Government Programs Committee

Tuesday, October 10, 2017
11:00pm – 12:30pm

Isabel Becerra, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Isabel Becerra	A
II. Approval of Agenda	• Executive Summary	Isabel Becerra	A
III. Approval of Minutes	• July Meeting Minutes	Isabel Becerra	A
IV. 340B	• 340B Memo • NACHC 340B Federal Update	Andie Patterson	D
V. Licensing	• Licensing Memo	Emily Shipman Ginger Smith	I
VI. OSHPD 3	• OSHPD 3 Memo	Andie Patterson Michael Helmick	A
VII. Managed Care	• Managed Care Update o Unseen Patients o Procurement o Mergers	Meaghan McCamman Nenick Vu	D
VIII. Behavioral Health	• BH Update Memo	Liz Oseguera Michael Helmick Allie Budenz	D
IX. Pharmacy & Adult Immunizations	• Pharmacy & Adult Immunizations Update	Meaghan McCamman Allie Budenz	D
X. Lifeline Grant Program	• Grant Program Memo	Beth Malinowski	D
XI. Immigration Update	• Immigration Memo	Liz Oseguera	I
XII. 2703 PCHH	• 2703 PCHH memo	Allie Budenz	I
XIII. Oral Health	• Oral Health Memo	Beth Malinowski Emili Labass	I
XIV. Adjourn		Isabel Becerra	A

California Primary Care Association

Executive Summary

Date: October 10, 2017
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy

MEMORANDUM

340B

- CPCA met with DHCS staff on how to develop a 340B reporting process for covered entities that utilize contract pharmacies in Medi-Cal managed care.
- The state remains concerned that there is no value to the state to allow contract pharmacies in 340B.
- CPCA is engaging legal counsel to better understand DHCS' assertions regarding the 340B program.

Licensing

- CPCA met with Licensing & Certification leadership in September to go over process improvements related to licensing application checklists, backlog within the Centralized Applications Unit, and licensing process challenges.
- Through this meeting, CPCA successfully established the prioritization of clinic applications and immediate assignment of affiliate and consolidated applications to analysts for processing.
- CPCA will weigh in on the drafted application checklists from L&C with a release date goal of end of October. CPCA & L&C will partner to offer training on licensing processes for clinics.
- L&C will begin posting backlog metrics publically to help track current status and impact of improvement efforts, likely within the next month.

OSHPD 3

- Staff have conducted a legal, regulatory and legislative analysis of OSHPD3 and ascertain there is no quick and easy way to exempt health centers from OSHPD 3 requirements
- Staff have however outlined a multi-pronged approach to help alleviate the challenges of OSHPD 3, all of which help to lay the ground work for a future legislative attempt to exempt health centers

Managed Care

- CPCA's Unseen Patients Workgroup is currently tracking several managed care plan pilots, and is evaluating several policy strategies, each of which could potentially impact a portion of the unseen patient population.
- CPCA is tracking the DHCS commercial Medi-Cal procurement, and is reaching out to each of the impacted health plans to understand their strategy for the procurement and leverage their incentive to improve quality and data reporting.

- CPCA is tracking the investments made as a result of the recent managed care mergers. Opportunities for low-cost loans will be available soon.

Behavioral Health

- CPCA and CaliforniaHealth+ Advocates have developed a three-pronged approach to meeting our behavioral health goal of supporting CCHCs in providing the behavioral health services needed by their communities
- The approach includes 1) removing regulatory barriers, 2) expanding access to resources, and 3) ensuring health centers are included in all policy discussions.
- This memo provides an update on our full workplan

Pharmacy and Adult Immunizations

- CPCA will facilitate a short conversation around barriers to FQHCs providing high-cost injectable medications such as Vivitrol and adult immunizations.

Lifeline Grant Program

- The Budget Act of 2017 established the Community Clinic Lifeline Grant Program (Lifeline Program) within the California State Treasurer's Health Facilities Financing Authority (CHFFA) for small and rural health clinics suffering financial losses.
- CHFFA is responsible for developing additional selection criteria and a process for awarding the grants, which may not exceed $250,000 per health facility site.
- Since the enactment of the Budget Act of 2017, CHFFA staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. CPCA is in ongoing communication with CHFFA staff and leadership.
- CPCA is seeking additional member feedback on a variety of implementation areas – maximum awards; eligibility criteria; evaluation criteria; eligible use of grant funds; funding distribution; and emergency regulation triggers.

Immigration Update

- On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program via a "phase out."
- During Legislative Committee we will be voting on a number of federal bills related to immigration. Specifically we are asking members to take:
    - A support position on the Dream Act, which would provide young immigrants, including DACA recipients, to have a clear path to citizenship.
    - Oppose position on the RAISE Act, which would radically reduce legal immigration to the United States.
    - Oppose position on the SUCCEED Act, which would force immigrant youth to wait 15 years to be provided an opportunity to apply for citizenship.

2703 PCHH Update

- DHCS communicated that Health Homes for Patients with Complex Needs will begin in phase 1 counties in July 2018.

- Pilot must be cost neutral or yield savings within two years in order to keep the health homes benefit into perpetuity.
- CPCA leading effort to convene small workgroup of plans and providers to discuss how to best coordinate the execution and delivery of successful pilot.

Oral Health

- CPCA recently participated in the first meeting of the new Medicaid|Medicare|CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing's FQHC Dental Policy Workgroup, a workgroup designed to find national solutions for dental audits and other challenges impacting oral health access for the underserved.

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
July 13, 2017
12:30pm – 2:00pm

Members: Isabel Becerra – Chair, Antonio Alatorre, Tanir Ami, Alex Armstrong, Linda Costa, Lucinda Bazile, Doreen Bradshaw, Trisha Cooke, Irma Cota, Lynn Dorroh-Watson, Reymundo Espinoza, Rachel Farrell, Benjamin Flores, Cathy Frey, Jane Garcia, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Haleh Hatami, Virginia Hedrick, Kerry Hydash, Cathryn Hyde, Tina Jagtiani, Deena Lahn, David Lavine, Deborah Lerner, Marty Lynch, Alicia Mardini, Kevin Mattson, Louise McCarthy, Scott McFarland, Leslie McGowan, Danielle Myers, Christine Noguera, Justin Preas, Carole Press, Tim Pusateri, Tracy Ream, Tim Rine, Melinda Rivera, Corinne Sanchez, Suzie Shupe, Paulo Soares, Graciela Soto-Perez, Terri Lee Stratton, Vernita Todd, Henry Tuttle, Christina Velasco, Terri Vise, David Vliet, Paula Wilson

Guests: Jason Vega, Anitha Mullangi, Jennifer Hunter, Susie Foster, Sergio Bautista, Jill Damian, Esen Kurdoglu, Maria Paz

Staff: Carmela Castellano-Garcia, Andie Patterson, Meaghan McCamman, Daisy Po'oi, Mike Witte, Allie Budenz, Emily Shipman, Nenick Vu, Ginger Smith, Val Sheehan

I. Call to Order
Isabel Becerra, Committee Chair, called the meeting to order at 12:32pm.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (K. Mattson, N. Gupta)**

III. Approval of Minutes
A motion was made to approve the minutes of January 12th, 2017. **The motion carried. (T. Rine, S. McFarland)**

IV. Medi-Cal Managed Care Procurement
DHCS has announced plans to re-procure all Medi-Cal Managed Care Commercial plan contracts in 2019/2020. This will affect at least one plan in every county except COHS counties. In procuring all new contracts, DHCS has indicated they will seek to improve the quality of the Medi-Cal managed care program.

V. Assigned but Unseen Patients
With the growth of the Medi-Cal program, the problem of assigned patients who do not ever seek care at their assigned PCP is growing. Not only are assigned but unseen patients dragging down HEDIS scores, but in some cases FQHCs are having to reconcile their managed care capitation. CPCA is launching a workgroup to explore solutions to this issue.

VI. Licensing & OSHPD3
CPCA asks the committee to evaluate options for streamlining and improving the current licensing process. CPCA has released both the licensing and OSHPD 3 surveys to inform our strategy in both areas. CPCA is working with Deborah Rotenberg, Consultant, on the issues stated in the survey. The results of the survey will be shared with this group in advance of the October board meeting. The committee would like CPCA to put together a written plan of action and timeline of when these issues will be addressed and with whom.

VII. 340B
The Governor is expected to sign a state budget that does not include the 340B proposal. CPCA staff will be working with DHCS and other stakeholders to create a process where health centers can continue to use contract pharmacies in 340B.

VIII. Behavioral Health

DHCS is awarding 15 grants to implement the Hub and Spoke services, with particular attention to rural counties. CHCs are ideal partners to serve as outpatient "spokes" in this model because of their integrated medical/behavioral approach to medication assisted treatment. CHCs can sign on after the grants are awarded. CPCA is working with a coalition to thoughtfully build consensus around the use of Prop 64 dollars. This committee will discuss proposed principles and priorities for CPCA to bring to the coalition.

According to the Draft Program Guidelines released by the Department of Housing and Community Development, counties applying for funding under NPLH are required to submit a supportive services plan listing the services that will be provided to tenants. CPCA has been successful in ensuring that as part of these services, counties must include linkage to physical healthcare. In May CPCA submitted a comment letter providing recommendations on how HCD could improve the supportive services offered to tenants benefitting from NPLH.

Under MHSA, counties who do not spend portions of their MHSA funding within three years are required to revert those funds back to the state. Unfortunately this has not been occurring. Thus the OAC has put forth recommendation to ensure counties are reverting unused funds back to the state. The OAC has created a subcommittee that is tasked with revising its PEI and Innovation regulations to accommodate the needs of very tiny counties (counties with a population of 50,000 or less).

IX. Immigration Update

CPCA has been leading the effort in collaborated with other state PCA's, NACHC, and immigration partners, such as the Nation Immigration Law Center (NILC), to develop an FAQ that provides a detail review on what health centers can do to prepare themselves and their patients for an ICE raid. An Immigration workgroup was created in CPCA to provide members updates on the immigration work we are undertaking and receive input from members on resources, trainings and other technical assistance developed by CPCA. CPCA is planning to host trainings in the summer to provide health centers with guidance on how to protect patients, staff and the health center itself from immigration enforcement. CPCA in coordination with the NWPCA is working to finalize the Policy and Procedures.

IX. Adjourn

The meeting was adjourned at 1:59pm. **The motion carried. (L. McCarthy, N. Gupta)**

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

DISCUSSION

Date: September 25, 2017

To: Government Programs Committee

From: Andie Patterson, Director of Government Affairs

Re: 340B Update

MEMORANDUM

I. State Budget Proposal

The passed FY 17-18 budget includes no changes to contract pharmacies or other provisions relating to the 340B Program. Neither the Governor's May Revised 2017 Budget proposal that would have eliminated the use of contract pharmacies in managed care 340B nor the Governor's January proposal to eliminate 340B savings in managed care, made it into the final budget deal. Despite losing the budget proposal, DHCS remains concerned that health plans and covered entities are not appropriately reporting 340B drug claims, thus putting the state at risk of duplicate discounts and impairing their ability to secure drug rebates.

II. Meeting with the State

CPCA along with the California Hospital Association and the California Association of Public Hospitals met with DHCS to continue discussions in mid-September. The stakeholders' purpose for the meeting was to begin negotiations on a process that can achieve both the covered entity objective to continue using contract pharmacies in 340B managed care as well as the state's objective to avoid duplicate discounts. Prioritizing these conversations now will allow stakeholders to be prepared when the legislature returns in January 2018. In particular, if deemed necessary, CaliforniaHealth+ Advocates, working with other stakeholders, may proactively introduce legislation to address this matter.

A. Challenges for the State

The state started off the meeting by sharing that they are in the "same place as before," or, in other words, are not comfortable with contract pharmacy arrangements. Their argument for not liking contract pharmacies is multi-fold:

1. It brings no value to the state, just the providers (i.e. no general fund savings).
2. They can't track the claims well.
3. They can't control the program.
4. There is great liability on them for misreporting.

The state is, unsurprisingly, not moved by the "value" health centers or hospitals put back into the delivery system from their 340B savings. The additional services to patients is not a winning argument for them. In their estimation they should be receiving Medi-Cal drug rebates to the

general fund instead of covered entities receiving 340B savings. They are concerned that they are liable for paying back millions of dollars if they unknowingly submit a batch of claims for a Medi-Cal drug rebate where even just one claim was actually a drug purchased at 340B prices but was not coded as such. In these circumstances, according to the state, they have to pay back the full amount of the rebate received from the batch submitted to the manufacturer, not just the one claim. Further, they allege that drug manufacturers are allowed to contest Medi-Cal drug rebate claims back to the start of the 340B program in 1992 so the liability on the state is tremendous.

B. 340B Rules

Part of the reason they cannot track claims is because the state has not created the rules to do so. CPCA raised the challenge covered entities face by the lack of rules provided by the state, to which the state contends there are rules. The state is arguing that the FFS rules on 340B also apply to managed care because they are for the Medicaid program writ large. It is their contention that covered entities in FFS are appropriately following the rules but not covered entities in managed care. The state also argued that there are rules for covered entities and HRSA has made them clear.

HRSA issued a notice in the Federal Register in March 2010 that states:

> (i) Neither party will use drugs purchased under section 340B to dispense Medicaid prescriptions, unless the covered entity, the contract pharmacy and the State Medicaid agency have established an arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the OPA, HRSA, by the covered entity.

C. Approved Models

According to DHCS, the only such approved arrangement is the Partnership Health Plan model. No other contract pharmacy arrangements have been approved and thus are not technically allowed. They acknowledge that they have not set the rules by which approval is done, but contend no other plan or covered entity has reached out for approval. Further, while Partnership Health Plan is the only model they have approved, they cautioned not to use it as a model, insinuating the arrangement could be terminated.

In the Partnership model, the health plan submits claims, including 340B coded claims, every four weeks. In their arrangement a patient goes to Walgreens, for example, and purchases a drug. Walgreens submits a claim to the pharmacy benefits manager (PBM) on behalf of the health plan who then sends it to a third party administrator (TPA) that "matches" health plan data (payments) and pharmacy data (drugs bought at 340b) on a monthly basis. The PBM ultimately aggregates the claims and provides them to the plan who submits to the state. The state then submits quarterly for drug rebates, excluding the Partnership 340B coded claims.

D. Reporting

When the stakeholders questioned the state's allowance for in-house pharmacy arrangements, the state argued the rationale was because in-house pharmacies can do point of sale reporting. Most, if not all, contract pharmacy models involve retrospective 340B claims. The reason for this is the pharmacy is not able to tell if the individual picking up a prescription is 340B eligible or not. This tracking must be done retrospectively. The Partnership model presents a methodology where retrospective reporting is done and still protects the state. It is not clear to us why point of sale reporting is desired by the state if they only submit for drug rebates quarterly.

III. Next Steps

The meeting was a success in terms of having an honest conversation and hearing all the elements of the DHCS argument. We left the meeting having made the case that we are valuable partners at the table to create a strong reporting program that will allow contract pharmacies. The state agreed to circle back with the stakeholders after further internal discussions.

DHCS made a number of assertions that require additional research. CPCA has sought legal guidance on a number of them including:

1. Does the FFS SPA for 340B apply to Medi-Cal managed care?
2. Is the law clear that the state must approve an arrangement in order for contract pharmacies to be used for 340B?
3. If so, is there financial exposure for health centers who are or have been utilizing contract pharmacies in the 340B program?

We recognize the questions and the information is of utmost importance and we will be providing the information as quickly as possible.

Additionally, while the state insinuated that the Partnership Health Plan model was not the example to follow, we note that it has been approved, claims are appropriately coded, and it does allow the state to appropriately seek the drug rebates. We will continue exploring this and other models that provide the same protection to covered entities and the state.

CPCA is currently engaging with a wide variety of stakeholders, including many of the statewide associations that united together earlier in 2017 to push back on the administration's budget proposals. In addition to continuing our work with CHA and CAPH, we are also engaging with 340b venders and contract pharmacies (Walgreens), Apexus, NACHC and other PCA partners for technical assistance and problem solving.

340B Federal Policy Update

As of 8/4/2017
Developed by NACHC

340B on the Hill: While Congress was consumed with repeal and replace for the majority of the past several months, we continue to hear conversations around 340B on the Hill. Specifically:

- House Committee leadership expresses concerns re: program management and audits. In early June, leadership of the House Energy and Commerce Committee wrote a letter to HRSA expressing concerns around 340B program management and requesting information related to audits. Specifically, the letter expressed concerns around the recent growth of the program without additional oversight, the lack of reporting around how savings from the program are used, auditing processes, and concerns related to diversion and duplicate discounts. HRSA submitted the requested information to the Committee just prior to the hearing (see below.)

- House Subcommittee holds oversight hearing: On Tuesday, July 18th, the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing which focused on HRSA's oversight of the 340B program. Witnesses included a representative from HRSA's Office of Pharmacy Affairs (OPA), which oversees the 340B program, along with representatives from HHS OIG and GAO, both of whom have made recommendations to HRSA about potential areas for improvement within the program.

  Overall, throughout the hearing there was broad, bipartisan support for the mission of the 340B program and its commitment to allowing covered entities to stretch scarce federal dollars to provide care to vulnerable populations. However, both the subcommittee and the panel of witnesses expressed general concern over the lack of program transparency and the need for additional oversight. In particular, concerns were raised around:
    - the lack of requirements for covered entities – especially hospitals – to report how they use 340B savings,
    - the definition of an eligible patient and
    - whether HRSA should be given more regulatory authority.

  The issue of rising drug costs was also addressed several times, with members noting that increased transparency in drug pricing is critical to controlling drug prices overall. A handful of Democratic committee members stressed that the recent CMS proposed rule, which would reduce Medicare Part B drug reimbursement for hospitals participating in 340B, would significantly reduce support for the program. (See a description of this proposal below.)
  In advance of the hearing, NACHC submitted a statement for the record (also attached to this email.)
- NACHC staff meet with staff from House Subcommittee**:** The day after the hearing, NACHC staff met with staff from the E&C Oversight and Investigations Subcommittee to provide them with information about the importance of the 340B program to health centers, including examples of how health centers use 340B savings to benefit their entire patient population.

Leaked, draft Executive Order (EO) on drug pricing appears to target multiple contract pharmacy arrangements: In late June, a draft version of a potential EO on drug pricing was leaked to the press. This draft EO specifically mentioned 340B, calling on HRSA to ensure that 340B savings "primarily

benefit the lower income or otherwise vulnerable Americans for which the program was intended" and to revise or rescind policies that allow benefits to accrue to "entities other than the safety net healthcare providers". This latter language has been interpreted as directing HRSA to rescind its policy permitting FQHCs and other 340B providers to contract with more than one contract pharmacy. While such a policy change would be very concerning, it is important to note that the draft EO has not been signed, and could be significantly revised before being signed.

PCAs continue working to protect FQHCs' ability to retain 340B savings on Medicaid managed care drugs; two PCAs discuss their success to date. The requirement that Medicaid reimburse no more than the ceiling price for *fee-for-service* drugs purchased under 340B became effective on April 1, with state plans due to CMS not later than June 30. While there is no requirement that state Medicaid agencies take the 340B savings for drugs reimbursed under *managed care*, many states are seeking to do so. Both California and Ohio have had some success in pushing back on these efforts, and spoke about their experiences at the recent 340B conference. Their slides are attached to this email.

HRSA expected to launch ceiling price database very soon: HRSA is expected to launch the long-awaited Ceiling Price Database this fall. Since the inception of the 340B program in 1992, there has been no universal, reliable way for providers to determine if they are being charged the correct amount for a 340B drug. The database will address this concern, by creating a central location where manufacturers, providers, state Medicaid agencies, and HRSA can view and verify 340B ceiling prices.

Fines on manufacturers who overcharge provider scheduled to start on October 1, 2017: After two delays by the Trump Administration, on October 1, 2017, HRSA is scheduled to receive authority to fine manufacturers who "knowingly and intentionally" overcharge providers for 340B drugs. These fines are officially known as "Civil Monetary Penalties" or CMPs.

Medicare seeks to reign in what it sees as abuses by 340B hospitals: Earlier this month, CMS proposed a regulation outlining how hospital outpatient departments will be reimbursed in 2018. One of their proposals would significantly reduce how much 340B-eligible hospitals are reimbursed for drugs that they purchase under 340B, eliminating much of the 340B savings that these hospitals accrue on their Medicare patients. Note that this proposal:

- does not impact FQHCs. (It's limited to hospital outpatient departments)
- will not save CMS money. While CMS estimates that the proposal will reduce drug payments to 340B hospitals by as much as $900 million, all these savings will be used to increase other types of payments. This suggests that CMS' goal is not cost-savings, but rather to correct what they consider to be abuses caused by the 340B program.

Over 300 health center staff attend 340B Summer Conference in DC; NACHC hosts three FQHC-specific sessions From July 10 -12, over 300 health center representatives came to DC to attend the 340B Coalition's Summer 2017 conference. (The Coalition consists of groups representing 340B providers, including hospitals, HIV/AIDS clinics, and health centers. NACHC is an active member.) Sessions covered a range of issues, including compliance, the loss of 340B revenues to Medicaid and private insurers, and potential efforts to limit the use of contract pharmacies. During the Opening Plenary, NACHC staff spoke about the importance of 340B to health centers and their patients. NACHC then hosted three sessions for health center participants, addressing: general policy updates; developing an in-house pharmacy; and reimbursement issues. In addition, both the California and Ohio PCAs discussed their efforts to push back the states' efforts to limit their ability to retain 340B savings under Medicaid. (See discussion above, and attached slides.)

California Primary Care ASSOCIATION

INFORMATIONAL

Date: October 10, 2017

To: Government Programs Committee

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

Re: Licensing

MEMORANDUM

I. Background

Since the consolidation of licensing applications from the local L&C offices to the Centralized Applications Unit (CAU) beginning in 2015, the timeline for approval of licensing applications has grown significantly. The latest word from Licensing & Certification is that they have a backlog of at least 3 months. Both the consolidation and application accuracy issues are compounding the delays for health centers.

In response to those challenges, CPCA formed a Licensing Workgroup to identify problem areas, facilitate ongoing dialog with the California Department of Public Health (CDPH), and support reforms. We expanded the staff and contractors involved in this issue to include Deborah Rotenberg, formerly with the Planned Parenthood Affiliates of California and now operating in private practice, to assist in strategizing and pushing our licensing work forward.

II. Licensing Strategy Update

As discussed during the last Government Programs Committee meeting, CPCA has pursued an aggressive administrative strategy to help push licensing process improvements forward:

A. Meeting with L&C Leadership: CPCA met with leadership from the Licensing & Certification division at the end of September to raise our outstanding concerns on the current status of licensing and challenges in working with CAU. Our meeting focused on sharing the compounding consequences faced by clinics when their applications and renewals are delayed; lack of clear guidance in the current application checklists; and need to address the current backlog. We came out of that meeting with promising next steps in our priority areas:

- **Application Checklists:** Current application checklists are unclear, contributing to processing inconsistencies and delays.
    - L&C has a draft checklist document combining all primary care clinic applications together (primary, affiliate, mobile, consolidated, intermittent), that is under internal review and will then be reviewed by CPCA, with the goal of releasing by the end of October.
    - Once the final checklist is agreed upon, CPCA & L&C will partner to offer webinar-based training to interested CHCs statewide that will cover the applications checklist, submitting change requests, and renewals.
- **Backlog:** For the past year, the Centralized Applications Unit has built up a backlog, due in part to consolidation of district office functions, creating months of delays for applications and even minor change requests.

    - New CAU staff have been added and trained on processing primary care clinic applications- given the tremendous role CHCs play in serving Californians, clinic applications (affiliate, consolidated) are being given immediate priority in assignment to an analyst, over applications from other provider types.
- **CAU Metrics:** To gauge the current impact of the backlog and effects of process improvement efforts, CAU needs to be tracking and sharing data on these timeframes.
    - CAU is working to finalize development of a platform to publically display processing metrics that will show current processing timeframes and specific details around which phase of the process the application is at.
    - The public view is almost ready (within the next 30 days) and will provide a snapshot of where applications are at in the process, how long they have been there, and establish a higher level of accountability overall.
- **Electronic Applications:** Inefficiencies related to paper applications processing and submission could be addressed through an appropriate electronic application option.
    - L&C has secured a different vendor for this project and is back on track with a promising product in development. The primary care clinic applications will begin being built out soon, based on the finalized applications checklist. CPCA will be involved in user testing once the project is in the final phases.

B. Quarterly Stakeholder Meetings: We continue to meet with CAU leadership for quarterly clinic licensing stakeholder meetings. During our most recent meeting (August), we were successful in establishing that full applications will now take priority over the change request workload.

III. Consolidated Licensing

The consolidated clinic licensure option made available through AB 2053 went into effect January 1st of this year. As CPCA has worked with the California Department of Public Health (CDPH) to implement this bill and educate members on the process, guidance has been sent informing members that consolidated clinic sites may choose to bill under a parent PPS rate or alternatively, may opt to go through the rate-setting process. Unfortunately, we have recently learned that the Department of Health Care Services (DHCS) does not interpret the bill's provisions to allow for billing under a parent, and instead is requiring all consolidated sites to secure their own PPS rate through the traditional rate-setting process. We have looked at the language in the licensing and PPS statutes, and have confirmed that DHCS is correct in their interpretation. To allow for consolidated sites to bill under a parent's rate as the bill intended, we need additional legislation. We have already begun conversations with DHCS to amend the necessary sections as soon as possible, but we do not know that we can accomplish the change in 2017.

For community health centers with an existing licensed site, the consolidated licensure option remains the most streamlined way to license an adjacent site, with a 30-day timeframe for review by the Centralized Applications Unit and exemption from full licensure application. Our focus with AB2053 was solving the licensing challenge, and it was an oversight not to ensure PPS rates were appropriately impacted. We are focused on resolving it as soon as possible.

Any questions about this matter can be directed to Andie Patterson, apatterson@cpca.org. If you have questions about the consolidated licensing process, please contact Emily Shipman at eshipman@cpca.org.

ACTION

Date: September 26, 2017

To: Government Programs Committee

From: Andie Patterson, Director of Government Affairs

Re: OSHPD 3- Options for Relief

MEMORANDUM

I. Overview

Since the onset of the OSHPD 3 building standards, health centers have been challenged by the associated increased costs and time delays. CPCA has conducted surveys to better understand the challenges and explored a political strategy with the goal of exempting health centers from the OSHDP 3 standards. None of these efforts however have yet resulted in a change to the standards or the challenges faced by members. As such, CPCA staff have conducted a full vetting of what we believe to be all possible options in order to determine if there are any measures, short or long term or both that can help to alleviate the challenges for health centers.

While the research has resulted in additional avenues we can pursue, we have concluded that there is no quick and easy way to alleviate the challenges health centers face with OSHPD 3. There are no legal remedies, the regulatory options are scarce and still a bit unknown, and the politics for a legislative strategy are complicated because the Building Trades lobby is strong and committed to the OSHPD 3 standards. To prevail, we have to pursue a strategy that is multifaceted and uses short term strategies to achieve long term gains.

II. Process: OSHPD 3 and the Building Standards Commission

OSHPD 3 are the minimum construction standards for licensed clinics and any freestanding building under a hospital license where outpatient clinical services are provided. Among the facilities that are regulated under these standards are outpatient services of a hospital, primary care clinics, and specialty clinics. Specialty clinics include surgical clinics, chronic dialysis clinics, rehab clinics, and alternative birth centers. Code changes are proposed and promulgated by OSHPD, but the California Building Standards Commission (CBSC) is the entity with jurisdiction to finalize any changes.

OSHPD has a triennial adoption cycle where they work to bring California Building Standards Code (CA Code of Regulations Title 24) (Codes) into compliance with Federal model code, as established by Federal Guidelines Institute (FGI). First, OSHPD works with their inter-agency committees to determine where, or if, California needs to propose changes to be in compliance with FGI standards. Second, recommendations are sent to the Code Advisory committees at the CBSC for review. Third,

the codes enter into a 45 day public comment period on the recommended changes. Lastly, the codes are sent to the CBSC for final approval and publishing.

The most recent code adoption cycle began in April of 2015 and was finalized with the publication of the 2016 Codes in January of 2017. Currently, OSHPD is entering into a new code adoption cycle which began September of 2017 and will conclude with the publication of the 2019 Codes.

The responsibility for licensing and certification of OSHPD 3 facilities is given to the California Department of Public Health (CDPH) in accordance with Title 22, CA Code of Regulations. The review, permitting, and inspection of clinics, however, is under the jurisdiction of the local building official.

III. Potential Options—Refer to the attached chart

IV. Proposal

After reviewing the array of options, staff conclude that there are no quick solutions to alleviate the challenges of OSHPD 3. Ultimately to alleviate the challenges we need either the Building Standards Commission or the Legislature to exempt us from OSHPD 3 standards or licensing altogether. None of this can be done immediately. The political strength of the Building Trades Lobby is too formidable and there is no external, non-biased evidence or research demonstrating that the current process is not working. We have to build up our political capital, initiate objective research, engage and deepen relationships within OSHPD and CBSC, and test a few methods to remove OSHPD 3 requirements to demonstrate public health and services can be maintained without the standards in place.

As immediate next steps, staff recommend the following:

- External research
    - Our first choice would be to have the Little Hoover Commission explore OSHPD 3 standards. We acknowledge that we cannot necessarily control the outcome of such research but we strongly believe an external, respected, and objective voice must weigh in in order to begin to meaningfully engage the legislature on these issues. The Little Hoover Commission reports and recommendations do not carry force of law but they are respected and can help initiate public legislative hearings on the issues.
- OSHPD
    - The next Triennial has just commenced and staff are engaging with the process and working to build up credibility as thoughtful and engaged partners.
    - There are OSHPD 3 exemption opportunities that we do not believe health centers are using optimally. Both flex requests and alternate methods of compliance ought to be utilized as appropriate. We recommend better understanding how the hospitals have so readily used these options and learn from the architects who have secured the exemptions. Our goal would be to work with a few health centers concertedly to help them through the process and see if we can get exemptions. Lessons learned would be spread to all health centers.
- California Building Standards Commission
    - There is an open seat on the commission that we aim to fill with a health center friendly perspective.

- 1206g licensure exemption
    - There exist a few exemption categories in the clinic licensing code. We believe the 1206g - Operated or affiliated with an institution of higher learning of healing arts- is an opportunity to explore with a subset of health centers interested. CPCA would work with these clinics to fill out the paperwork and then handle the Medi-Cal enrollment procedures. The goal would be to better understand the process and obstacles to learn lessons to spread to other health centers.

v. Resources

- OSHPD 3 Options Chart

California Primary Care ASSOCIATION

DISCUSSION

Date: October 10, 2017
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy
Re: Medi-Cal Managed Care Update

MEMORANDUM

I. Unseen Patients

"Unseen patients" or "shadow patients" are those enrollees who have been assigned to a community clinic or health center (CCHC) as their primary care provider (PCP), but do not actually seek care at the health center. Since the Medicaid Expansion under the ACA, this issue has grown in importance, as a population that has historically foregone care or sought care in emergency rooms has moved into a managed health system. In addition, the move toward value-based payment means that the state and managed care plans are putting greater pressure upon assigned PCPs to provide population health management through preventive and primary care. Assigned members who do not utilize their PCP drive down quality scores, increase costs to the health system, and forego many of the care coordination benefits available to managed care enrollees.

CPCA has developed an Unseen Patients subgroup which reports to the Managed Care Task Force to explore possible solutions. The subgroup has met twice and the next meeting is scheduled for October 23rd.

Workplan Development

Two distinct member populations have been identified that may fit the criteria of "unseen patients." Each may have unique solutions:

a) Assigned members who are seeking care elsewhere; and
b) Assigned members who are healthy and do not utilize care, even if they do identify the CCHC as PCP.

a) Potential Solutions: Assigned members who are seeking care elsewhere

One of the reasons that patients may be seeking care elsewhere is that they were default assigned to a health center who is not their usual source of care.

- Meet with Maximus to explore possible mechanisms for selecting a provider at the point of enrollment and ensuring better contact information to mitigate problems associated with default patient assignment and poor patient contact information.
- Explore the removal of regulatory barriers that prevent reassignment if patients are utilizing care at other sites/clinics. This includes dual eligible patients who seek primary care at their Medicare provider but are still assigned by the managed care plan to a Medi-Cal PCP, as well as some rules, meant as patient protections, which prevent managed care plans from transferring patients from one PCP to another without the patient's active request.

b) Potential Solutions: Assigned members who are healthy and not seeking care at all

These patients may not seek care, but may be incentivized to utilize preventive care if they can be reached via updated and accurate contact information.

- Develop pilot programs with health plans to use updated patient contact information to locate and engage patients. Contact information from recent encounter data, such as hospital or pharmacy data sources, is often more recent and accurate than information provided by the member at the point of enrollment. A motivated health plan could find ways to share updated contact information with a PCP, or even work on contacting the patient and incentivizing them to come in for a visit themselves.

We are also exploring the possibility of policies that remove unseen members from the denominator when calculating quality scores.

Managed Care Plan Pilots

The Unseen Patients Workgroup is currently monitoring three efforts to develop local solutions to address Unseen Patients.

- Arroyo Vista Health Center has just finished a 3 year survey of their Unseen Patient Population in partnership with their IPA to determine the cause of underutilization. The survey revealed that 17% of unseen patients were seeking care at another PCP. Interestingly, many were dual eligible patients that were assigned to Arroyo Vista but sought care at a Medicare PCP. Arroyo Vista continues to monitor its unseen patient population with its IPA on a quarterly basis, identifying "members without office visits, and the topic of unseen patients is a standing item on monthly QI/HEDIS calls. CPCA staff will be documenting Arroyo Vista's partnership to develop best practices that may be replicated by other health centers to develop formalized processes for member management with their managed care partners.
- Integrated Health Partners is continuing to pilot with Molina Health Plan a formalized process to report assigned patients with poor or outdated contact information back to the health plan for increased outreach and engagement services. This pilot has led to interest from Molina's VP of Quality, Dr. Ellen Rudy to engage with Nathan Nau, DHCS Chief for Managed Care Quality and Monitoring conversations about exploring changes to how quality measures are impacted by the unseen patient population. Dr. Rudy is interested in coordinating advocacy with CPCA to develop solutions to the problem, which will be explored in CPCA's upcoming quarterly meeting with Molina on October 25th.
- Community Health Center Network has just finalized a strategy with their health plan to develop an algorithm to validate that patients are utilizing care where they are assigned. The pilot will analyze claims data to determine where patients are seeking care and compare that data to the clinic where the patient is assigned. If there is a lack of alignment between patient utilization of care and patient assignment, the data will allow for the health plan to develop processes to reassign patients where they are seeking care. CPCA will monitor the development of this algorithm to develop a best practice model for other health plans to replicate a similar strategy to use claims data to validate patient assignment and create momentum for patient reassignment to reflect utilization.

Statewide Partners

Realizing that CCHCs are unlikely to be the only provider type impacted by this change in Medi-Cal demographic, CPCA has reached out to the California Association of Provider Groups (CAPG) and the California Association of Public Hospitals (CAPH) on the issue of Unseen Patients. CAPG recognizes the problem and is open to supporting CPCA's efforts in developing solutions. CAPH has recently developed a workgroup that is working on the issue of Unseen Patients as well, and is open to combining efforts with CPCA's workgroup to develop solutions.

II. Medi-Cal Managed Care Commercial Contract Procurement:

Early in 2017, the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) announced plans to re-procure all Medi-Cal Managed Care commercial contracts by 2020. Since that time, the procurement timeline for some commercial contracts has been pushed back. Specifically, Anthem has negotiated with DHCS to put the regional model counties (Anthem/California Health and Wellness counties of the rural north) and San Benito (Anthem/FFS) on a longer procurement timeline than the rest of the state, to be implemented in 2024. This is reflected in the most recent version of the procurement timeline, which is linked to the resources section of this memo and summarized below.

Procurement timeline summary – current

- Most of the state will see an RFP in late 2019/early 2020, with an implementation date of July 2021.
- Kern, San Joaquin, Stanislaus, Tulare counties – RFP in 2021, implementation 2023
- "regional model" & San Benito (Anthem) counties – RFP in 2020/2021, implementation 2024.

CPCA has reached out to each of the state's commercial health plans, seeking the opportunity to learn more about their plans for the procurement. Due to the competitive nature of the procurement, commercial plans seeking contracts may have an incentive to develop robust quality partnerships with their provider networks, which we will explore during these meetings.

Meetings with commercial plans participating in the procurements will take place throughout the rest of 2017.

III. Health Plan Mergers

In 2014 and 2015, four major health plan mergers were announced: Blue Shield/Care1st, Centene/HealthNet, Anthem/Cigna, and Aetna/Humana. Of the four, only the Blue Shield/Care1st and Centene/HealthNet mergers were eventually approved by federal and state regulators.

As a part of the merger approval process, the state Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) required that the surviving health plans undertake specific investments in the state health care delivery system.

Blue Shield/Care1st was required to provide:

- $140 million over ten years to the Blue Shield Foundation or other DMHC-approved organization;
- $50 million toward a statewide provider directory and all-payor claims database; and
- $10 million toward Medi-Cal outreach and enrollment.

Blue Shield has begun to distribute these funds, via ~$35 million per year contributions to the Blue Shield of California Foundation, grants to the Legal Aid Society of San Diego and Health Consumer Alliance, and significant work with IHA on standardizing a provider directory and claims database.

Centene/HealthNet was required to provide $340 million in community investments over 5 years, including:

- $5 million for consumer assistance
- $10 million to improve enrollee health outcomes in rural/underserved areas
- $50 million to strengthen the Medi-Cal delivery system
- $75 million infrastructure investment to provide capital to entities in underserved areas
- $200 million to build a service center and create 300 jobs

The distribution and use of these funds is guided by two advisory committees, including the Community Investment Advisory Committee to advise on the development and implementation of the $5 million consumer assistance grant program; $10 million health outcomes grant program; and $50 million delivery system grant programs; and the Infrastructure Investment Advisory Committee to advise on the development and implementation for the $75 million in infrastructure investments.

Undertaking 29	Purpose	Target Region(s)
Community Investments $65M	**a) Locally-based consumer assistance programs** ($5M over 5 years)	Statewide
	b) Improved health outcomes in rural and/or underserved communities ($10M over 5 years)	Statewide with focus on Central Valley: Kern, Kings, Fresno, Madera, Merced, Tulare, Stanislaus, San Joaquin
	c) Improved completeness & accuracy of encounter data ($50M over 5 years)	Statewide
Infrastructure Investments $75M	**g) Capital investments for health care infrastructure and care delivery improvements**	Statewide

Community Investment Grant Program - $65 million
The community investment grant program advisory committee consists of the following members:

- Patrick Johnston, Committee Chairman and Former State Senator
- Sean Atha, SVP Business & Network Development for River City Medical Group
- Jennifer Kent, Director of the California Department of Health Care Services

- Carol Kim, Vice President of Community Investments & Public Affairs for Health Net
- Jim Lott, Management Consultant, former Chief Strategy Officer of MLK Community
- Hospital
- Louise McCarthy, President & CEO of Community Clinic Association of LA County
- Chris Perrone, Director of Improving Access of California Health Care Foundation
- Shelley Rouillard, Director of the California Department of Managed Health Care
- Stephen Schilling, Chief Executive Officer of Clinica Sierra Vista

Awards to date under the Community Investment Grant program include many CCHCs. The grants are beginning slowly; the award totals will increase in future years.

Enhanced Access: Outreach, Enrollment & Retention $1M total over 18-months	
NORTHERN CALIFORNIA	Ampla Health
	Sacramento Covered
CENTRAL VALLEY	Community Health Initiative of Kern County
	Centro La Familia Advocacy Services
SOUTHERN CALIFORNIA	East Valley Community Health Center
	Maternal and Child Health Access
	Northeast Valley Health Corporation
	Southside Coalition of Community Health Centers
	The Children's Clinic

Culture of Quality: Quality Improvement Technical Assistance $500K total over 18-months	
GRANTEE	• Bridget Cole, Institute for High Quality Care • Bobbie Wunsch, Pacific Health Consulting Group
SCOPE OF WORK	• Assess QI Capacity for 6-10 PCPs/ FQHCs • Create improvement roadmap for each • Customize and facilitate QI learning • Produce QI improvement dashboard
COUNTIES	• Sacramento • San Joaquin • Los Angeles
HEDIS MEASURES	• Cervical Cancer Screening • Childhood Immunizations • Prenatal Care

Infrastructure Investment Grant Program
The Centene/HealthNet leadership has yet to announce the names of participants on the Infrastructure Investment advisory Committee, but we understand that at least a few CCHC-friendly representatives will take part. The first committee meeting is scheduled for early October. The Infrastructure Investment is a *loan* program, rather than a grant program, but is one we would like CPCA members to benefit from.

IV. Discussion:

- Are there outstanding low-interest loan needs that CCHCs would like the committee to consider as they're building the parameters for their $75 million loan program?
    - Ex: setting aside X million for low-cost loans to CCHCs in case of delays in HRSA 330 grants due to federal legislation.

V. <u>Resources</u>

a. DHCS Procurement Timeline

California Primary Care ASSOCIATION

DISCUSSION

Date: October 10, 2017
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. Behavioral Health Framework

To meet the needs of California's Medi-Cal population, it is imperative for all three parts of the behavioral health delivery system (Managed Care, Specialty Mental Health, Drug Medi-Cal) to understand and leverage CCHCs in order to ensure that patients have access to high-quality, culturally competent, cost-effective and patient-centered care. It is CPCA's goal to support CCHCs in providing the behavioral health services needed by their communities by removing regulatory barriers, expanding access to resources, and ensuring health centers are included in all policy discussions. This memo provides an update on the various efforts and successes CPCA, and our affiliate, CaliforniaHealth+ Advocates, have had in supporting health center's behavioral health integration.

II. Removing Regulatory Barriers

CPCA's goal in this space is to remove barriers to CCHC participation and reimbursement for the full spectrum of behavioral health care.

SB 323 (Mitchell)

CaliforniaHealth+ Advocates sponsored SB 323, a bill which clarifies that FQHCs may provide behavioral health services within their PPS rate, or may elect to carve out specialty mental health and/or Drug Medi-Cal and provide those services under contract with the county mental health plan (MHP) and/or the Drug Medi-Cal system. This bill was in direct response to a change in policy at DHCS A&I, which had suddenly begun to disallow FQHC reimbursement for services provided as a part of the SMI and DMC delivery systems. The bill is on the Governor's desk awaiting signature.

Billing for MFTs (AB 1863)

CaliforniaHealth+ Advocates continues the work to implement AB 1863 no later than July 2018, which allows FQHCs to utilize and bill for MFT services for Medi-Cal enrollees. After Advocate's success with AB 1863, the California Association of Licensed Professional Clinical Counselors sponsored AB 1591 (Berman), which is awaiting possible signature by the Governor and would add licensed professional clinical counselors (LPCCs) to the list of FQHC billable providers on the same timeline as the addition of MFTs.

Confidentiality Regulations and Guidance

Along with SUD providers around the country, CPCA successfully advocated for federal changes to 42 CFR Part 2, which streamline data sharing requirements between SUD providers and other physical, behavioral, and social service providers. Additionally, CPCA was a reviewer for the CalOHI State Health Information Guidance on Sharing Sensitive Health Information. This document provides state level guidance in plain language that explains when, where, and why mental health and SUD information can be exchanged and also provides clarification on state and federal laws. Both 42 CFR Part 2 and CalOHI guidance can be found in the *resources* section, below.

President's Commission on Drug Addiction and the Opioid Crisis

The Commission recently released a DRAFT report that recommends that all FQHCs be *mandated* to require all of their physician, NP, and PA providers hold an X-waiver to prescribe buprenorphine as an attempt to increase the amount of Medication Assisted Treatment (MAT) providers. CaliforniaHealth+ Advocates is working with NACHC to ensure that the recommendation is removed from the final report. CaliforniaHealth+ Advocates is also exploring the possibility and appetite for a federal advocacy strategy that would remove some or all of the training requirements for providers to hold an X-waivered license.

III. Expanding Access to Resources

CPCA's goal is to ensure that FQHCs receive the resources necessary to support the provision of behavioral health services. Historically, counties have received the bulk of BH funding in California and have had great flexibility in their expenditure and use of funds, with little reporting and even less accountability. CPCA's advocacy priorities in this space include ensuring that FQHCs are able to pull down resources requisite to their participation in the BH system, and ensuring that counties are held accountable to use their funds to provide robust access and thorough coordination of care within and outside of the county system.

Proposition 64

CaliforniaHealth+ Advocates, along with the California Association of Alcohol and Drug Program Executives (CAADPE) is playing a leadership role in the development of programs funded under Proposition 64, the Adult Use of Marijuana Act (AUMA). CaliforniaHealth+ Advocates has developed a set of recommendations around workforce investment that seek to ensure primary care providers serving underserved communities are leveraged as a part of the youth SUD spectrum of care, especially around education, prevention, and early intervention. CPCA's initial funding proposals are included as an attachment in the *resources* section, below.

No Place Like Home (NPLH)

The 2016 initiative dedicates a portion of Mental Health Services Act (MHSA) funds to secure $2 billion in bond proceeds to support the construction and rehabilitation of permanent supportive housing for individuals who are in need of mental health services and are homeless, chronically homeless, or at-risk of homelessness. The program is administered by the State Department of Housing and Community Development (HCD). CaliforniaHealth+ Advocates has successfully engaged with HCD, both through meetings and comment letters, to ensure that the

application for NPLH funds includes a requirement that residents of the supportive housing be linked to a primary care provider.

California Hub and Spoke Services (H&SS) Funds

Under the 21st Century CURES Act, California was awarded $90 million in grants over two years to curb the opioid epidemic by improving access to MAT. Eighteen Narcotic Treatment Programs and one FQHC around the state were awarded grant funds to develop a network of Hubs and Spokes designed to coordinate care for opioid addicted patients in underserved and rural communities with the high rates of drug overdose deaths. CPCA is actively involved in the H&SS steering committee and has coordinated conversations between Hubs and CCHCs. CPCA is also referring CCHCs to training and technical assistance for MAT program development through partners like CHCF's Treating Addiction in Primary Care, SAMHSA, and Project ECHO.

SB 82 - Triage Grants work

SB 82 passed in 2013 and provides for three year grants, administered by the MHSOAC and the California Health Facilities Financing Authority (CHFFA), to counties to provide triage services. The goals of these programs are to ensure that patients have access to the BH delivery system, improve the overall capacity of the BH system, and divert patients away from law enforcement and emergency departments, when appropriate. While many CCHCs around the state run successful triage programs, only a few are funded through this county-run funding stream. As part of our efforts, we have worked with CaliforniaHealth+ Advocates to meet with, and submit written comment to, the MHSOAC to request that the next RFA award additional points to counties who partner with FQHCs and to include language which incentivizes county collaboration with CCHCs. In addition, CPCA has had the MHSOAC and California Behavioral Health Director's Association (CBHDA) present during our Behavioral Health Peer Network meeting to speak on improving collaborations between counties and FQHCs when it comes to MHSA and Triage grants.

PCP/Psych and Addiction Medicine Fellowships

The University of California, Davis (UCD) and University of California, Irvine (UCI) offer two fellowship programs meant to provide mentorship and training in the area of primary care psychiatry and addiction medicine. CPCA has developed a robust partnership with the University of CA teams, and have provided presentations and information to MCPs and counties on funding PCPs in their network to attend the fellowships, thereby enhancing access in areas where psychiatry may be unavailable. More information on fellowships, including CPCA-created supporting materials for CCHCs, are available in the *resource*s section.

Innovation and PEI Regulations

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is revising regulations that enhance reporting requirements for county expenditures of PEI and Innovation funds under then Mental Health Services Act (MHSA). CaliforniaHealth+ Advocates is actively participating in these conversations with the goal of ensuring that counties report robust information on their expenditure of MHSA funds, especially around demographic information.

IV. Raising awareness

In California, the behavioral health delivery system is not only divided into three distinct parts, but is largely administered and funded at a county level, with very little state oversight. Much of our work to increase the visibility and awareness of CCHCs in behavioral health must be done in close concert with our members and with other statewide organizations representing other parts of the local county delivery systems. Much of our work seeks to support CCHCs in their own conversations with their counties and to encourage counties to leverage their CCHC networks. Below, we list a few of the statewide conversations through which we address larger delivery system issues while recognizing that the *real* work of behavioral health must grow from local partnerships

Statewide Partnerships

CPCA and CaliforniaHealth+ Advocates are focused on ensuring that the critical role of CCHCs is recognized and leveraged by the counties and the state. CaliforniaHealth+ Advocates staff has been appointed to serve on California's Mental Health Planning Council (CMHPC), an advisory body staffed by DHCS which informs the Administration and the Legislature on priority issues and feedback on mental health policy and regulations. In addition to CMHPC, California Health+ Advocates has grown our participation in a variety of venues in order to expand our influence in behavioral health policy in the Capitol, including participation in the California Hub and Spoke Steering Committee, the California Access Coalition, monthly Irregulars meetings of behavioral health lobbyists, and active participation in MHSOAC committees and the MHSA forum.

In particular, we note a success in the recognition of the importance of integrated behavioral health and primary care in the amendments included in AB 1315 (Mullin), which creates a new Early Psychosis and Mood Disorder Detection and Intervention program at counties, overseen by the MHSOAC. The bill's authors accepted a number of amendments offered by California Health+ Advocates, and the bill, as passed, requires that the advisory committee include a primary care provider from a clinic with an integrated behavioral health and requires that awards made under the program include a core objective of increasing coordination of medical and mental health care and increasing physical health. This bill, along with a broad partnership of behavioral health organizations who worked together to support California Health+ Advocates' sponsored bill, SB 323 (Mitchell), are concrete examples of the growing partnership between CPCA, CaliforniaHealth+ Advocates, and behavioral health policy makers.

CPCA staff are proactively engaged with DHCS SUD division to ensure that CCHC spokes are recognized in the H&SS care continuum and are able to receive and retain resources necessary to support their efforts. We have presented at the Statewide SUD Conference and to the H&SS Steering Committee about the role of FQHC's in MAT and considerations that NTPs need to acknowledge for CCHCs. We have also connected NTP/Hubs with CHC/Spokes in various service areas, including the coordination of a meeting between Aegis (NTP) and CCHCs in the central valley to provide an open forum to work through opportunities and challenges between these new partner entities.

CPCA is engaged with the DHCS Pharmacy Division to identify how CCHCs may begin to diversify their MAT programs by prescribing long acting injectable naltrexone (Vivitrol).

CaliforniaHealth+ Advocates continues to provide written and public comment at MHSOAC meetings, including subcommittee meetings, to ensure that clinics role in providing behavioral health services is recognized and leveraged. These efforts are amplified through our legislative advocacy and our relationship building efforts with the behavioral health community.

V. Conclusion

To truly meet the needs of California's Medi-Cal population, it is imperative for all three parts of the behavioral health delivery system to understand and leverage CCHCs and ensure that patients have access to high-quality, culturally competent, cost-effective and patient-centered care.

VI. Resources

- Little Hoover Commission: Promises Still to Keep: A Decade of the Mental Health Services Act.
- Updates in Substance and Opioid Use Disorder Programming
- 42 CFR Part 2 Final Rule and Health Center Compliance
- State Health Information Guidance (SHIG) on Sharing Sensitive Health Information
- Potential youth SUD workforce funding recommendations under Prop 64
- No Place Like Home Comment Letter
- SB 82 Comment Letter to MHSOAC
- SB 82 One-Pager

California Primary Care ASSOCIATION

DISCUSSION

Date: October 2, 2017

To: Government Programs Committee

From: Meaghan McCamman, Assistant Director of Policy

Re: Pharmacy and Adult Immunizations

MEMORANDUM

I. Overview

CPCA staff have been approached in two separate venues about the barriers to FQHC provision of expensive injectable medications. Proponents of the medication Vivitrol (naltrexone), used to treat opioid and alcohol use disorders, have asked CPCA to determine why FQHCs are unable to utilize the drug, costs of which run approximately $1,000 per month. Similarly, the California Department of Public Health has sought CPCA's opinion about the barriers to increasing the use of adult immunizations at FQHCs. After some internal independent research, CPCA staff posits that the barriers to both the use of Vivitrol and the use of adult immunizations stem from the inability of FQHCs who do not have an onsite pharmacy to bill for the drugs outside of the PPS rate. The high cost of the drugs – both vivitrol and adult immunizations – make it cost prohibitive to provide those drugs with only PPS reimbursement.

II. Discussion

With this memo, CPCA staff hopes to facilitate a discussion around the barriers to FQHC provision of injectable Vivitrol and injectable adult immunizations. We hope to:

1) Ensure that our understanding is correct that the greatest barrier to FQHC provision of injectable medications is their high cost and inability to be reimbursed outside the PPS rate;
2) Confirm that an FQHC with an onsite pharmacy is able to bill separately for these drugs and therefore would not encounter these barriers; and
3) Discuss with the Committee whether CPCA should be leveraging the expanded interest in treating opioid disorders with Vivitrol, and CDPH's interest in expanding the use of adult immunizations, to explore with DHCS the possibility of creating a process whereby FQHCs without an onsite pharmacy are able to bill for certain injectable medications outside of the PPS billable visit.

California Primary Care Association

DISCUSSION

Date: October 3, 2017

To: Government Programs Committee

From: Beth Malinowski, Deputy Director of Government Affairs and Michael Helmick, Senior Policy Analyst

Re: Community Clinic Lifeline Grant Program – Implementation

MEMORANDUM

I. Background

The Clinic Lifeline Act of 2017 (the "Act"), signed into law by Governor Jerry Brown on July 10, 2017, established the Lifeline Grant Program (the "Program"). The Program, within the California State Treasurer's Health Facilities Financing Authority (CHFFA) assists small and rural health facilities, including CHCs, that may be adversely affected financially by a reduction or elimination of federal government assistance and that have little to no access to working capital.

The budget appropriates $20 million from the Health Expansion Loan Program (HELP II) fund for this one-time purpose. Funds must be used to support health facilities that meet certain eligibility criteria. Under the Act, health facilities must either be a tax-exempt nonprofit licensed health facility with an annual gross revenue not exceeding $10,000,000, a tax-exempt nonprofit licensed health facility located in a rural medical service study area (MSSA), or a clinic operated by a district hospital or health care district.

CHFFA is responsible for developing additional selection criteria and a process for awarding the grants, which may not exceed $250,000 per health facility site. Since the enactment of the Budget Act of 2017, California State Treasurer's office has moved forward with implementation-related activities and discussion to meet the core objectives of the program.

CPCA is working with CHFFA staff on the implementation of the program.

I. Current Considerations

California Health Facilities Financing Authority (CHFFA) staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. CHFFA has hosted two stakeholder webinars where they've begun to outline their perspective on a variety of key issues. Among the current considerations are the following:

- Max Awards: With a commitment to provide awards on a per facility basis ($250,000 per heath facility), staff are currently considering if there should be a maximum or cap placed on the number of awards that can be received by each parent organization. Currently, staff are leaning towards having no maximum award. This means that a parent organization with

multiple sites meeting the determined criteria could apply for, and receive, multiple awards across its sites.

- Eligibility Criteria: In addition to the statutorily required criteria, CHFFA is considering program eligibility criteria that relates to individuals served, geographic location, types of services provided, utilization of grant funds, and ability to leverage additional funding:
    - Population Served: CHFFA is recommending an additional eligibility criteria – 50% or more of the individuals served participate in Medi-Cal. CHFFA, and CPCA, have already received feedback that this would undermine the ability of frontier and rural health center to participate in this program. CHFFA is open to considering different criteria for rural or frontier communities. On a recent call, CPCA reiterated that CHFFA consider the uninsured population and CPCA will continue to advocate for eligibility criteria that meets the unique needs of our rural and frontier communities.
    - Services Provided: In their initial webinar, CHFFA had recommended creating an additional requirement that all facilities, with the exception of those in MSSA, must show proof of providing services beyond medical services. On a recent phone call, CHFFA stated that they are no longer looking to pursue this criteria.

- Evaluation Criteria: Once an entity has met all eligibility criteria, CHFFA is currently considering evaluating grants on a points scale (100 point max). These points will be dependent on health facility location, service provided, overall patient needs, proposed use of grant funds, populations served (percent Medi-Cal, uninsured, etc.), planning and sustainability. No information has been provided yet on how CHFFA plans to collect this information through the application process or how points will be distributed across these areas. CPCA will provide recommendations to CHFFA on their broad evaluation criteria, including identifying ways to align this program's evaluation criteria with prior funding evaluation metrics and data already submitted to state entities like OSHPD.

- Eligible Use of Grant Funds: Recognizing that these funds are for facilities that are in need of immediate core operations support, we are concerned that CHFFA has articulated a desire to see "innovative uses" for these funds. While we have not seen a clear definition of "innovation," and are generally committed to innovation too, we also recognize that these funds are critical for health centers that have working capital (example: payroll/leases/utility bills) and/or small capital expenditure needs (example: critical facility repairs). We look forward to further engagement on this item and striking the right balance.

- Funding Distribution: CHFFA is currently considering three different distribution plans to guarantee funds are well distributed across the state:
    - Option 1: Applications with the highest rank
    - Option 2: Application with the highest rank with geographical distribution limitations. This option would aim to account for county population and breaks funding into four regions (Central - $4,500,000; LA/Ventura – $6,000,000; Northern - $4,000,000; and Southern $5,500,000).
    - Option 3: Application with the highest rank with annual gross revenue limitations. This option would aim to create an inverse relationship between gross revenue and Lifeline funding, the higher the gross revenue the fewer overall grants will be provided.

CPCA aims to provide feedback on these funding distribution options as each option has unique benefits and limitations. While all three of these options can be seen as meeting elements of statutory goals, option #2 does appear to be most aligned with the Lifeline Program's core objectives. We look forward to getting additional member feedback on this item on the 10/17 webinar and have already seen some preference to option #2 from our rural partners.

- Emergency Regulations and Application Triggers: On a recent call, CPCA staff learned that CHFFA staff are interpreting the statuary language to be requiring of a "triggering event" to fully execute the program. In particular, they believe federal funding reductions are a formal trigger for this program – both a trigger for the Office of Administrative Law's review of the program's administrative regulations and a trigger for launching the application window. CPCA is working to better understand this statutory interpretation and, in the interim, are intending to propose federal funding trigger language that is representative of the various federal funding threats.

II. Next Steps

In the last week of October (Thursday, 10/26), the Authority's board will discuss CHFFA's staff recommendations for selection criteria, application process, and other implementation-related items. The Authority's board is not expected to take action on that day, but will likely be taking action at the Authority's December meeting.

While CPCA has had ongoing dialog with staff since August, CPCA is aiming to submit formal comments to the Authority in advance of their 10/26 board meeting.

Lifeline Grant Program Webinar:
On Tuesday, October 17 at 11:00 a.m., CPCA staff will host an important webinar to provide updates on The Clinic Lifeline Act of 2017, discuss CPCA's engagement with California Health Facilities Financing Authority (CHFFA) staff, and solicit your feedback on CPCA's proposed comments to the Authority. If you have immediate questions or feedback on the Lifeline Grant Program please e-mail Michael Helmick at mhelmick@cpca.org.

To learn more about the Lifeline Grant Program, please visit CHFFA's website at http://www.treasurer.ca.gov/chffa/clg/index.asp

Please register for the Clinic Lifeline Grant Program Webinar on Tuesday, October 17, 2017 11:00 AM - 12:00 PM PDT at: https://attendee.gototraining.com/r/8821061118056466177

III. Resources

- CHFFA Lifeline Grant Program Website: http://www.treasurer.ca.gov/chffa/clg/index.asp

California Primary Care ASSOCIATION

INFORMATIONAL

Date: September 25, 2017

To: Government Programs

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Immigration Update

MEMORANDUM

I. Federal Immigration Update

The Trump Administration has severely impacted the immigrant community through several executive orders (EO) that have been issued or rescinded.

Executive Orders

- *Deferred Action for Childhood Arrivals (DACA)*
  On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program via a "phase out." All properly filed DACA applications and renewals that were accepted by the Department of Homeland Security (DHS) on or before September 5 will be processed. For more information about the details for the proposal and resources for employers, please see the resource section below.

  The President has met with Democratic leaders, including house minority leader, Nancy Pelosi, to discuss possibly moving legislation that codifies the DACA program into law before its expiration date on March 5, 2018, but nothing has yet been decided. However, the President has asked democratic leaders to consider adding portions of the RAISE Act into the DACA bill. In the meantime, the California Attorney General as well as the University of California system have filed lawsuits against the administration for ending the DACA program.

Federal Legislation

- *Reforming American Immigration for Strong Economy Act (RAISE Act)*
  On August 2, Senators David Perdue (R-GA) and Tom Cotton (R-AR), alongside the President, introduced the RAISE Act (S. 354), which proposes to radically reduce legal immigration to the United States. The bill would need 60 votes in the Senate to pass. Since the measure will be seen as extreme by all Democrats and even some Republicans, it is unlikely that it would achieve the necessary 60 votes. For more information on the RAISE Act, please see the resources section below.

  Action Item: Would CPCA members like to take an oppose position on this bill?

- *Dream Act*
  Senators Richard Durbin, D-Ill., and Lindsey Graham, R-S.C., have introduced the Dream Act. The Act would offer a path to permanent legal status to people who arrived in the U.S. as children, can pass a background check, and otherwise fit the DACA criteria. This bill has not yet been taken up by the Senate, and thus has not moved.

  Action Item: Would CPCA members like to take a support position on this bill?

- SUCCEED Act
  On September 25 Republican Senators Thom Tillis, James Lankford and Orrin Hatch have introduced the SUCCEED Act (Solution for Undocumented Children through Careers Employment Education and Defending our nation) to provide a pathway to citizenship for immigrant youth. However, the SUCCEED Act would make eligible immigrant youth wait 15 years to become U.S. citizens and would prevent them from sponsoring family members to the United States. It would also force them to forgo due process rights, place conditions on their ability to stay and live in the U.S., and bar them from seeking other forms of immigration relief for which they could become eligible. It is likely that the SUCCEED Act will be paired with a border security bill to appease requests by the White House.

  Action Item: Would CPCA members like to take an oppose position on this bill?

Executive Orders on Immigration

- *Travel Ban*
  Per the executive order, the Department of Homeland Security has submitted a study on the available security and intelligence information in countries worldwide. Based on the findings, the Trump administration issued a proclamation, "Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats," that indefinitely bans travel from Iran, Libya, Syria, Yemen, Somalia, Chad and North Korea. Certain government officials from Venezuela will also be barred. This proclamation was signed on September 24, 2017, when the 90 day travel ban for the six Muslim countries was due to expire. It is very likely that lawsuits will be filed against the new travel ban, but considering that a study was conducted to place these countries on the list, which now includes non-Muslim countries, it will be more difficulty to prove that this proclamation is discriminatory against Muslims.

  Prior to the proclamation being signed and in response to lower court rulings blocking portions of the revised travel ban executive order, the Supreme Court had decided to hear the administration's appeal and allowed parts of the travel ban to go into effect during the interim. Specifically the Supreme Court allowed the ban to go into effect for foreign nationals who lack any "bona fide relationship with any person or entity in the United States." At this time, only non-citizens with relationships with persons or entities in the United States can enter the country (this applies to the proclamation as well).

  On September 12, 2017 the Supreme Court issued an order blocking the Ninth Circuit Court of Appeal's September 7, 2017 ruling that would have allowed refugees who have agreements with U.S. settlement agencies to qualify as having a bona fide relationship, and therefore qualify to enter the country (this portion of the executive order is due to expire on October 24). However,

the Supreme Court did not disturb the Ninth Circuit's ruling allowing grandparents, grandchildren, brothers-in-law, sisters-in-law, aunts, uncles, nieces, nephews, and cousins to qualify as having a bona fide relationship, allowing these folks to continue entering the country.

Additionally, since the President has signed a proclamation that created new provisions around the travel ban, the Supreme Court has decided to postpone the hearing originally scheduled for October 10.

- *Sanctuary Jurisdictions*
  On September 15, 2017 U.S. District Judge Harry Leinenweber ruled that the Trump administration may not withhold public-safety grants to so-called sanctuary cities / jurisdictions.

  The judge issued a temporary nationwide injunction that prevents the Justice Department from withholding grant money until there is a final determination in the lawsuit, which could take months.

II. State Legislative Update

CaliforniaHealth+ Advocates is closely monitoring legislation that impacts immigrants and is working with our immigration advocacy partners to support policy that ensures California has in place the proper safeguards to prevent patient information collected by a health center or public benefit programs from being shared with immigration enforcement. SB 244 (Lara, 2017) and SB 54 (De Leon, 2016) help to accomplish this goal.

- SB 244, (Lara, 2017)
  - Reinforces "good government" by ensuring that agencies elicit and record only the information necessary to administer a program or service, and disclose the information only for the purpose of administering the program or service.
  - This bill no longer contains language to protect patient health information, however the author has made this a two year bill to allow more time to work out issues with the Department of Health Care Services.
  - CPCA holds a support position on this bill.

- SB 54 (De Leon, 2016) The California Values Act
  - Builds upon the TRUST Act and increases protections for Californians from landing into the deportation pipeline, and sets a minimum standard restricting law enforcement interaction with ICE.
  - Requires specified health facilities operated by the state, and encourage other health facilities, such as FQHCs, to establish policies that limit immigration enforcement on their premises. CaliforniaHealth+ Advocates has been a proud supporter of SB 54 and the protections it allocates to Californian's immigrant community. Please contact your legislative member and voice your support.
  - Passed out of the Legislature and is going to the Governor's Desk for signature.
  - CPCA holds a support position on this bill.

III. CPCA Strategy to Address Immigration Issues

At the direction of members, CPCA in collaboration with CaliforniaHealth+ Advocates, has been working diligently to develop materials that provide information on the legal rights of clinics, and their patients, in regards to immigration enforcement.

Immigration Resources for Patients and Clinics

CPCA, in collaboration with CaliforniaHealth+ Advocates, has been leading an effort in collaboration with other state PCAs, NACHC, and immigration partners, to develop materials that can help health centers prepare themselves and patients for an encounter with immigration enforcement. Through this effort CPCA has developed six sample policies and procedures, Know Your Rights handouts, FAQs and much more. These documents can be found in the resource section below.

Immigration Peer Network

CPCA has created an Immigration peer network to help gather member feedback on the immigration resources that we are developing as well as guide the policy work we are undertaking. This is also a great space for members to share the resources they've gathered/produced and to ask any questions that may be coming up for clinics and their patients.

Please contact Daisy Po'oi at dpooi@cpca.org if you would like to join the peer network.

Provider Survey: The Mental Health of Immigrant Children and their Parents

CPCA, in collaboration with Children's Partnership is evaluating the data collected through our provider survey to capture the mental health of immigrant children and their parents. We've also collaborated with various behavioral health partners, including The California Association of Social Rehabilitation Agencies, Mental Health America, the California Mental Health Planning Council, and California Association of Marriage and Family Therapists, to have this survey shared with their members.

Upcoming Immigration Trainings for Members

In response to requests from members, CPCA has hosted 3 webinars that were part of the immigration webinar series. The first webinar, which took place in June, provided an overview of the FAQs and best practices for implementing the recommendations included in the FAQs. The two subsequent webinars, held on September 13 and September 20, provided an in depth overview of the sample policies and procedures.

Below is more information on the remaining webinars for the immigration series this year. To register please visit CPCA's webinar registration page.

- Utilizing Community Health Workers to reduce fears in immigrant patients
- The Mental Health of Immigrant Children and their Parents
- Behavioral Health Services for Immigrant Patients

IV. Resources

- DACA Phase Out: Background and Talking Points
- Guidance for DACA Employers and DACA Recipients
- Background on the RAISE Act
- Immigration Bill List
- Sample Policies and Procedures
- Immigration Patient FAQs

California Primary Care ASSOCIATION

INFORMATIONAL

Date: October 10, 2017

To: Government Programs Committee

From: Allie Budenz, Associate Director of Quality Improvement

Re: Section 2703/Health Home Program Update

MEMORANDUM

HHP Status Update

In August, DHCS announced in a stakeholder communication update that they are moving forward with a state plan amendment (SPA) to implement ACA Section 2703 Health Homes for Patients with Complex Needs (HHP) and are targeting July 2018 implementation for 11 counties in phase 1 of 3.

HHP Savings Strategy

The state has stated on numerous occasions that the HHP benefit will not continue post the pilot if the pilot does not yield savings within two years to the state. Experts generally agree that savings in this short of a time frame is nearly impossible. However, some plans and providers have been testing out the HHP model already and have yielded savings. It is CPCA's contention that a small and contained pilot of expert plans and providers can yield savings thus positioning the pilot for success, and laying the foundation for a benefit for all Medi-Cal beneficiaries and the opportunity for all health centers to offer additional services to their patients.

To this end, CPCA has taken the lead with the health plan associations- the California Association and Health Plans and the Local Health Plans of California- to convene a small workgroup of plans and providers deeply invested in the HHP to discuss how to best to coordinate the execution and delivery of a successful pilot. CPCA is hoping to convince the plans in phase one to be very selective about the providers participating, to limit the size of the pilot, and to coordinate with their colleagues across county lines. The small workgroup will design a larger stakeholder engagement strategy that will be deployed to CHC's and health plans in the three implementation counties. Should the small workgroup agree on the strategy and desire a larger stakeholder convening, CPCA will invite possible health center community based care management entities (CB-CME's) to participate.

Technical Assistance Update

DHCS has contracted with Harbage Consulting to provide technical assistance on outreach, education, and communications to managed care plans, providers, CB-CMEs, eligible Medi-Cal beneficiaries, and other stakeholders through all 3 implementation phases of the HHP. Harbage's approach will be to release toolkits for these specific audiences with plan-specific information. CPCA is coordinating member review of these documents.

California Primary Care Association

INFORMATIONAL

Date: October 11, 2017

To: Government Programs Committee

From: Beth Malinowski, Deputy Director of Government Affairs; and Emili LaBass, Senior Program Coordinator of Health Center Operations

Re: Oral Health Update

MEMORANDUM

MSDA Medicaid-FQHC Dental Policy Workgroup

CPCA recently participated in the first meeting of the new MSDA Medicaid - FQHC Dental Policy Workgroup. This workgroup is being convened over the next eighteen months by the Medicaid|Medicare|CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing; an organization with a broad interest in advancing Medicaid dental policy and oral healthcare for FQHC beneficiaries. Launched in response to recent FQHC dental services' payment issues, the goal of the workgroup is to study existing federal and state legislation, regulation, policies and practices as they relate to the delivery and billing of dental services by FQHCs; and develop guidelines for use by state Medicaid dental programs aimed at improving Medicaid-FQHC dental program policy and administration.

This initial meeting, held in Washington D.C. on September 18, was attended by over two dozen federal, state, and health center leaders by MSDA invitation. Angie Melton of the Margolin Group, attended in person on behalf of CPCA. Additional attendees included representatives of National Network of Oral Health Access (NNOHA), CMS, HRSA, DHCS and other state Medicaid agencies, NACHC and other PCA representatives, and California dental leaders from Asian Health Services, Borrego Health, Clinica Sierra Vista, and La Clinica de la Raza.

While the stated intent of the group was rather broad, the initial meeting was nearly solely focused on dental program audits. The agenda, aimed at laying the groundwork for future dialog, was dedicated to reviewing federal and state authority and guidance relevant to dental services-related audits, including Medicaid Integrity Contractor (MIC), Payment Error Rate Measurement (PERM), and Recovery Audit Contractors (RAC) audits. Emerging issues, including definition of "standard of care" and FQHC Medicaid Audits, were given particular attention. While a variety of state and provider perspectives were introduced, particular attention was given to the recent audit situation in California – challenges with the process, auditors, and findings. There was general consensus that providers, state, and federal partners must work together to create a more consistent auditing environment. Furthermore, there was general agreement that there are gaps in policy and guidance. As MSDA pursues its interest in developing solutions, CPCA looks forward to continuing to participate in any and all discussions that could benefit the audit environment in California.

Lastly, it is important to note that while the MSDA workgroup compliments the efforts that will take place with DHCS A&I, it is in fact completely independent from the workgroup CMS has asked DHCS to create for California's specific dental related issues that arose from the 2016 Medicaid Integrity Program (MIP) audits.

In the coming months, we will continue to bring any new developments to the Dental Directors Peer Network.