem to develop a quality incentive program for directly contracted safety net providers such as FQHCs. Unfortunately, Anthem's lead quality staff has left and we are struggling to continue our QI conversations.

CPCA is an ongoing participant and partner in statewide initiatives to improve encounter data reporting. Improving encounter data across the state of California is a primary undertaking of the Health Net/California Health and Wellness/Centene merger and is supported by a budget of 50 million dollars. An initial grant was awarded to IHA to develop a market research survey of the barriers to high quality and high volume encounter data reporting in the safety net, of which was disseminated through the Managed Care Task Force and the Clinicians Committee. The results of the market research revealed issues resulting from a lack of encounter data standardization, the need to incorporate more technological solutions, the need for better training and education of providers, and the need for incentives to encourage and sustain data submission. Currently, a Phase 1 program is underway to provide consultation to health centers and other providers to better understand how to strengthen and support providers to improve encounter data submission.

Priority 4: Enrollment Efficiency and Default Assignment
The goal of this priority is to forward an agenda of modernizing and streamlining the Medi-Cal enrollment system. 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.

As a first step, CPCA is partnering with the two most common EHR vendors, eClinical Works and NextGen, to begin pilots to develop member roster management modules within EHRs. This functionality would allow for health centers to input assigned Medi-Cal Managed members into their EHRs and match seen and unseen patients with membership from contracted health plans or IPAs. As health centers are better able to identify and manage their Medi-Cal members, more data will become available to align member assignment and utilization. Four health centers have been recruited into the NextGen pilot and are slated to begin in mid-July, while discussions continue to add health centers to the eClinical Works pilot.

II. Provider Directory Utility Update

CPCA continues to track and support the implementation of the statewide provider directory. Led by Integrated Healthcare Association (IHA), the initiative will create a single statewide Provider Directory Utility that all health plans and providers will use to maintain accurate provider data. To govern the initiative, a Utility Management Committee was formed, of which CPCA's CMO, Mike Witte is a member. Through an RFP process, the committee selected Gaine as a vendor, which has developed a similar regional provider directory in Southern California.

Currently, a Soft Launch has begun to stand up and test the functionality of the Provider Directory Utility and has recruited three health plans, Blue Shield, Health Net, and Anthem, as well as a small number of providers and provider organizations that contract with the participating plans to participate. Two health centers have volunteered to participate in the Soft Launch to test how health centers' unique provider status interfaces with the Provider Directory Utility. CalHIPSO has also been brought in to provide technical assistance for health centers and other smaller providers in this initial phase. The Soft Launch phase will continue until the end of the year.

The Provider Directory Utility is anticipated to be deployed in Q1 of 2019 and begin to encourage additional health plans, providers, and provider groups to participate. Currently, IHA welcomes the engagement of managed care organizations such as MSOs and IPAs as they stand up the utility in order to better understand and accommodate the various managed care arrangements across the state.

III. Resources

- DRAFT checklist of plan partnership elements
- DRAFT Crosswalk

California Primary Care ASSOCIATION

DISCUSSION

Date: July 12, 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

CPCA continues our work to support CCHCs in expanding the breadth and depth of their behavioral health services within the existing delivery structure. We have also begun developing our action plan for envisioning a new and improved behavioral health delivery system of the future.

II. Behavioral Health "Visioning" for the Future

In advance of the 2020 Specialty Mental Health Waiver negotiations, CPCA has begun our planning to begin a dialogue about visioning a behavioral health delivery system for the future.
The educational schedule for facilitating this dialogue is included in the "Resources" section of this memo.

III. Current Efforts

Our work to support CCHCs in the current delivery system has focused on three priorities: removing regulatory barriers to FQHC participation in the full spectrum of care; expanding access to resources; and ensuring health centers are included in all behavioral health policy discussions.

Removing regulatory barriers to FQHC participation in the full spectrum of care:

1. *SB 323 Implementation*

CPCA has developed an FAQ, decision making flow chart, and two webinars to help CCHCs evaluate the programmatic and fiscal impact of carving out specialty mental health and drug Medi-Cal services under SB 323.

2. *SB 1125 – Same Day Billing*

CPCA continues to advocate to advance SB 1125, Same Day Billing for medical and behavioral health services. A full discussion on this bill will be held during the Legislative Committee.

3. SB 1004 – *MHSA Prevention and Early Intervention Priorities*

CPCA successfully worked with our partners at the Steinberg Institute to ensure that partnership with CCHCs is a key priority for counties in developing their PEI programs. The bill directs the Mental Health Services Oversight and Accountability Commission (MHSOAC) to set policy guidelines for counties in developing programs utilizing prevention and early intervention MHSA funds. Under the bill amendments suggested by CPCA, county priorities for MHSA PEI funds include:

(1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
(2) Early psychosis and mood disorder detection and intervention, including mood disorder programming that occurs across the lifespan.

(3) Outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
(4) Culturally competent and linguistically appropriate prevention and intervention, which is defined as "a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code."
(5) Other programs the commission identifies, with stakeholder participation

Expanding access to resources:

1. *Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH)*

HRSA announced $350 million in supplemental funding for the purpose of supporting health centers in expanding access to SUD and integrated mental health services. Supplemental grant applications are due July 16, 2018.

2. *Rural Communities Opioid Response Program Planning (RCORP)*

HRSA released a grant opportunity for rural communities to support treatment and prevention of SUD, including OUD in rural counties at the highest risk for SUD. Grants are due July 30, 2018.

3. *MAT Expansion Alumni Learning Network*

CPCA received a grant from the California Department of Public Health to coordinate a MAT Expansion Alumni Learning Network for graduates of the Treating Addiction in Primary Care (TAPC) and Camden Coalition programs. The grant is from May 1, 2018 through August 31, 2018. While offered only for a short while, it provides clinics with 10 hours of expert consultation and free connection to two webinars on MAT best practices. CPCA will use part of this funding to pass through scholarships for 7-10 health center clinicians to participate in the next cohort of the UC Davis Train the Trainer in Primary Care Pain Management fellowship.

4. *CA Hub and Spoke Services (CA H&SS)*

CPCA has met on several occasions with the DHCS SUD Division and UCLA ISAP, CA H&SS implementation team, to outline strategies for engaging health centers in the hub and spoke infrastructure. CPCA presented a case to DHCS as to why the state needs to directly fund health centers to build and expand MAT capacity but DHCS. The success of the VT H&SS (from which the California model is replicated) is largely due to the active engagement of CHCs as outpatient MAT providers. DHCS is applying for a no-cost extension of unspent year one hub and spoke funding. And they have directed UCLA ISAP H&SS implementation team to coordinate a series of regional trainings for health center clinicians on the science and practice of treating patients with pain and opioid use disorders.

5. *Proposition 64 Funding*

With strong encouragement from CPCA members and advocates, CaliforniaHealth+ Advocates began participating in a larger coalition looking at how California should spend funding from Proposition 64, the California Marijuana Legalization Initiative. These funds are to be made available for SUD education, prevention, intervention, and treatment for youth and will be collected through the Marijuana tax in the state; 60% of which must be allocated to a youth SUD programs after other state entities receive their share. Through our advocacy efforts, we've been able to promote a more integrated system of care that acknowledges the importance of including all providers who offer primary care and/or SUD services to youth in the funding allocation of

Proposition 64. This is reflected in the language of SB 275, which would require DHCS to work with an expert panel, of which health centers will be a part of, to develop quality standards for providing SUD services to TAY population and lists health centers as a key provider of these services.

Ensuring Health Centers are included in all behavioral health policy discussions:

1. *Leveraging FQHC's in California's Behavioral Health Care Continuum*

CPCA published a report (funded by the Blue Shield of California Foundation, supported by Harbage Consulting, and endorsed with a forward by the California Behavioral Health Directors Association) that builds on the CaliforniaHealth+ Advocates 2017 legislative victory of Senate Bill 323. The content provides a wealth of context about California's behavioral health delivery system and, most importantly, elaborates on four models of partnership to improve consumer access to specialty mental health and substance use disorder treatment by leveraging FQHCs as the centerpiece of the behavioral health delivery system.

CPCA staff have presented findings from this report at numerous venues, most recently presenting to the Drug Medi-Cal-Organized Delivery System (DMC-ODS) Waiver forum, a group of county SUD administrators tasked with developing and implementing the ODS in their county. CPCA's goal with these presentations is inform the audience about the dynamic breadth and depth health centers SUD services and the valuable role CHCs can play in meeting network adequacy requirements in or out of DMC.

2. *MHSA - Innovations Incubator*

CPCA has been invited and participated the Mental Health Services Oversight and Accountability Commission's (MHSOAC) Innovations Incubator discussions. The Incubator would help improve the process of developing, approving, and implementing County Innovations programs. In addition to participating in these meetings, CPCA has joined our partners at CPEHN in making recommendations to the MHSOAC on how they can effectively improve the community planning processes for all MHSA programs. These recommendations included targeted outreach to CCHCs, and other linkages to safety-net providers. For more information please see the resource section below.

3. *California Behavioral Health Planning Council*

As a member of the California Behavioral Health Planning Council, CPCA has representation in discussions occurring around the Medicaid 2020 waiver and the development of the Workforce Education and Training Program (WET) 5 year plan to ensure the health center perspective is represented in these important discussions. As part of the Council, we are also advocating to improve how mental health services are offered to our underserved and culturally diverse patient population.

IV. Resources

- *Envisioning the future of the BH delivery system*
- *Leveraging FQHC's in California's Behavioral Health Care Continuum*

California Primary Care ASSOCIATION

INFORMATIONAL

Date: July 12, 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 has modified the HHP implementation schedule significantly based on feedback they received from MCP preferences for implementation phases. San Francisco will go live July 1, 2018, followed by Riverside and San Bernardino in January 2019; and the remaining 26 counties who indicated interest will go live in July 2019.

Health centers interested in being a HHP CB-CME should reach out to their managed care plan with contract inquiries. Plans are currently developing their HHP business plans with program guidance from DHCS. JSI deployed a rate setting tool for CB-CME health centers to consider the costs, staffing, and infrastructure needs associated with HHP or other care management/coordination initiatives.

FQHCs are not at risk of reconciling out supplemental HHP payments due to protections that CPCA was successful in getting into the SPA.

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 three implementation phases of the HHP. CPCA has reviewed the member toolkit and the Care Coordination curriculum (not yet available for public comment) and given feedback to Harbage on a number of occasions about their approach. Our impression of the materials is that it outlines the HHP requirements but it falls short of explaining *how* to be successful in care coordinating HHP patients. Harbage insists that MCPs are responsible for developing a training plan for their CB-CMEs with information unique to their plan and their care management approach.

CPCA will continue to advocate that the state provide CB-CMEs with the training and resources they need to be successful in health homes. We are also coordinating a series of peer to peer learning opportunities for health centers to strategize business plans, care models, and trouble shoot common barriers in order to maximize their chances for success as CB-CMEs.

Resources

- DHCS HHP: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
- 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
- Rate Setting Tool: http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=19343&thisSection=Resources

California Primary Care ASSOCIATION

INFORMATIONAL

Date: July 12, 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. Applications for grants available under the program were due on March 26th, 2018.

In the first round of grants, CPCA worked with CHFFA to develop the following triggering event: Any federal executive, administrative or legislative action or inaction that impacts any reimbursement or eligibility for participation in any federal program or initiative. This definition was selected in response to a wide-array of Federal instability, such as the Health Center Fiscal Cliff, heightened immigration enforcement, CHIP repeal, and Title X uncertainties.

II. Update

On June 28, 2018 CHFFA held their meeting where the first round of Lifeline Grant Awardees were announced. There was a total of 56 grant applications received by CHFFA, however only 42 grants were deemed eligible by CHFFA. Some examples of federal triggers cited by applicants included: a reduction in Title X funding, a reduction in Medicaid/Medicare reimbursements, the elimination of the Individual Mandate Penalty, and reductions in federal grant funding such as the Health Infrastructure Investment Program.

FQHCs were awarded 26 grants and received $5,385,066 out of $8,276,310 awarded at this stage. The additional 16 grantees were Planned Parenthood Affiliates. The remaining 13 applicants were deemed either incomplete or ineligible.

Please see the table below which highlights the awardees.

Clinicas del Camino Real	$750,000 (3 awards)
Golden Valley Health Center	$1,240,450 (9)
Health and Life Organization	$250,000 (1)
JWCH Institute	$250,000 (1)
Laguna Beach Community Clinic	$219,415 (1)
Lifelong Medical Care	$750,000 (3)
Livingstone Community Health	$250,000 (1)
Mountain Health and Comm. Serv.	$1,250,000 (5)
Operation Samahan	$175,201 (1)
Winters Healthcare	$250,000 (1)

III. Next Steps

The Lifeline Grant Program was created to provide $20 million in emergency funds to small, and rural health facilities in response to federal instability following the 2016 election. $11,723,690 remains unallocated from the Clinic Lifeline Program fund after the first round of grants. Additionally, if the grant awardees are not able to demonstrate a loss of funds resulting from a federal trigger those funds would also revert back to the unallocated pot of funds for distribution at a later date.

CHFFA Staff is presently working to develop permanent regulations to be finalized by their August authority meeting. If the permanent regulations are implemented then CHFFA has until 2022 to expend all remaining funds.

Staff will continue to engage with CHFFA to ensure that any permanent regulations are implemented in a manner which continues to allow health centers and our partners to qualify.