Government Programs Committee

Tuesday, January 15, 2019
10:00am-11:30am
Henry Tuttle, Chair

Registration URL: https://attendee.gototraining.com/r/9014415744827361025

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Henry Tuttle	A
II. Approval of Agenda	• Executive Summary	Henry Tuttle	A
III. Approval of Minutes	• October 2018 Meeting Minutes	Henry Tuttle	A
IV. Year in Review	• 2018 Year in Review	Andie Patterson	D
V. 340B Federal and State	• Memo: 340B Update	Liz Oseguera	D
VI. Behavioral Health	• Memo: Behavioral Health Convening • Memo: Behavioral Health Update	Allie Budenz Liz Oseguera Michael Helmick	D I
VII. Managed Care	• Memo: Managed Care Update • Memo: DHCS APLs	Andie Patterson Nenick Vu	D D
VIII. OSHPD 3 and Licensing	• Memo: Licensing & OSHPD 3 Update	Michael Helmick Emily Shipman	D
IX. Care Coordination	• Memo: Health Homes Program Update	Allie Budenz	I
X. CMS Proposed Rules	• Memo: Summary of Medicaid and Exchange Rules	Andie Patterson	D
XI. HIT	• CPCA Comments on *ONC Draft Strategy to Reduce Health IT Burden*	Lucy Moreno	I
XII. Adjourn		Henry Tuttle	A

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
October 02, 2018
11:10am – 12:30pm

Members: Robin Affrime – Chair, Antonio Alatorre, Doreen Bradshaw, Kathryn Powers, Jill Damian, Deb Farmer, Ben Flores, Susie Foster, Aaron Fox, Cathy Frey, Naomi Fuchs, Alvaro Fuentes, Alonso Garcia, Greg Garrett, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Maria Paz, Kerry Hydash, Dave Jones, Deena lahn, Karen Lauterbach, David Lavine, Becky Lee, Deborah Lerner, Marty Lynch, Alicia Mardini, Kevin Mattson, Louise McCarthy, Leslie McGowan, Nichole Mosqueda, Anitha Mullangi, Danielle Myers, Rakesh Patel, Justin Preas, Joanne Preece, Carole Press, Tim Pusateri, Tim Rine, Gary Rotto, Laura Sheckler, Suzie Shupe, Paulo Soares, Graciela Soto-Perez, Brenda Storey, Deanna Stover, Terri Lee Stratton, Dong Suh, Mary Szecsey, Vernita Todd, Chad Vargas, Denis Vega Tapia, Christina Velasco, Richard Veloz, David Vliet, Christy Ward

Guests: John Blaine, John Price, Paula Zandi, Raphael Irving, Ellen Piernot, Yamilet Valladolid, Teresa Tillman, Angie Melton, Esen Sainz, Ryan Yamamoto, Sergio Bautista, Erika Sockali, Chloe Guazzone

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Elizabeth Oseguera, Michael Helmick, Emily Shipman, Allie Budenz, Nenick Vu, Mike Witte, Ginger Smith, Emily Shipman, Beth Malinowski, Cindy Keltner, Victor Christy, Buddy Orange

I. Call to Order
Robin Affrime, Committee Chair, called the meeting to order at 11:16am.

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 July 12, 2018. **The motion carried. (K. Hydash, D. Farmer)**

IV. 340B Federal and State
The federal and state government have expressed interest in increasing transparency around the 340B drug discount program, specifically in having covered entities (CEs) report how they are using 340B savings. With approval from the 340B Savings workgroup, CPCA presented the board with five funding areas where health centers can commit to use their 340B savings; (1) Workforce, (2) Drug Management Programs & Increasing Access to Medication, (3) Clinical Care Coordination, (4) Expanded Access to Healthcare Services, and (5) Infrastructure Support. The CPCA Board approved the 340B PN subgroup to develop a formula to calculate the costs of operating a 340B program in order to differentiate between 340B proceeds and savings, to help ensure that health centers are defining 340B savings in the same way.

MOTION – 340B Savings
A motion was made and seconded that CPCA members commit to investing their 340B savings exclusively in the identified six areas which are 1) Access to Affordable Medication & Pharmacy Programs (2) Expanded Access to Healthcare Services, (3) Workforce, (4) Clinical Care Coordination, (5) Infrastructure Support, and (6) Quality Improvement. **The motion carried. (Pusateri, T., Guerrero, B)**

V. OSHPD3 and Licensing
The Licensing and OSHPD 3 Research project has begun and is scheduled to be completed by mid-2019. Update on Licensing and OSHPD 3 related legislation. CPCA has continued to address the board approved strategies to reduce

administrative and regulatory barriers caused by licensure.

VI. Behavioral Health

Results from 2018 bi-annual Behavioral Health Survey which tracks the trends and trajectory of CHCs in the behavioral health service system. Updates on CPCA's work to expand CHCs access to and participation in MHSA, Prop. 64, and SUDs. CPCA is undertaking a "Visioning" meeting to bring together health center leaders from across the state to define our priorities and strategies moving forward.

VII. Care Coordination

CPCA is participating on the DHCS Care Coordination Advisory Committee to discuss findings of a systemic assessment of care coordination services for Medi-Cal Members and formulate future policy recommendations. CPCA positions will be vetted through the Managed Care Task Force. Health Homes Program has launched in San Francisco County and expects to be fully implemented across 29 counties by January 2020. CPCA is coordinating a three part webinar series on care management foundational concepts for CHC CB-CMEs. DHCS confirmed in writing that FQHCs may participate in and be paid outside of PPS for services that follow the patient in specific state programs.

VIII. Clinic Lifeline Grant Program

CHFFA has readopted their regulations to allow for a continuous application process, and moving forward health centers can begin applying as a triggering event occurs. $11,723,690 remains in the Clinic Lifeline Grant fund.

XI. Managed Care

Regional Consortia and CPCA continue to develop the four managed care priorities. CPCA supports and coordinates with stakeholders to support the implementation of health plan mergers undertakings.

X. Adjourn

The meeting was adjourned at 12:30pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care Association

Government Programs Committee
2018 Year in Review

Date: January 4, 2019

To: Government Programs Committee

2018: What we projected

- Health Care Reform
  - ACA repeal is still desired by some in the Republican Party, but many do not see it as politically feasible and want to move on to other projects. Unlikely major policy will pass but small destructive policies may be included as riders in other legislation.
  - HHS and CMS likely to exert their regulatory authority to challenge the ACA, and move Medicaid into a more restrictive space.
  - The federal deficit is likely to force a national conversation on entitlement reform which will include Medicaid.

- 340B
  - At the federal level the results of the covered entities audit will be revealed.
  - The Trump Administration, and Azar if appointed to lead HHS, likely to push for changes to the 340B program- and likely will receive a lot of push back from advocates.
  - CPCA hopes to either enter into conversations with the state or help foster county conversations between plans and health centers to ensure that reporting on 340B drugs is done clearly, consistently and timely.

- Patient Centered Health Home (PCHH) / Section 2703
  - HHP will launch in group 1 counties in July 2018
  - Without state guidance, there will be challenges in sharing patient data between MCPs, counties, and CB-CME's in an effort to coordinate care for shared patients.
  - The pilot will struggle to demonstrate cost savings in the next two years, which it must do in order to remain a benefit in perpetuity. Data from previous iterations of complex care management programs demonstrate a minimum of 18 months before cost savings are realized.

- Licensing
  - CPCA will continue our efforts to support licensing process improvements, including individualized technical assistance, ongoing dialogue with Licensing leadership, and legislative efforts as necessary.
  - Increased staffing at CAU will reduce wait times for application processing
  - An electronic application process will be released for primary care clinics

- OSHPD 3
    - CPCA, with the support of outside counsel, will identify, vet, and support a health center or centers through the process of obtaining a 1206(g) exemption and/or 1231(a) exemption from OSHPD 3.
    - CPCA will continue to work with the state and engage in the building standards regulatory cycle.
    - CPCA will continue to work with members to understand and make tangible the impact that OSHPD 3 has on health centers.

- Managed Care
    - The Medi-Cal commercial plan procurement offers an enormous opportunity to leverage CCHC market power and CPCA political power to influence the selection of Medi-Cal managed care plans
    - CPCA and RAC will continue a coordinated effort to push Medi-Cal managed care plans toward the IHA standardized P4P program.
    - CPCA will push DHCS to have a clear and more inclusive process around important policy changes

- Behavioral Health
    - MFTs will become billable providers in FQHCs as of July 1, 2018
    - CPCA will support health centers in expanding their scope to include Drug Medi-Cal, MAT, and specialty mental health
    - The FQHC Partnership Toolkit and recent regulatory changes that encourage county engagement with community-based partners will provide an opportunity to increase CCHC/county partnerships for specialty mental health, MHSA, No Place Like Home, and SB 82 triage.

- Oral Health
    - CPCA looks forward to continuing to work with DHCS and health centers to increase participation in the Dental Transformation Initiative for Program Year 3.
    - While CDPH moves forward with official departmental approval of the State Oral Health Plan (Plan) under the state dental director, Dr. Kumar, CPCA will continue to support the Oral Health Department in communicating and implementing the Plan.
    - CPCA has recently submitted its application for participation in its second year of the National Oral Health Integration and Innovation Network and expect approval later on this month. We look forward to continuing to champion oral health issues locally and across the country.
    - CPCA is excited to continue to actively participate in the California Oral Health Network as a member of its Core Group working towards developing the Network's goals and foundation.

2018: What Happened?

- Patient Centered Health Home (PCHH) / Section 2703
  - Implementation began on July 1, 2018. Several counties moved implementation start date to group 3 (of 3) so now 26 of the 29 counties will go live on July 1, 2019.
  - The state is not issuing guidance that would standardize the approach so health plans have a lot of discretion with how they implement HHP. Without consistency across approaches, there is potential that CB-CMEs contracted with multiple plans will have different workflows, resulting in more cost. The ability to make statewide comparisons diminishes.
  - DHCS and Harbage Consulting launched a health plan learning cohort for plans to share best practices. The cohort has yet to meet and does not have a set of deliverables or outcomes.
  - DHCS shared the evaluation plan, which includes an iterative evaluation of each group. The first evaluation is expected in May 2020.

- Behavioral Health
  - On March 30, 2018 DHCS submitted to CMS SPA 18-003 which included, among other things, how the state proposes to implement MFTs as billable providers in FQHCs/RHCs. Since then CMS has provided feedback to the state on the pending SPA. DHCS amended the SPA and reapplied. The negotiation between DHCS and CMS can continue for many months; there is no timeframe for which CMS must approve a SPA.
  - CPCA sponsored SB 1125 (Atkins), which would have allowed FQHCs to bill for medical and behavioral health visit on the same day. The bill successfully passed the legislature and received a veto message from the governor.
  - CPCA has successfully expanded CHCs ability to participate in a large array of behavioral health services, like SMH/DMC, MAT, No Place Like Home, and SB 82 triage. There remains additional work to remove some of the daunting programmatic requirements which inhibit health centers from participating in the full care continuum – like documentation burden and data sharing.
  - The federal administration's approach to addressing the worsening opioid crisis was to reduce barriers to SUD treatment by infusing additional funding for SUD treatment and prevention to states, localities, and health centers. CA health centers received several tens of millions of dollars to integrate MAT, either directly through HRSA or through state pass-through.
  - CPCA, in collaboration with our behavioral health partners, has continued to advocate for a more inclusive Mental Health Services Act, which includes ensuring funding is used throughout the behavioral health system, including health centers.
  - Members came together to develop a vision for behavioral health and health centers in the larger health care delivery system. The visioning work will drive CPCA and Advocates' agenda for the coming years.

- 340B
  - CPCA was successful in preventing the state from dismantling the 340B program in Medi-Cal Managed Care.
  - CPCA has worked in coalition with our hospital partners to push DHCS to release rules to help capture duplicate discounts, which they plan to release in early 2019

- The board has approved to have health centers invest their 340B savings into six identified areas to increase transparency within the 340B program.

- **Licensing**
  - Ongoing engagement with DPH and OSHPD related to clarifying and improving clinic licensing requirements and processes.
  - Legislation allowing for shared reimbursement for consolidated sites.
  - Began ongoing research project into history and value of clinic licensing.

- **OSHPD 3**
  - CPCA continued to gather information and data in order to bolster our arguments against OSHPD 3, and licensing overall.
  - CPCA has increased our advocacy efforts at OSHPD to ensure that they are aware of the distinct needs of health centers and their patients.
  - CPCA had two volunteers for the 1206(g) license-exemption, however, for numerous reasons the two health centers have not chosen to move forward at this point.

- Managed Care
  - RAC outlined four managed care priorities that now align CPCA and RACs collaborative statewide and local efforts
  - CPCA and RAC established a collaboration with Integrated Healthcare Association to begin efforts to standardizing P4P measures in Medi-Cal
  - CPCA is developing a collaborative of stakeholders to explore and impact Medi-Cal enrollment, the unseen patients issue, and drive policy change

2019: What we project?

- Patient Centered Health Home (PCHH) / Section 2703
  - DHCS and Harbage Consulting will launch their required CB-CME training program; MCO's will supplement with their HHP-specific operational trainings. The trainings will be high level. Other interested stakeholders (like CPCA) will supplement with trainings that the state and contractors do not provide.
  - Plans within one county will have to address how to standardize assessments and care plans so CB-CMEs do not have multiple processes. Furthermore, they will need to identify a process for sharing historical diagnosis data for new patients to a CB-CME.
  - The pilot will struggle to demonstrate cost savings in the next two years, which it must do in order to remain a benefit in perpetuity. Data from previous iterations of complex care management programs demonstrate a minimum of 18 months before cost savings are realized.

- Behavioral Health
  - SPA 18-003 will be approved by CMS and MFTs will become billable providers in FQHCs. SPA 18-003 is slated to be retroactive to July 1, 2018, however, DHCS may attempt to amend this to a later date.
  - The 1915(b) waiver, which establishes the carve-out of Specialty Mental Health Services will be up for renewal. CPCA will establish a set of waiver renegotiation

principles that will guide our efforts in this space. Additionally, CPCA will work with our partners to push more
    - The state will continue to focus on the opioid epidemic and incentivize (mainly through grants) outpatient providers to integrate MAT.
    - The state will continue to make incremental improvements to the Mental Health Services Act, particularly in regards to fiscal transparency and continuity of care.

- 340B
    - CPCA will work with health centers to help implement the requirements within the All Plan Letter that DHCS plans to release in early 2019.
    - A bill may be necessary to ensure 340B continues to operate as it currently does- where savings flow to the covered entities.
    - CPCA will work on producing a guidance to help health centers invest their 340B savings within the six identified areas

- **Licensing**
    - Research on the history and challenges with licensing will conclude with clear recommendations for solutions.
    - Advocates will sponsor legislation to improve the process and reduce barriers to health center licensing.

- **OSHPD 3**
    - Based on the results of our research project, CPCA will increase our deliberate engagement on OSHPD 3.
    - CPCA will continue to push for OSHPD to formally convene a Community Clinics Advisory Committee.
    - CPCA will continue to work to find at least one health center to complete the 1206(g) license-exemption.

- Managed Care
    - CPCA will support RACs in aligning regional and statewide efforts along the Managed Care Priorities.
    - Deeper alignment with the managed care plans and influence in the larger health delivery discussions.

DISCUSSION

Date: December 20, 2018

To: Government Programs

From: Elizabeth Oseguera, Senior Policy Analyst

Re: 340B Drug Discount Program

MEMORANDUM

I. 340B State Developments

CPCA continues to work in partnership with hospitals and plans to express our concerns regarding the 340B program to the Department of Health Care Services (DHCS) and the legislature. Our goal is to have DHCS provide managed care plans and covered entities workable rules on how to manage the 340B program and prevent duplicate discounts.

DHCS All Plan Letter (APL)

DHCS released an APL in December to clarify the role that Medi-Cal managed care organizations (MCOs) are required to have in eliminating duplicate discounts under the 340B program. The APL aims to implement the requirements set forth by the 2016 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. For a copy of the draft APL please see the resource section below.

This APL is a positive step forward in that it creates a set of rules for how covered entities can participate in Medi-Cal Managed Care 340B. It provides both MCOs and covered entities direction on how to submit utilization data to the state with the goal of preventing duplicate discounts. However, we had concerns with the specifics as to how DHCS was interpreting the law and their intentions prior to meeting with the state on December 20.

CaliforniaHealth+ Advocates, CPCA's affiliate, along with coalition partners at the plans and hospitals, met with DHCS to talk through the concerns that were outlined in the comment letter submitted in response to the APL (letter can be found in the resources section below). **The meeting was productive and ultimately Advocates and partners left understanding the 340B program could remain in place.**

- DHCS clarified that they do NOT need 340B modifiers added at the point of sale as long as when DHCS receives the data files from the plans they contain the correct data and modifiers (which is how the Department is defining 'adjudication' to mean in the 3-way agreement requirements that were released).
- It appears DHCS will afford plans and CEs 6 months to implement the APL, which will likely be July 1st since DHCS is looking to implement the APL by the end of this year.
- The APL is a requirement on all managed care plans that contract with 340B covered entities.
- DHCS is not dictating reimbursement for 340B drugs.

- Regarding the 3-way agreements, DHCS has agreed to accept arrangements between the CE and managed care plan as long as the plan can prove that there are policies and procedures in place by the CE, the plan and contract pharmacy that prevent duplicate discounts.
    - Please see the 3-way requirements that DHCS have released in the resource section below. This essentially means that CEs would need to update their contracts / arrangement with the plans while also updating their agreements with contract pharmacies to ensure there are clear policies and procedures in place.

During the meeting we were also able to confirm that the Partnership Health Plan model can be an example for other plans so long as the plan mandates every 340B covered entity to comply. Today the 340B compliance plan is optional, not mandatory.

What is not addressed in this APL is the how for health plans. So long as the arrangements are approved by the state, and the data gets to the state appropriately coded and in a timely fashion they are willing to allow any structure. There is no mention of costs / fees charged or how strict a plan could be with their covered entities, for example in how fast they want the appropriately coded claims.

The opportunities to address the above potential issues are either one on one covered entity and health plan negotiations, or legislation. CaliforniaHealth+ Advocates, on behalf of CPCA, will explore a legislative fix for the issues related to fees charged and timeliness of data submission.

340B Saving Areas

Given health center's commitment to improving the 340B program, while also acknowledging the federal and state government's goal to increase transparency, the board has approved CPCA to work with the 340B Peer Network (340B PN), along with CFO's, to determine areas where all health centers could agree to invest their 340B savings.

Thus, with approval from the board, CPCA is working with the 340B Savings workgroup to create a guidance that will help health centers implement the six areas of funding listed below. CPCA hopes to have a guidance for the boards review and approval by April.

6 Areas to invest CHC 340B Savings

(1) Access to Affordable Medication & Pharmacy Programs
(2) Expanded Access to Healthcare Services
(3) Workforce
(4) Clinical Care Coordination
(5) Infrastructure Support
(6) Quality Improvement

II. Federal 340B Update

CVS-Caremark Issue (Discriminatory Contracts)

CVS-Caremark is changing its provider manual starting January 1, 2019 to allow any pharmacy that dispenses 340B to pay less for all drugs sold. NACHC refers to this as 'discriminatory contracts,' since other parties are effectively attempting to take 340B savings for themselves and reducing reimbursements for covered entities. As a result of CVS-Caremark actions, in-house pharmacies could often lose money when filling non-340B prescriptions, while outside pharmacies will be dis-incentivized to contract with covered entities, as doing so will reduce their reimbursement for other CVS-CM drugs.

The issue with CVS-Caremark has been growing rapidly this fall as we are beginning to see examples of these practices by Humana and Centene as well. NACHC is currently working on this issue and evaluating different

strategies and approaches for resolution. However, NACHC has informed us that unfortunately, at this time, there is nothing in statute or regulation that prevents CVS-Caremark's actions. In response the Pharmacy Access Workgroup met at CHI provided NACHC with recommended action steps that can be taken to help protect covered entities and their 340B savings in these type of situations.

These recommendations were to have NACHC:

- Explore options for adding an anti-discrimination clause to the 340B statute.
  This clause would prohibit outside groups from accessing the 340B savings that Congress intended to provide to health centers and other covered entities. To do this, the clause would prohibit third parties (e.g., private insurers, PBMs, TPAs contract pharmacies, possibly Medicaid) from having different reimbursement or fee structures for drugs purchased under 340B than for the same drugs purchased outside 340B.

- Explore non-legislative options to respond to discriminatory contracting practices that cause health centers to lose 340B savings.
  This would include responding to CVS-Caremark's plans to dramatically reduce reimbursement for brand-name drugs purchased under 340B by FQHCs with in-house, closed-door pharmacies.

CPCA will continue to follow these conversations and work closely with NACHC to attempt to find a reasonable solution.

Penny Pricing and Manufacturer Compliance

Penny pricing is a HRSA policy regarding the 340B ceiling price calculation in circumstances when a manufacturer increases the Average Manufacturer Price of a brand-name drug more quickly than the rate of inflation to such a degree that it causes the 340B ceiling price calculation to result in a price of $0.00. In such situations, HRSA directs manufacturers to charge 340B covered entities $0.01 per unit of measure for the drug.

In 2010, Congress mandated that regulations be put in place around penny pricing, which were finalized by the Obama administration in early January 2017. The Trump administration has finally announced that starting January 1, 2019 Obama-era regulations will be implemented to improve the 340B program, the changes would:

- Make 'penny pricing' official policy
  Until now, penny-pricing has been unofficial, and therefore could be changed at any time. But now that it's in regulation, it's much harder to change.

- Provide HRSA Enforcement Authority
  According to the rule, HRSA will be allowed to fine manufacturers that knowingly and intentionally" overcharge for 340B drugs. This will be the first time in the program's 26-year history that there will be a mechanism for penalizing manufacturers who fail to comply with the law's pricing requirements. In the past, 340B providers have gone all the way to the Supreme Court seeking to enforce manufacturer compliance, and been told there was no way that they – or HRSA – could do so.

340B Ceiling Prices

Starting on April 1, 2019, HRSA will make 340B ceiling prices available in OPAIS. The regulations detailing this change will go into effect on January 1, 2019. During the first quarter of 2019, manufacturers will be required to upload pricing data, which HRSA will use to calculate 340B ceiling prices. These 340B prices will be made available to health centers and other 340B providers through a secure website.

III. 340B Upcoming Events

The 340B Coalition, which is an umbrella organization of groups that represent safety-net providers and programs participating in the 340B drug pricing program, will be hosting the 340B Coalition Winter Conference in San Diego from January 30 through February 1st. During the conference there will be three sessions designed exclusively for health centers. The sessions will provide an overview of the latest developments in the 340B program, discussion regarding discriminatory contracting and inventory management. For more information on registration please see the resource section below.

It meets twice annually, during the summer in Washington, DC and during the winter on the West Coast.

IV. Resources

- DHCS Draft APL on 340B
- Coalition Comment Letter on the APL
- DHCS Minimum Requirements on 3-Way Agreements
- 340B Coalition Winter Conference Registration Link

California Primary Care ASSOCIATION

Discussion

Date: January 15, 2019
To: Government Programs Committee
From: Allie Budenz, Associate Director of Quality Improvement
Re: Behavioral Health Convening

MEMORANDUM

I. Overview

CPCA convened a workshop on November 8, 2018 to facilitate a conversation among community health centers that would outline a policy-driven vision for the future of the behavioral health delivery system. This workshop provided CHCs with substantial context about the history and current limitations of the delivery system. In part, the goal of this effort was to equip health centers with the information needed to create bridges between fractured funding streams and delivery systems in order to create an efficient and seamless system for patients. It also provided CPCA with the necessary direction for statewide 2020 waiver advocacy.

Approximately 45 CPCA members, representing northern and southern California, attended the convening on November 8th. The audience was a mix of health centers and regional consortia staff from behavioral and executive leadership.

The morning began with a panel presentation to provide context and level the understanding about how the "carve out" is structured, funded, and interpreted by counties and health centers. Panelists also discussed the challenge and benefits of this system to patient care and health outcomes, and presented results from the CPCA behavioral health survey about how it affects health centers. The afternoon was a series of break-out conversations aimed to define the role of CHCs in the behavioral health delivery system.

The results from the convening align nicely with CPCA's existing public policy platform. There is synergy between the administrative advocacy and relationship building with the new administration and all of the legislative advocacy areas listed in CPCA's policy prioritization.

One area that is not addressed in the policy prioritization is the assertive stance the group would like to take on the 1915(b) waiver negotiations (see Section V). As an immediate next step, CPCA staff will work to better understand the waiver, the players, and process. Concurrently, we will package the preferences articulated at the meeting into a series of principles about renegotiating the waiver. The goal of our work is to identify changes that would lead to a reduced burden for dual FQHC and SMH contractors to manage specialty contracts. The principles could also guide CPCA's active involvement and advocacy in the waiver negotiations. We will also use them with stakeholders invested in the waiver negotiation to identify points of commonality that we can jointly advocate on together.

II. Envisioning an "Ideal" System for Behavioral Health Services

Comprehensive, client-centered coverage

In the ideal system:

- There would be on-demand access to the full range of community-based mild to moderate to severe mental health services as well as SUD services.

- "Covered" diagnoses would include most in the DSM-V.
- There would be no barriers to care for Medi-Cal beneficiaries or the uninsured and services would be culturally and linguistically appropriate.
- Patients would move seamlessly between providers and transportation would be available for those in need.
- Services would include prevention, annual behavioral health "wellness visits" and case management for high-need patients.
- Patients would have behavioral health homes which would provide coordinated primary and specialty services.
- There would also be services directed at addressing patients' social determinants of health.
- Patients' satisfaction and well-being would be paramount.
- Service delivery in this ideal system would be facilitated through adequate staffing of diverse licensed/
- Unlicensed professionals and a myriad of technological options such as telehealth.

Organizational, policy and financial integration in a "healing system"

- This ideal system would be integrated in such a manner as to include services under one "roof" with a single unified payer system.
- It would not have today's existing service, program and regulatory silos and would support regional flexibility.
- While it may not be logistically realistic to include all services in one place, they would be connected and coordinated as a holistic or whole person "healing system" with minimum bureaucracy.
- Patient health information would be shared seamlessly between providers with a comprehensive HIPAA and privacy understanding across the system.
- The system would include easy access to research and best practices and would be amenable to testing changes.
- This system would have features, including integrated leadership and governance, similar to an Accountable Community for Health.
- Meaningful data would be collected and shared on widely accepted standards of care (e.g. timely access, accountability for turn-around time, etc.).

III. Defining the Health Center role within the Ideal Model

Behavioral Health Homes and "No Wrong Door" to Services

In the ideal behavioral health system envisioned above,

- CHCs are central to its organizational success and patient well-being.
- Community health centers are the natural "health home" for patients' comprehensive preventive, early intervention, primary care and behavioral health needs and serve as important care managers.
- Moreover, as system navigators, CHCs support patients' seamless transitions between providers if the CHC doesn't provide all needed services.
- CHCs are the portal through which patients access all needed services, the "no wrong door" entryway.
- It is critical for patients to experience a seamless health care system, which puts them in control of when, how, how much, and where they can access care.
- CHCs also serve as training ground for providers.

Discussion

Financing and Payment to Achieve the Ideal System

- Financing from multiple payers (e.g. county MHSA and specialty mental health, Medi-Cal) would be integrated and flow to CHCs from a single source.
- This single payer would offer value-based capitated rates which included payment innovations for meeting or exceeding quality and other performance standards.
- These payment innovations would also include shared savings incentives or reinvestments.
- Community health centers would accept capitated per-member-per month payments and accept full risk to serve as behavioral health homes.
- Moreover, bundled payment rates would be available for high-risk and complex patients (e.g. Whole Person Care population).
- Ultimately, with CHCs are the helm, the ideal system would see a reduction in duplicative administrative requirements and clinical interventions, allowing for a reinvestment of the savings into preventative care.

IV. Perceived Barriers to Achieving the Ideal

There are two different systems of management for mental health services: Medi-Cal managed care plans and county Mental Health Plans creating a challenging bifurcated system. There exists a third, entirely separate system for substance use disorder services in Drug Medi-Cal. Each system has separate and often onerous billing and payment, compliance, reporting and other regulations. There has been no statewide leadership on streamlining or otherwise improving behavioral health financing, policy and solving systemic challenges. Another significant barrier is posed by the required confidentiality of SUD patient records in federal regulations as mandated by 42 CFR Part 2. DHCS requirements for FQHC scope changes and ensuing PPS rate changes for adding services is also onerous and challenging. Lastly, numerous workforce challenges hinder CHCs ability to adequately address service needs.

V. Considerations for CPCA's Behavioral Health Advocacy in the Near-Term

As mentioned earlier, there is significant overlap between existing CPCA policy priorities and what the convening attendees wish to prioritize. The full list of advocacy actions identified at the convening are listed below:

- Revisit and amend, as needed, behavioral health priorities in Strategic Plan and Policy Priorities
- Advocacy and relationship building with Newsom Administration
    - Establish CPCA priorities, including behavioral health, with Governor and staff
    - Meet with incoming DHCS Director and CHHS Agency Secretary
- Legislative advocacy
    - Same-day billing
    - Enhance role of non-licensed staff across the system with appropriate reimbursement
    - Direct access to MHSA funds
- DHCS administrative advocacy
    - 1915(b) waiver renewal to include changes that would allow:
        - Remove the MHP/MCP bifurcation into one source of payment for all acuity levels
        - New payment methodologies (e.g. move away from CPEs)
        - Integration and streamlining of specialty mental health services

        - Reduced documentation requirements for Short-Doyle billing
        - The MHP to assume responsibility for SMH patients with Medicare and dual Medicare/Medi-Cal
        - Establish a statewide objective criteria to assess acuity and a process for transferring between the appropriate levels of care
    - Continue to participate and inform DHCS activities as it relates to Care Coordination benefits
    - Advocate for flexibility to use alternative therapies (such as home health, telehealth, group visits) without reconciliation
- Other stakeholder advocacy
    - CBHDA to discuss CPCA behavioral health priorities and 1915(b) waiver renewal
    - MHSOAC to discuss access to MHSA funds and use of Full Service Partnership resources
    - Federal advocacy for 42 CFR Part 2 changes to allow for easier patient information exchange

VI. Next Steps

CPCA has already cross referenced the policy priorities to ensure legislative advocacy areas are represented. As an immediate next step, CPCA staff will work to better understand the waiver, the players, and process. Concurrently, we will package the preferences articulated at the meeting into a series of principles about renegotiating the waiver. We will also reach out to colleagues in the county behavioral health system to identify their pain points in managing the SMH system to identify areas of joint concern. The goal of this work is to identify changes that would lead to a reduced burden for FQHCs to participate in the full care continuum and support better integration and care coordination within the system.

California Primary Care ASSOCIATION

INFORMATION

Date: December 19, 2018
To: Government Programs Committee
From: 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. Our work to support CHCs 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.

II. Mental Health Services Act

Assembly member Todd Gloria introduced AB 43, which includes intent language aimed and ensuring MHSA funds are used in accordance with the provisions of the action and that there is adequate oversight of excess unspent funds. This bill is in direct response to the lack of transparency and reporting from counties on how MHSA funds are currently spent.

In December, the Mental Health Services Oversight and Accountability Commission's Executive Director, Toby Ewing, presented MHSOAC's Transparency Suite to the Behavioral Health Peer Network and Work Group. MHSOAC's Transparency Suite is an online tool that target three areas: 1) Fiscal Reporting, 2) Statewide Programs and Services and 3) Outcomes.

FQHCs can use these tools to see how their counties are distributing MHSA funds and start dialogue on how to include your organization in these programs and services. The Fiscal Reporting Tool is now live on their website, and the full Transparency Suite is expected to be live at the end of January 2019. CPCA will be inviting MHSOAC's Executive Director present to the BHPN and BHWG to build bridges and collaboration with FQHCs and behavioral health delivery system.

III. Proposition 64 Update

Proposition 64, the Adult Use of Marijuana Act, approved by voters November 2016, specifies funding for substance use disorder services (prevention and treatment) in two sections of the new law:

- $10 million per year beginning in 2018, increasing by $10 million per year to $50 million in 2022-23 to the Governor's Office of Business and Economic Development (Go-Biz) for a community reinvestment program, at least 50% of which in grants to community nonprofits, for job placement, substance abuse and mental health treatment, legal and other services to communities dis-proportionately affected by the war on drugs.
- 6% of funds are allocated to a Youth Education, Prevention, Early Intervention and Treatment Account for youth programs to prevent drug abuse.

California Community Reinvestment Grants Program

Governor's Office of Business and Economic Development (GO – Biz) will award grants beginning no later than January 1, 2020, to local health departments and qualified community-based nonprofit organizations (50% of the funding must go to non-profits/CBOs) to support the following activities for communities disproportionately affected by past federal and state drug policies:

- Job placement
- Mental health treatment
- Substance use disorder treatment
- System navigation services
- Legal services to address barriers to re-entry
- Linkages to medical care

For several months, Go-Biz has hosted stakeholder convening's throughout California to gather input on how funding in the California Community Reinvestment Grants Program should be spent. CPCA has attended and encouraged members to also attend. Go-Biz also asked the public to submit general comments regarding how funding should be used from the California Community Reinvestment Grants Program. CPCA has shared a draft comment letter with the Behavioral Health Workgroup for review and submitted comments by the deadline.

CPCA will continue to follow this issue and inform members of any other opportunities to engage in conversations to help advocate to have some funding be allocated to health centers.

Prop 64 Funding for Youth

At the direction of members, CPCA joined the Proposition 64 coalition, ran by the California Association of Alcohol and Drug Program Executives (CAADPE), to discuss how the 60% allocated to youth SUD should be spent. Given the diverse membership, the coalition decided to author and share with the legislature a set of guiding principles for Prop 64 funding allocation. CPCA was successful in including language to ensure that non-profits and health centers have access to this funding.

IV. Resource Section

- CPCA's Comment Letter to Go-Biz
- Proposition 64 Coalition Principals

DISCUSSION

Date: January 4, 2019
To: Government Programs Committee
From: Andie Patterson, Director of Government Affairs
Nenick Vu, Associate Director of Managed Care
Re: Medi-Cal Managed Care Update

MEMORANDUM

I. Overview

CPCA's managed care work has expanded and deepened through the 4 overarching priorities developed by the RAC during a managed care focused convening in January 2018. These priorities were identified based both on challenges presented by health centers in regards to working with managed care plans, as well as opportunities for health centers to build upon with the new Administration. Below we outline each priority as well as an update on status as appropriate to the timeframe of this memo. An overview of each priority goals, objectives and tasks can be found below in resources.

II. RAC Managed Care Priorities

Priority 1: Educating the New Administration and Leadership

The work in this priority has been focused on how to best articulate the value of CCHCs within the scope of the Medi-Cal managed care delivery system. Staff are working to find the most appropriate and compelling data, specifically looking at UDS, OSHPD, and DMHC statewide and local data. CPCA is nearing completion of its work to develop an infographic one pager. The data points cover a range of topics, including:

- Community health center market share of the assigned patient population
- PCHH certification
- Behavioral health and substance abuse disorder treatment integration
- The value of RACs in local partnerships

We also aim to create customizable templates for RACs or regions to use local data. Elements we are considering including are as follows:

- Methodology to calculate local Medi-Cal Managed Care market share
- Methodology to calculate linguistic competency of member clinics
- Comparisons of clinic quality performance in comparison to local health plan performance by county
- CPCA's data staff is preparing a CCHC utilization heat map for each of the consortia regions using UDS data. The maps will display the patient utilization of each zip code, which will help identify geographic locations with high CCHC use.

Priority 2: Commercial Plan Procurement

DHCS continues to maintain the position that the procurement of commercial health plans will continue on schedule as posted on the website. The document indicates a late 2019 or early 2020 date for the counties of Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara, Los Angeles, Riverside, San Bernardino, Sacramento, San Diego, and Imperial. We have also heard rumors and speculation that procurement will not happen any time in the near future. Regardless, the work in this priority will continue as staff enhance managed care relationships and proceed accordingly.

CPCA has contracted with Athena Chapman, formerly the VP of Government Affairs at the California Association of Health Plans to help us in this work. She will support the development of evaluation metrics for health plan relationships with CCHCs. The principles and assessment aim to be developed in Q1 and Q2 of 2019.

Priority 3: P4P, HEDIS, and Quality Alignment

While waiting for DHCS to articulate a position on P4P, CPCA has continued to develop strategies for standardizing Medi-Cal P4P measure sets. In December, CPCA and RAC leadership met with Integrated Healthcare Association (IHA) to explore industry solutions to standardize P4P measures.

The goal of the work with IHA is to standardize and advance P4P in Medi-Cal managed care. Our aim with IHA is to ensure all Medicaid plans adopt the core measure set so there is ultimately one core measure set for CA. We will continue to develop the infrastructure to achieve this goal both through work at CPCA, at IHA, and then jointly.

Priority 4: Enrollment Efficiency and Default Assignment

CPCA has commenced working to articulate the challenges with enrollment and assignment as well as solutions to resolve. In the preliminary research we have learned that the issues are complicated and there are many political interests at play be it consumers, counties, plans, and state and legal limitations. We will continue conversations with the variety of stakeholders to ascertain areas of opportunity.

III. Resources

- Priority 1: New Administration and Leadership at DHCS
- Priority 2: Commercial Plan Procurement
- Priority 3: P4P, HEDIS, and Quality Alignment
- Priority 4: Enrollment Efficiency and Default Assignment

DISCUSSION

Date: January 4, 2019
To: Government Programs Committee
From: Nenick Vu, Associate Director of Managed Care
Re: DHCS All Plan Letters

MEMORANDUM

I. Overview

All Plan Letters (APLs) provide instruction to Medi-Cal Managed Care Organizations about the changes in federal or state law and regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries. CPCA staff monitor and provide comment on draft APLs that potentially impact CHCs. Below are a list of notable APLs in the past year that CPCA has provided comment and feedback on, or is actively engaged in implementing.

II. All Plan Letters

APL 18-009 - Memorandum of Understanding for Medi-Cal Managed Care Health Plans and Regional Centers
This APL outlines the standards of MOUs made between Medi-Cal managed care plans and Mental Health Plans. CPCA submitted comments requesting that MOUs between MCPs and MHPs be publicly available to allow for increased transparency.

APL 18-014 – Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
This APL outlines the new standards of Alcohol and Behavioral Health treatment in primary care settings. CPCA submitted comments approving the use of AUDIT, AUDIT-C, or NIAAA for assessment. Changes requested include ensuring that primary care providers only should offer referrals and behavioral health counseling intervention rather than requiring it, and requesting the APL be specific as to the behavioral health providers

APL 18-018 – Diabetes Prevention Program
This APL requires Medi-Cal Managed Care Plans to provide access to the Diabetes Prevention Program (DPP) services as a member benefit for eligible patients diagnosed as pre-diabetic. CHCs are ideally positioned to implement this program, as many already provide chronic disease management programming. However, the funding stream associated with the program has not been officially recognized by DHCS as excluded from PPS reconciliation. Currently, CPCA staff are identifying health centers, RACs, and stakeholders interested in implementing this program and supporting regional engagement of health plans to discuss models and partnerships in building local programs. In addition, CPCA is awaiting DHCS' anticipated position

on the exclusion of P4P incentives from reconciliation before engaging in the advocacy to determine whether DPP payments can also be excluded.

APL 18-XXX – Informing Materials
This APL set new standards in how Managed Care informing materials are to be created. Due to the size of managed care informational materials, this APL allows for health plans to develop inserts that refer members to online materials. CPCA submitted comments requesting:

- That online materials be made accessible on mobile devices
- Managed care plans should invest in improving the digital literacy of members
- Digital materials should have query and search functions, particularly for the provider directory
- Provider directories should be regularly updated to show if providers are accepting new patients
- A stakeholder review process should exist to give feedback on online materials
- Informing materials should be publicly available

APL 18-XXX – *Drug Rebates*
Updates can be found in the 340B section of the board memo.

APL 18-XXX – *Provider Credentialing/Recredentialing and Screening/Enrollment*
This APL is to further clarify standards and processes for managed care plans screening and enrollment of providers.

DISCUSSION

Date: January 15, 2019

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst; Emily Shipman, Senior Program Coordinator

Re: Licensing & OSHPD 3 Update

MEMORANDUM

I. Background

California's primary care clinic licensing process, which includes OSHPD 3 building requirements, continues to pose delays and challenges to providers seeking to establish new points of access and update existing sites. Delays in processing applications and changes, unclear requirements, and inflexible building standards threaten patients' access to care and providers' sustainability while providing little benefit to either. CPCA staff continue to work on a number of initiatives related to demonstrating the brokenness of this system and working to repair or replace it.

II. Updates

Licensing and OSHPD 3 Research Project

CPCA's research project led by Bobbie Wunsch at Pacific Health Consulting Group (PCHG) has continued according to schedule, with the PHCG team focused on documenting the history and rationale behind the disparate regulation of California's primary care providers. The research thus far has included comparisons of licensing models for primary care clinics in other states as well as looking at quality measures for clinics who are unlicensed versus licensed.

The team has established a timeline of how our current licensure process came to be, as well as a breakdown of requirements across primary care provider types and is currently working to investigate whether and how clinic building standards impact patient safety and/or quality of care.

We are still on track to finalize the project by summer 2019, including presenting findings and recommendations to the Board. Our goal is to use these independent findings as the basis for legislative action and/or formal legislative inquiry that could exempt clinics from standards that limit access to care with no clear benefits.

Legislative Updates

- **2018 Licensing Bills:**
    - AB 2428 was signed by the Governor and went into effect 1/1/19. This bill provides the options for consolidated licensed sites to be reimbursed via a shared PPS rate with a parent site or by setting an individual rate.
    - AB 2204 was signed by the Governor and took effect 1/1/19. This bill increased intermittent clinics weekly hours of operation from 30 maximum per week up to 40.
- **2019 Licensing Legislation Concept:** CPCA staff, at the direction of the board and the Licensing and OSHPD 3 workgroup (LOWG), have explored a provisional license concept.
    - Following feedback by LOWG and our outside counsel, staff propose that we sponsor legislation which would remove barriers for clinics to use intermittent sites as a stepping stone to full licensure.
    - The goal of the bill is to streamline the full licensure process by removing barriers which inhibit the establishment of an intermittent site in the case that a full licensure application will be submitted. Currently intermittent sites must separately enroll in and notify numerous departments as part of the intermittent site operation.
    - At time of writing, staff is working with outside counsel on drafting legislative language.

1206(g) Licensure Exemption

The 1206(g) licensure exemption that allows a clinic affiliated with an institute of learning that teaches a healing art to opt out of State licensure, including OSHPD 3 (this is a site-specific exemption, not organization-wide).

Staff have continued to work with two health centers who initially volunteered to be the first health center to utilize this exemption. Unfortunately, at this time, neither health center is currently able to move forward. This exemption is part of CPCA's multi-pronged strategy to demonstrate that license-exempt, non-OSHPD 3, sites do not fall short of safety and other standards as compared to their licensed counterparts.

Staff have begun reaching out to additional health centers to determine if there is any additional interest in this exemption. If you are interested in this process, please contact Michael Helmick at mhelmick@cpca.org.

Triennial Building Code Cycle:

OSHPD is currently in the middle of their 3-year code cycle. In their most recent proposed changes staff was concerned with one amendment that we thought lacked basis or a clear understanding of the potential implications. Following conversations between CPCA, OSHPD, and CDPH CPCA staff drafted a comment letter and requested additional health center advocacy. However, OSHPD staff decided to move forward with the proposed regulation regardless of the concerns expressed in our letter.

Staff is currently reviewing our options for challenging the regulation with the Office of Administrative Law. Staff has also shared our letter with legislative staff who expressed concerns with OSHPD's lack of attention to our concerns.

Additionally, CPCA met with Senate and Assembly Appropriations staff in December to discuss challenges related OSHPD building requirements and was informed that many in the Capitol are hearing of these challenges from licensed providers across the board, including health centers. CPCA shared with them our concerns and the information that we have received from our members.

There appears to be growing interest in an approach that would allow greater flexibility and/or waivers for providers who are challenged by building standards. Staff will be providing the legislative staff with additional information to help them better understand how OSHPD 3 impacts our member health center's ability to increase access to care for their patients.

California Building Standards Commission (BSC) Composition
Staff was recently informed that Governor Newsom has decided to re-appoint the two commissioners who formerly filled the two vacant seats. However, there are additional vacancies upcoming in 2019 and staff will work with health center members and our partners to ensure health center friendly candidates apply.

California Primary Care Association

Information

Date: January 15, 2019
To: Government Programs Committee
From: Allie Budenz, Associate Director of Quality Improvement
Re: Health Homes Program Update

MEMORANDUM

I. ACA Section 2703 Health Homes Program

As of January 1, 2019, Health Homes for Patients with Complex Needs (HHP) has been implemented for members with eligible chronic physical conditions and substance use disorders in San Francisco, Riverside, and San Bernardino counties. San Francisco County will begin implementation for members with serious mental illness on January 1, 2019. HHP is expected to be fully implemented across 29 counties by January 2020, and will provide services in the following core areas: comprehensive care management; care coordination (physical health, behavioral health, community-based long-term services and supports); health promotion; comprehensive transitional care; individual and family support; and referral to community-based and social support services.

Since the last update to this committee, staff responded to the Department of Health Care Services' Draft Evaluation Design for the Health Homes Program. CPCA staff have also been tracking implementation in San Francisco county and ongoing preparation happening in group 2 and 3 counties. CPCA continues reiterating to DHCS and Harbage Consulting the concerns we hear from CHC CB-CMEs in an attempt to inform the agenda for the state's health plan learning cohort. Our goal is to try and create as much consistently across approaches as possible so we maximize the lessons learned and expend resources wisely.

II. Plan and Provider Reaction

CPCA staff have identified several areas for CHC CB-CMEs (or potential CB-CMEs), to be aware of as they negotiate their contracts and plan for implementation. Staff are in communication with the State implementation team and feeding these concerns to them.

1) **Lack of assessment and care plan standardization**. The only standardized data elements across the HHP are quality, operational reporting, and encounter metrics. There is no standardized template for CB-CME's to assess member need or create required Health Action Plans. The lack of uniform guidance opens the potential for varying data collection processes and differing measures across plans. Without consistency among HAP, CB-CME's may have to use multiple HAP formats and report on different indicators. This is a workflow challenge and reduces the likelihood a HAP will be incorporated into the electronic record. On an optimistic note, some counties have launched an organized pre-planning effort to coordinate among plans to reduce discrepancies in approach.

2) **Situations when CB-CME does not have historical data for HHP members.** It is possible that a CHC may be assigned a member to their CB-CME that they have not seen (either because the patient was never assigned to them or did not establish care). In this case the CB-CME would not have historical diagnosis data, making it difficult to establish a HAP specific to their chronic condition. CHCs should bring this situation to the attention of their plans and work to establish a process for getting historical data, when available. Additionally, health centers should consider how they will incorporate a care team with a licensed PCP (to assess and diagnosis) into the HHP team and workflow.

3) **Outreach and engagement takes time.** CB-CMEs are receiving eligibility lists from their plans and are starting outreach, but the process of engaging and enrolling members is taking much longer than expected. Incorrect contact information remains a problem, exacerbated by the fact that the HHP targets people with inconsistent or nonexistent housing, who are inherently difficult to reach. It can take several touches (we've heard approximately 5-6) before a patient is enrolled in care management. Given that the HHP program must demonstrate clinical effectiveness and financial efficiencies in a short two years, it is worrisome that much of that time may be spent on simply enrolling a person.

4) **Payments may decrease in years 2 and 3.** Several potential CB-CMEs we've spoken with have noted that their health plan intends to drastically reduce rates in years 2 and 3 for all patients, including newly enrolled HHP beneficiaries. The state's perspective on rates is that each group is guaranteed 8 quarters of enhanced federal match. Any decisions about whether to keep the benefit will hang on the evaluation findings, which are iterative. CPCA has not taken a position on rates and believe it is more appropriate for the plans to push back on the state.

It is important to note that plans have a lot of discretion with how they choose to implement HHP and each plan may take a different approach. The following are common questions CPCA has fielded about HHP roll-out:

1) **IPAs**: Health plans may contract with an IPA to subcontract with clinics; or they may contract directly with clinics; or they may do both.

2) **Capacity building grants**: Some plans have provided a start-up grant to CB-CME's to hire and onboard Care Coordinators and establish the necessary infrastructure changes. In conversations with providers, we found that a significant driver of successes is the training and institutional support provided for care managers.

3) **Training**: Managed Care Plans are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the program. DHCS (via Harbage Consulting) will provide webinar based training that will fulfill the core components (which include HHP Overview, Health Action Plan, Coordination, and Care Transitions within the Health Homes Program, and Community Resources and Referrals). Plans must follow the required high-level trainings with more specific HHP operational training for CB-CMEs that includes MCP-specific information on operations, workflows, data reporting, and other implementation issues.

   CPCA has reviewed the required trainings and provided feedback to Harbage Consulting. The trainings are extremely high level and do not address the *how* of care management. HHP will only be successful if CB-CMEs are well-prepared and resourced to offer this intensive service. To fill this training gap, in February and March, CPCA is hosting a three-part web-based training and peer learning series for CHCs interested in contracting as CB-CMEs. The webinars also seek to offer health centers practice workflows policies, procedures, and business/operational plans that have been tested and are currently active within health center care management programs. Resources presented during the presentations, such as sample policies and procedures, will be compiled and shared with health centers at the end of the series.

III. Resources

- DHCS Medi-Cal Health Homes Program Guide: https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Program_Guide-Final_6-28-18_Clean.pdf
- CPCA Health Homes Program Training for Community Health Centers
  - Part 1 (Feb 12) https://www.cpca.org/CPCA/CPCA/Training_Events/Event_Display.aspx?EventKey=1WL021219

- Part 2 (Feb 26) https://www.cpca.org/CPCA/CPCA/Training_Events/Event_Display.aspx?EventKey=1WL022619
- Part 3 (Mar 12) https://www.cpca.org/CPCA/CPCA/Training_Events/Event_Display.aspx?EventKey=1WL031219

California Primary Care ASSOCIATION

DISCUSSION

Date: January 3, 2019
To: Government Programs Committee
From: Andie Patterson, Director of Government Affairs
Re: Federal Regulatory Changes

MEMORANDUM

- Overview

The Trump Administration has released several proposed rules related to Medicaid and the Affordable Care Act (ACA) in the third quarter of 2018. Both NACHC and CPCA are closely tracking these proposed changes to monitor potential impact to CHCs and our patients related to access, quality of care, reimbursement, and coverage.

CPCA often submits comments on federal proposed regulations in support of points raised by NACHC. In addition, CPCA reviews proposed rules to determine whether there are specific impacts to California to include in our comments. In some cases, summaries of proposed rules will be disseminated to CPCA members and feedback requested. CPCA's final comments to the federal agency are published in the CPCA Weekly Update.

- Recent Proposed Regulatory Changes

A. Proposed Rule on Exchange Program Integrity

On November 7, 2018, the Department of Health and Human Services (HHS) issued a proposed rule on exchange program integrity. The proposed rule is largely technical in nature and focuses primarily on exchange and subsidy eligibility. However, HHS proposes significant changes to the way that insurers and consumers must offer and pay for abortion services in qualified health plans (QHPs) under the ACA, which intersects with California law. A summary of the proposed rule is linked in the *resources* section below. **CPCA will submit comments on the proposed rule based on member feedback before the deadline of January 8, 2019.**

B. Proposed Rule on Medicaid and CHIP Managed Care

On November 14, 2018, the Trump administration published its long-anticipated proposed modifications to Medicaid managed care regulations issued by the Obama Administration in 2016. The proposed rule revises, rather than replaces, the existing regulatory framework, and appears aimed at limiting federal financial exposure to the cost of Medicaid managed care and curtailing certain beneficiary safeguards, most of which are

backfilled by the state of California. It is unlikely that the changes proposed in this rule will have any impact on California consumers or the Medi-Cal system. A summary of the rule is included in the *resources* section below. **As the rule is unlikely to impact California CHCs or our patients, CPCA will be following the NACHC comments to support the Medicaid more broadly and to support our national association.** The comment deadline is January 14, 2019.

- Resources

- Summary of Proposed Rule on Exchange Program Integrity
- Summary of Proposed Rule on Medicaid and CHIP Managed Care

December 19, 2018

Don Rucker, M.D.
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Stree SW, Floor 7
Washington, DC 20201

Re: Comments Regarding Draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*

Dear Dr. Rucker,
On behalf of California's more than 1,300 California community health centers (CHCs) and 6.9 million patients that we serve, The California Primary Care Association (CPCA) thanks you for the opportunity to comment on the Draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.* California Community Health centers are uniquely positioned to comment on this proposed strategy since they are using the EHR to provide more than 22 million patient encounters to over 6 million patients each year. CHC's rely on the EHR to provide care to underserved communities and they have valuable experience and knowledge that can help guide the recommendations of reducing the burden on use of the EHR.

The draft identifies three overarching areas to enhance the use while reducing the burden to health care providers and staff in using the EHR. CPCA shares the goal of reducing the EHR administrative and regulatory burden of health center physician and clinical staff. We offer the following recommendations to achieve this goal.

Clinical Documentation: *In order to limit the amount of physician burden and hence increase the patient experience, it is proposed that EHR's be revamped by streamlining and standardizing documentation and reporting.*	
	Comments
Reduce regulatory burden around documentation requirements for patient visits.	Health centers will benefit from the streamlining and reduction of evaluation and management visit codes. In addition, CPCA agrees that there should be a reduction in redundant documentation. **CPCA recommends that community health centers are included in current and future stakeholder input convening's in order to complement current provider workflows.**
Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.	The patient chart in the electronic health record could sometimes be overloaded with extraneous information. Patients chart should be useful and helpful to the provider and patient. **CPCA recommends that health centers are given the ability to determine what limitations they want to set in their EHR based on their needs (i.e. limiting the use of "copy and paste").**

Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	Health centers have increased burden in documenting services with prior authorization. CPCA supports HHS to evaluate and identify standardization in documentation requirements for services with prior authorization. **CPCA recommends that community health center staff are active participants in testing the new approaches when they have come to fruition.**

Health IT Usability and the User Experience: In order to decrease the burden of the end user, there should be increase communication between HIT developers and end users to develop an EHR that is accepted by both parties.	
	Comments
Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.	CPCA agrees that there should be increased communication between HIT developers (EHR vendors) to ensure that there is alignment between provider workflow and the EHR.
Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	As providers may switch between using different systems, it is recommended that there be similar common approaches embedded in the EHR to minimize confusion. CPCA agrees that there should be limited opportunity for clinical operations and HIT developers for customization so as to increase standardization.
Promote harmonization surrounding clinical content contained in health IT to reduce burden.	CPCA agrees that there should be increased standardization around medication, order entry, and display of results.
Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	CPCA agrees that end-users should be considered when deploying HIT systems. This will overall increase the user satisfaction and reduce burden.

EHR and Public Health Reporting: Effectively standardizing and harmonizing reporting measurements in order to ease the reporting requirement burden.	
EHR Reporting	**Comments**
Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Measures will be simplified and new scoring methodology will be introduced. CPCA believes that measure simplification is important to achieve, additionally, **we recommend that the measures be aligned with those that are pertinent to the health center's community**.
Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.	CPCA agrees.
Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.	CPCA agrees. **CPCA recommends that health centers be given ample time and opportunity to learn and be trained on the measures.**
Public Health Reporting	
Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.	**CPCA recommends that continuous sharing of best practices be achieved as this helps health centers understand what others are doing and how to make the HIT/EHR successful.**

Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.	**CPCA recommends that California's community health centers be involved with stakeholder input in developing an inventory and harmonizing reporting requirements.**

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Lucy Moreno by telephone at (916) 440-8170 or lmoreno@cpca.org if you have any questions or comment or if you require any clarification on the comments presented herein.