Government Programs Committee

Tuesday, October 2, 2018
11:10am-12:30pm
Robin Affrime, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Robin Affrime	A
II. Approval of Agenda	• Executive Summary	Robin Affrime	A
III. Approval of Minutes	• July 2018 Meeting Minutes	Robin Affrime	A
IV. 340B Federal and State	• Memo: 340B Update • Memo: 340B CVS	Liz Oseguera	A I
V. OSHPD 3 and Licensing	• Memo: Leg Update & Overall Progress • Memo: OSHPD Triennial Cycle Advocacy	Michael Helmick Emily Shipman	I D
VI. Behavioral Health	• Memo: Behavioral Health Visioning • Memo: Behavioral Health Update	Allie Budenz Liz Oseguera Michael Helmick	D I
VII. Care Coordination	• Memo: Care Coordination	Allie Budenz	D
VIII. Clinic Lifeline Grant Program	• Memo: Update on new funding	Michael Helmick	I
IX. Managed Care	• Memo: Managed Care Update	Nenick Vu	I
X. Adjourn		Robin Affrime	A

Executive Summary

Date: September 19, 2018
To: Government Programs Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

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

OSHPD 3 and Licensing
- The Licensing and OSHPD 3 Research project has begun and is scheduled to be completed by mid-2019
- Update on Licensing and OSHPD 3 related legislation
- CPCA has continued to address the board approved strategies to reduce administrative and regulatory barriers caused by licensure

Behavioral Health
- Results from 2018 bi-annual Behavioral Health Survey which tracks the trends and trajectory of CHCs in the behavioral health service system.
- Updates on CPCA's work to expand CHCs access to and participation in MHSA, Prop. 64, and SUDs.

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

Clinic Lifeline Grant

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

Managed Care

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

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
July 12, 2018
11:10am – 12:30am

Members: Robin Affrime – Chair, Dolores Alvarado, Doreen Bradshaw, Linda Costa, Maximiliano Cuevas, Deb Farmer, Rachel Farrell, Rosa Fernandez, Ben Flores, Aaron Fox, Timothy Fraser, Cathy Frey, Naomi Fuchs, Alvaro Fuentes, Jane Garcia, Greg Garrett, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Alicia Hardy, Kerry Hydash, Constance Kirk, Deena Lahn, Karen Lauterbach, Becky Lee, Deborah Lerner, Marty Lynch, Burn Margolin, Kevin Mattson, Louise McCarthy, Nichole Mosqueda, Anitha Mullangi, Danielle Myers, Christine Noguera, Rakesh Patel, Courtney Powers, Joanne Preece, Carole Press, Phil Curtis, Tim Rine, Gary Rotto, Corinne Sanchez, Laura Sheckler, Graciela Soto-Perez, Deanna Stover, Terri Lee Stratton, Mary Szecsey, Vernita Todd, Henry Tuttle, Chad Vargas, Christina Velasco, Christy Ward, Tony Weber, Anthony White

Guests: Sabra Matovsky, Raphael Irving, David Vliet, Paula Zandi, Yamilet Valladolid, Cathryn Hyde, Chloe Guazzone, Maria Paz, Melissa Eidman, Krista Kazhe,

Staff: Carmela Castellano-Garcia, Andie Patterson, Meaghan McCamman, Daisy Po'oi, Elizabeth Oseguera, Michael Helmick, Nenick Vu, Allie Budenz, Val Sheehan, Ginger Smith, Jodi Samuels, Dr. Witte, Meghan Nousaine, Victor Christy, Jana Castillo, Emily Shipman

I. Call to Order

Robin Affrime, Committee Chair, called the meeting to order at 11:17am.

II. Approval of Agenda

A motion was made to approve the agenda as presented. **The motion carried. (T. Rine, M. Szecsey)**

III. Approval of Minutes

A motion was made to approve the minutes of April 26, 2018. **The motion carried. (D. Myers, N. Gupta)**

IV. 340B Federal and State

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

MOTION – 340B Savings

A motion was made and seconded that CPCA work with members to explore the concept of commonly reporting specific programs or areas where 340B savings can be invested for the purposes of effective and coordinated 340B advocacy. **The motion carried. (M. Lynch, D. Stover)**

V. OSHPD3 and Licensing

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

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

VII. Behavioral Health
CPCA has developed a draft 'action plan' to prepare CCHCs for a conversation around envisioning a better and less fragmented BH system in the 2020 waiver. We also continue our work to support CCHCs in the current delivery system by removing regulatory barriers to FQHC participation in the full spectrum of care; expanding access to resources; and ensuring health centers are included in all behavioral health policy discussions.

VIII. 2703 PCHH
Plans are currently developing their HHP business plans with program guidance from DHCS. Health centers interested in being a HHP CB-CME should reach out to their managed care plan with contract inquiries. CPCA's impression of the Harbage training materials is that it outlines the HHP requirements but it falls short of explaining how to be successful in care coordinating HHP patients. MCPs may train on care management best practices; but CPCA is also considering a webinar series to get care management trainings to CB-CME health centers.

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

X. Adjourn
The meeting was adjourned at 12:26pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

Action

Date: September 12, 2018

To: 340B Peer Network

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Project to Standardize how Health Centers use Savings Generated from 340B Program

MEMORANDUM

I.

340B Saving Areas – Increasing Transparency

The federal and state government have expressed interest in increasing transparency around the 340B drug discount program, specifically in having covered entities (CEs) report how they are using 340B savings. For this reason it is very important that health centers are not only tracking these funds, but are also ensuring their 340B savings are being used "**to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services**."[1]

As safety net providers, health centers use 340B savings to help expand the healthcare services offered to patients while also working to increase patient access to these services. Without these savings health centers would NOT be able to provide many of the services that care for the whole patient.

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

With approval from the 340B Savings workgroup, CPCA presents the board with five funding areas; (1) Workforce, (2) Drug Management Programs & Increasing Access to Medication, (3) Clinical Care Coordination, (4) Expanded Access to Healthcare Services, and (5) Infrastructure Support. It is our hope to have California health centers all agree to invest their 340B savings into these five areas.

Funding Areas for Investing 340B Savings

1. *Workforce*
   Horizon 2030: Meeting California's Primary Care Workforce Needs (2016), a recently released report commissioned by California Primary Care Association shows that six out of nine California regions experiencing a primary care provider shortage, and a ratio of primary care physicians in Medicaid that is half the federal recommendation, California ranks 32nd in physician access. The report also estimates that California will need 8,243 additional primary care physicians by 2030 (2016).

[1] H.R. Rep. No. 102-384(II), at 12 (1992)

Given the severe health workforce shortage in California, health centers have been allocating 340B savings to employ and retain providers to ensure we have the qualified staff needed to provide the best healthcare to our patients.

Specifically, health centers have been using their funds to:

- Support non-billable providers, including Ambulatory Care Pharmacists who conduct medication therapy and management services, scribes, care coordinators, dietitians, registered nurses, medical assistants, health coaches, and community health workers.
- Provide health center staff with incentive programs, which includes covering costs for trainings that help providers increase their knowledge in issues such as mental health, trauma informed care, Substance Use Disorder, and cultural competency. These incentive programs help with staff retention while also helping to improve the services offered to patients.
- Support hiring new health center staff, including culturally and linguistic appropriate providers, to ensure patients have access to the services and providers they need.
- Support provider salary levels to help retain and recruit staff.

2. *Drug Management Programs & Increasing Access to Medication*

Given the limited funding available to help improve patient access to medication and support all elements of drug management programs, health centers have been using 340B savings to provide these needed services.

Specifically, health centers have chosen to invest 340B savings to:

- Provide low cost or free medications to all low-income patients who are uninsured and underinsured.
- Establish and support in-house pharmacies, including extended pharmacy hours and pharmacy staff, such as pharmacy billing technicians.
- Support automated pharmacy delivery systems that electronically dispense prescribed medication to patients.
- Support mail-order prescription delivery programs for patients.
- Sustain innovative programs that are medication heavy, like SART (sexual assault response team).
- Robust care coordination, including drug management, for HIV and Hepatitis C patients, as well as STI prevention (PrEP and PEP).
- Support staff pharmacist who provide detailed consultations for asthma, diabetes and other chronic health conditions.
- Medication reconciliation of specialty drugs for specialty mental health patients and at hospital discharge.
- Further development of opioid addiction education and existing opioid abatement programs to reach out to more at-risk patients and help address opioid abuse.
- Support staff participation in medication assisted treatment programs (MAT) to help address opioid abuse in our patients.
- Support services and medications at no cost to students served at school-based health centers.

3. *Clinical Care Coordination*

Health centers believe that the best healthcare outcomes are achieved when providers work in partnership to care for the needs of the whole patient. To help support the integration of services and the creation of care teams, health centers have been relying on their 340B savings.

Care Coordination services that are funded by 340B savings include:

- Expanding care that may not be currently funded, this could include Behavioral health, OB/GYN, and dental services that are co-located and help create a continuum of care for patients.
- Support the Patient Centered Medical Home Initiative, which includes case management and care coordination, nurse triage and specialty referral support.

- Charity Care Programs, including Diabetes education and nutrition classes, legal advocacy, food pantries, transportation services, transitional housing and other enabling services.
- Population health and chronic care management services for chronically ill patients.

4. *Expanded Access to Healthcare Services*
   Sixty eight percent of health center patients are at or below 138% of the Federal Poverty Level, meaning that many are unable to pay for their healthcare. Currently health centers are reimbursed under the Prospective Payment System (PPS), however, many of the services our patients need are not covered by PPS.

   Thus, health centers have been using 340B savings to:
   - Ensure that all health center services are available to everyone, regardless of their ability to pay, and when appropriate offering patients the option to pay for care through the sliding fee scale. This would include subsidizing and paying deductibles related to the cost of care for homeless and low income patients, such as lab work.
   - Open new service delivery sites in underserved or unserved areas, including rural locations.
   - Health fairs, education, outreach, and care beyond the four walls of the clinic.
   - Help cover costs for delivering care through telemedicine.

5. *Infrastructure Support*
   To improve how services are provided, as well as increase these services for patients, health centers have invested 340B savings towards further developing processes in health centers, as well as expanding current infrastructure.

   This includes:
   - Modernizing IT infrastructures, including updating how electronic health records are maintained.
   - Added capital to expand capacity, such as building additional exam rooms.
   - Sustaining quality management programs and departments that are responsible for collecting, analyzing, and reporting data.
   - Training employees to use data to improve clinical and operational measures.

Discussion Questions

1. Is there an area where you invest your 340B savings and you're unable to fit in one of the five identified areas?
2. Are there any concerns with the Areas / identified services that are being proposed?
3. Are you able to commit to invest your 340B savings into these 5 areas only?

- ***Action Item: Does the Committee approve having CPCA members commit to investing their 340B savings exclusively in the identified five areas?***

II. Determining 340B Proceeds Amounts vs. Savings

The CPCA Board approved the 340B PN subgroup to develop a formula to calculate the costs of operating a 340B program in order to differentiate between 340B proceeds and savings.

As covered entities, health centers have the ability to offer 340B discount through in-house pharmacies, contract pharmacies, or a combination of both options. However, both options have an associated cost for doing business, meaning the 340B proceeds obtained by the health center differs from the amount of savings that are retained and used to provide services.

Definition for 340B Proceeds

Through the 340B program, health centers have been able to access medications, such as provider administered drugs, at a discount while still being allowed to be reimbursed for the full cost of the drug.

According to California health centers, 340B proceeds is defined as the total amount a covered entity receives through the 340B drug discount program. In other words, 340B proceeds is the similar to gross income, which would be calculated before deducting the cost of doing business. Currently, most health centers are able to pull the total amount of proceeds received from the 340B program, but wouldn't be able to provide a full breakdown of where exactly the savings are being used.

Per the above, the subgroup recommends defining 340B proceeds as the total income received from the 340B program, prior to deducting the cost of doing business. The formula would be:

340B Proceeds = ALL of 340B program earnings by the covered entity (prior to including the cost of business)

Defining 340B Savings

The 340B drug discount program allows health centers to access medications, including provider administered drugs, at a lower cost. The savings health centers accrue are then reinvested into expanding healthcare access for patients and expanding the services offered to patients. Without these savings health centers would NOT be able to provide many of the services that care for the whole patient.

To determine the amount of 340B savings a health center must deduct the cost of doing business from the 340B proceeds amount. The 'cost of doing business' includes:

- Fees from Third Party Administrators (TPAs), drug venders and contract pharmacies
- Legal fees
- Running internal audits
- Hiring independent auditors
- Cost to send staff to trainings
- Staff time for running the 340B program
- Dispensing fees
- ALL other costs associated with the 340B program.
- Indirect expenses (HR, IT, administrative and accounting fees, etc.)

340B savings, is the net proceeds received from the 340B program once all costs of running the business are deducted. The formula would be:

Savings= Total 340B Proceeds – Cost of running a 340B program

Discussion Questions

1. Are there any concerns in how we are defining 340B proceeds and 340B savings? Anything we missed?
2. Do you agree with our definition for the 'cost of doing business?'
3. Will your health center be able to abide by these definitions to ensure we are all referencing the same thing when saying 340B savings?

- ***Action Item: Does the Committee approve CPCA's definitions of 340B proceeds and 340B savings?***

INFORMATIONAL

Date: September 21, 2018

To: Government Programs

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Reduction in CVS-Caremark reimbursement for drugs dispensed by in-house pharmacies

MEMORANDUM

I. Background

In late July 2018, health centers in California, and at least six other states, that operate in-house, closed-door pharmacies (meaning pharmacies owned by a health center that serve only health center patients) received letters from CVS-Caremark, the Pharmacy Benefits Manager (PBM) that cover approximately one-third of outpatient prescriptions dispensed nationally. These letters stated that effective September 1, CVS-Caremark will dramatically reduce its reimbursement for brand-name drugs (except those covered under Medicare Part D) to Average Wholesale Price (AWP) minus 30%, with a 50-cent dispensing fee. Health centers are required to either accept these lower rates, or withdraw from all CVS-Caremark plans.

Due to the complexity of drug pricing, there is no standard way to compare these new reimbursement rates to health centers' actual costs; such comparisons must be done on a case-by-case basis. However, health centers report that these lower rates significantly reduce their ability to retain 340B savings, and can result in reimbursement that is less than actual costs.

II. Possible Resolution

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

These recommendations were to have NACHC:

1. Explore options for adding an anti-discrimination clause to the 340B statute.

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

2. Explore non-legislative options to respond to discriminatory contracting practices that cause health centers to lose 340B savings.

This would include responding to CVS-Caremark's plans to dramatically reduce reimbursement for brand-name drugs purchased under 340B by FQHCs with in-house, closed-door pharmacies.

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

Informational

Date: September 21, 2018

To: Government Programs Committee

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

Re: Licensing & OSHPD 3 Legislative Update and Overall Progress

MEMORANDUM

I. Licensing Research Project

CPCA has contracted with the consulting firm Pacific Health Consulting Group (PHCG) to undertake the research of the licensure process of CHCs and the associated regulations, including OSHPD 3 with the ultimate goal of providing recommendations for how to alleviate the challenges experienced by health centers that are impeding access and diverting much needed resources. PHCG consulting team brings a wealth of knowledge of not only CHCs, but also the regulatory and administrative challenges that CHCs face with licensure.

On September 18, the CPCA and PHCG teams met to kick off the extensive research project. The project will include a primary care licensing guidelines grid, documented history of the licensing guidelines, research into alternative models of licensure, calculation of costs, and recommendations. The project is scheduled to be completed in the summer of 2019.

Moving forward PHCG will work with the internal CPCA team, and we have also requested that they present and seek input from the CPCA Board and/or Government Programs committee and the Licensing and OSHPD 3 workgroup, as needed. At the culmination of the project PHCG will present their finding to the Board for approval of next steps.

The timeline for completion of the research project is scheduled for mid-2019, and the expectation is that there will be legislative recommendations. Considering the timeline, legislative action would then occur in 2020 (at the end of a two-year cycle) or in 2021 (at the beginning of a two-year cycle).

II. Legislative Updates

A. Consolidated Licensing – AB 2428 (Gonzalez Fletcher):

AB 2428, CPCA's sponsored bill, has successfully passed the legislature, and as of the writing of this memo, is awaiting action by the Governor. This legislation seeks to improve the consolidated licensure process by creating two pathways forward:

- The first pathway would create a defined process for health centers seeking a consolidated license. Newly consolidated facilities would be required to either apply for an interim rate for the new consolidated facility, or apply for a new rate which would combine the services of the existing and consolidated facilities. This path creates clarity as to the process of applying for a consolidated license.

- The second pathway creates a process for health centers that are in consolidated-like situations created by CDPH prior to January 1, 2017. These health centers would have the option to keep their existing rate, until a triggering event occurs.

B. Intermittent Clinics- AB 2204 (Gray):

AB 2204 was signed by the Governor on September 6th. This bill, which is sponsored by Central California Partnership for Health, was signed by the Governor on September 6, 2018. The bill expands the intermittent clinic hours from 30 to 40 hours per week. The suspected implementation date for AB 2204 is January 1st, 2019. We will work with our partners in the implementation of this AB 2204 and will assist members to ensure a smooth transition.

C. Provisional Licensing in the Case of Processing Delays:

Health centers have continued to be hampered by delays in CDPH's processing, approving, and issuing of licenses and requests for changes. Given the current and historical inability by CDPH to meet the timeframes defined by Health and Safety Code, CPCA has determined that there is a potential need to create or improve the provisional licenses awarding process.

During the most recent legislative session the California Hospital Association (CHA) sponsored AB 2798, which sought to create a similar provisional license process. Staff has engaged with CHA on that bill and had discussions on the palatability of running similar legislation that would encompass both organizations' members. As of the writing of this memo, AB 2798 has not been signed by the Governor and CHA has intimated that there is strong opposition by CDPH.

III. Ongoing Licensing and OSHPD 3 Efforts

A. Licensure Exemption

Health and Safety Code 1206 lists all of the opportunities for licensure-exemptions. Staff reviewed all of these exemptions and has determined that health centers would only qualify for the 1206(g) exemption. The 1206(g) exemption states "A clinic operated, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art."

CPCA has met with each department in CDPH and DHCS in order to ensure a clear pathway forward using the HSC 1206(g) licensure-exemption. Two member health centers have been selected to move forward with this exemption based on their qualifications and readiness to apply for this license-exemption. These health centers have begun the process of collecting and submitting the required documentation for Medi-Cal enrollment and license-exemption. The process can take up to 180 days (estimated time frame approximately April 2019) from enrollment, and CPCA will continue to provide guidance to the health centers. In addition, CPCA is working with a consultant who has experience with the license-exempt process for other clinic types to respond to any technical assistance needs that may arise. Once the health centers go through the process successfully, we will develop a process and pathway to share with other interested clinics and health centers for future use.

B. Building Standards Commission Composition

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

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

C. Additional efforts

In addition to our Board approved strategies, CPCA is participating in an additional effort being led by Health Center Partners of Southern California. HCPSC has undertaken a project to better understand the exact costs associated with OSHPD3 compliance and is hoping to see the effort replicated in other parts of the state to compare whether costs are the same or if there is regional variance. The group of consortia and CPCA plans to meet throughout the summer, gathering information that hopefully can be used to inform advocacy moving forward.

Discussion

Date: September 21, 2018

To: Government Programs Committee

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

Re: OSHPD Triennial Cycle Advocacy

MEMORANDUM

I. Background

CPCA has been undertaking a multi-pronged strategy with the goal of addressing member's concerns with the overly burdensome regulations caused by the licensure of community health centers (CHCs), including OSHPD 3 building standards. This strategy entailed steps to reduce the burden including administrative, legislative, and regulatory.

II. Discussion items

A. OSHPD Triennial Building Codes Cycle

The Office of Statewide Health Planning and Development (OSHPD) is in the middle of their building codes cycle. While much of the code cycle has focused on creating rules for Acute Psychiatric Hospitals (OSHPD 5), there is one suggested amendment which has concerned CPCA staff (see language in resource section below). This regulation would amend a code section to define "contiguous functions" and would state that each suite shall be contiguous and include access to each required function for that basic service. Our initial concerns centered around the potential impact caused by the increased ambiguity and the effects it would have on health centers and their ability to strategically expand access for their patients.

When first introduced, CPCA met with OSHPD staff and CDPH, to share our concerns, explain our reasoning and potential confusion, and recommend that the proposed amendment be removed from the proposed code cycle. To this point, CPCA has consistently advocated for OSHPD to remove this regulation from their proposed code cycle, while continuing to provide background on how health centers function, with the goal of improving the continuing amendments proposed by OSHPD. Staff has been participating in these conversations along with our outside counsel and Planned Parenthood Affiliates of California.

We believe that the newest proposed regulation is much clearer and less ambiguous than the originally proposed regulation, however, staff continues to be concerned about a few aspects. Particularly, we are concerned with the inclusion of a CDPH approval process and the implications of "basic services". Staff has developed amendments to the OSHPD language and plan on presenting this language to the board and the licensing and OSHPD 3 workgroup. Below we have outlined our planned advocacy efforts:

- Following feedback from the Board and Workgroup, Staff plan to meet with OSHPD to share our continued concerns and provide them our alternative language.
- Should OSHPD choose to disregard our alternative language, then staff will move forward with a formal oppose position and will work with health center leaders, and our partner organizations, to submit comments during the current 45-day comment period. Comment period ends on October 29th, 2018.

Discussion Questions

1. Does the committee agree with our proposed strategy to fight this proposed amendment?
2. Are there other strategies we should be engaging in?

III. Resources

OSHPD Regulations re: Corridors

- ***CPCA suggested amendments***
  1226.4.3 Corridors.
  1226.4.3.5 Contiguous functions.
  Basic services of a single licensed clinic may be located in separate suites. Each clinic suite shall be contiguous and include internal circulation to access each of the required functions identified for that specific basic service. For purposes of this regulation, "basic services" shall mean any service described in Article 3 (commencing with Section 75026) of Chapter 7 of Division 5 of Title 22 of the California Code of Regulations.

  Exceptions:

  1. *Various functions not directly related to the provision of a specific basic service can be provided outside the clinic suite and can be shared with other tenants. These functions include, but are not limited to, reception and waiting areas; drinking fountains; general housekeeping; waste management, general storage, laundry; and toilets, lounges, or storage used for clinic staff.*

- ***Current amendment:***
  1226.4.3 Corridors.
  1226.4.3.5 Contiguous functions. *Basic services of a single licensed clinic may be located in separate suites. Each clinic suite shall be contiguous and include internal circulation to access each of the required functions identified for that specific basic service.*

  Exceptions:

  1. Various functions including, but not limited to reception, waiting, staff support areas such as toilets, storage, and lounge may located outside of the clinic suite with approval from the California Department of Public Health.

  2. If toilets and drinking fountain(s) serving the public are provided as part of the overall building features, they need not be provided within the clinic suite.

  3. Shared services. Space for general storage, laundry, housekeeping and waste management may be shared with other tenants.

- **Original amendment:**
  1226.4.3.6 Departmental boundaries
  Licensed clinic space areas shall be contiguous and include internal circulation to access each of the rooms/spaces associated with it, as identified under the specific clinic type requirements.

- **Current law:**
  1226.4.3.5 Connections
  Refer to 1224.4.7.5 - Connections
  Corridor systems shall connect all patient rooms and basic services.

  Exceptions:

  1. *Covered pedestrian walkways connecting separate building are permitted for ambulatory, psychiatric, or chemical dependency patients.*

Discussion

Date: September 21, 2018
To: Government Programs Committee
From: Allie Budenz, Associate Director of Quality Improvement, Liz Oseguera, Senior Policy Analyst, Michael Helmick, Senior Policy Analyst
Re: Behavioral Health Visioning Discussion

MEMORANDUM

I. Background

Up to this point, CPCA's behavioral health work has prioritized expanding the availability of CHC-based behavioral health care in the delivery system. Beginning with the addition of MFTs as billable providers, expanding access to Mental Health Services Act (MHSA) funds, contracting as Drug Medi-Cal (DMC) and specialty mental health (SMH) providers, and culminating in our latest work on same-day billing, CPCA been focused on bolstering the provision of behavioral health care in CHCs.

While this work was an important first step, it does not fundamentally solve the fractured and badly-designed behavioral health safety-net that our patients must grapple with. With the expiration of the 1915(b) specialty mental health services waiver in 2020, the state has an opportunity to fundamentally redesign aspects of the mental health delivery system and as major players in the behavioral health care delivery system it is imperative that the health center patient and health center provider perspective is accounted for in the redesign.

II. Behavioral Health "Visioning" for the Future

In advance of the 1915(b) Specialty Mental Health Waiver negotiations, CPCA has commenced planning a health center visioning process to inform a behavioral health delivery system for the future. The BH Visioning efforts will shape how CPCA engages in these efforts, and it is our desire to have participation from a diverse array of health center leaders. For a description of the Visioning session please see the resources section of this memo.

Executive and behavioral health leadership from health centers and consortia are encouraged to attend this behavioral health policy prioritization process on November 8th from 9:00am to 3:00pm in Sacramento.

III. Discussion

In order to get a head start on our thinking around future waivers, staff appreciate hearing leadership perspective on the benefits and pitfalls of participating more deeply in the full behavioral health delivery system. As this group well knows, California's behavioral health delivery system is trifurcated into three categories -

1. Mild to moderate mental health: paid by managed care (or their intermediary) and provided by contracted providers;
2. Severe mental health: paid by the county Specialty Mental Health (SMH) plan and provided by county-contracted providers and/or the county mental health department;
3. Substance use disorder services: paid by the state's Drug Medi-Cal (DMC) system or the county Drug MediCal Organized Delivery system.

There are health centers contracted with one or more of each of these buckets. In order to get a head start on our thinking around future waivers, staff appreciate hearing from health center leadership.

Discussion Question:

1. What are the challenges and successes you face in participating (or not participating) in each of the three separate programs?

Additionally, with the passage of SB 323, which clarified how health centers can become dual FQHC and SMH/DMC providers, we presume there is more interest in health centers pursuing multiple service lines. CPCA seeks to understand why health centers would like to be more engaged with the county.

Discussion Questions:

1. Why (or why not) do health centers want to make a bigger investment in contracting with the county?
2. To what lengths health center leadership is willing to go to become more ingratiated with the county (e.g. Buying a new building to do DMC services?
3. Taking a revenue loss until the new service line evens out?).

IV. References

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

Informational

Date: September 21, 2018
To: Government Programs Committee
From: Allie Budenz, Associate Director of Quality Improvement, Liz Oseguera, Senior Policy Analyst, Michael Helmick, Senior Policy Analyst
Re: Behavioral Health Update

MEMORANDUM

I. Overview

CPCA's advocacy efforts for behavioral health services has recently centered on expanding CHC's ability to participate in, expand, and bill for the full array of behavioral health services. As the update shows below, these efforts have been largely successful in expanding the role of CHCs in behavioral health, albeit with additional work needed to ensure continued growth in these efforts.

II. Where We're At: Results of the 2018 Behavioral Health Services Survey

CPCA conducts a bi-annual survey in order to understand the trends and trajectory of CHCs in the behavioral health delivery system. The 2014 and 2016 versions of the survey emphasized topics around operations, billing, workforce, and funding, while the 2018 iteration focused on gaining insight into the relationships between health centers and county behavioral health. In 2018, we had 70 respondents representing a total of 481 CCHC sites. Respondent sites were almost evenly split between Northern and Southern California with only a few in Central California.

We have seen an enormous growth in behavioral health services in recent years – between 2010 and 2016, the number of mental health encounters at CHCs has skyrocketed by approximately 154%! A full 80% of respondents report having either co-located or fully integrated mental health services in primary care. In 2016, one quarter of respondents noted that their organization did not provide mental health services at all; this number dropped to zero in 2018.

We are seeing a similar growth in substance use disorder (SUD) services at CHCs, where only 10% of respondents report not providing SUD onsite, down from 30% in 2016. In fact, UDS shows that CHCs have nearly doubled their medication assisted treatment services in the past two years - in 2016, 275 FTE providers were managing 3,818 patients on MAT at CHCs in CA, but those values increased to 488 providers managing 6,416 patients in 2017. We note, however, that a full 33% of survey respondents do not provide MAT services. Stigma against individuals with substance use disorder and the high cost but low reimbursement for MAT were cited in the survey as two primary challenges to full adoption.

From the open-ended survey results, it is abundantly clear that the extent of FQHC participation in the BH delivery system is either facilitated or impeded by the relationship between providers and the county. County behavioral health departments are often the direct recipient of BH funds (such as MHSA) and hold the ultimate authority to dictate terms and agreements, including how county mental health plans will coordinate with other elements of the delivery system. The data shows that more health centers are either currently contracted or considering contracting for DMC (42% of respondents) than for specialty mental health (SMH) (27% of respondents). This

information confirms what CPCA staff hear anecdotally – that DMC, as a program and payer, is far easier to adopt because the contracting process, reporting, and billing is less onerous than SMH.

The BH Services Survey asked respondents to identify areas of confusion that they have with the process of contracting as a SMH or DMC provider with their county, and CPCA categorized the responses into comparable themes. Most notably, there is a need for more clarification and training on how to maintain DMC/SMH compliant accounting systems because this process differs remarkably from FQHCs standard practice. CPCA will use this information to inform future training and technical assistance.

III. Policy Landscape

Key State Behavioral Health Legislation 2018- *Staff engages on behavioral health legislation with the goal of improving the overall system of care and, as highlighted below, have strategically prioritized our participation in bills which would improve services for health center's patients or health center's ability to provide those services.*

1. SB 1125 (Atkins) – Same Day Billing (CPCA co-sponsored with the Steinberg Institute)
CPCA's advocacy strategy has supported the passage of SB 1125 from the legislature. The bill is now on the Governor's desk awaiting signature. If signed, and contingent upon securing funding in the budget, health centers will be able to bill for both medical and behavioral health services provided on the same day. A full discussion on this bill will be held during the Legislative Committee.

2. SB 1004 (Wiener) – MHSA Prevention and Early Intervention
CPCA successfully worked with our partners at the Steinberg Institute to include bill language that counties prioritize collaboration with CHCs when developing PEI programs. Specifically, CPCA was able to have language added that would prioritize the use of prevention and early intervention funds towards supporting critical linkages with community-based organizations, which explicitly calls out CHCs. This bill is on the Governor's desk awaiting signature.

3. SB 275 (Portantino) – Alcohol and drug treatment for youth
This bill establishes the Children, Adolescents, and Young Adults Substance Use Disorder Treatment Act, and requires the Department of Health Care Services (DHCS) to convene an expert panel to advise DHCS solely on the development of youth substance use disorder treatment quality standards. CPCA worked with SEIU, the sponsors of the bill, to ensure that the advisory panel includes a representative from a CHC that specializes in either school-based health programs or mental health services. This bill is on the Governor's desk awaiting signature.

4. SB 192 (Beall) – Mental Health Services Fund

- This bill was signed by the Governor and will require previously allocated MHSA funds that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, to revert to the MHSA Reversion Account. The bill also requires:A counties prudent reserve not to exceed 33% of the average Community Services and Support revenue received for the last 5 years. The maximum amount of the reserve must be assessed every 5 years.
- Counties that have not submitted a plan to the MHSOAC stating how they will reinvest unused MHSA funds by January 1, 2019, to return these funds to the Reversion Account no later than July 2019.
- Funds reverted to counties by AB 114 to be spent by July 1, 2020 or returned to the state.

Opioids and Substance Use Disorder- The federal administration's approach to addressing the worsening opioid crisis is to reduce barriers to SUD treatment by infusing additional funding for SUD treatment and prevention to states, localities, and health centers. Some of these additional funding opportunities are:

1. HRSA announced $350 million for the Expanding Access to Quality Substance Use Disorder and Mental Health Services. This supplemental funding will support health center's ability to expand services for SUD and integrated mental health services. HRSA funding to health centers is not restricted to MAT and may be used for general SUD services to address the community's defined need.

2. The state DHCS SUD Division applied for SAMHSA's State Opioid Response (SOR) grants, which if received would provide $138 million over two years to the state. In California, the precursor to the SOR grants - the State Targeted Response to the Opioid Crisis grants - were used to develop the CA Hub and Spokes system (H&SS). Award announcements are expected by the end of September. In developing the grant proposal, DHCS did NOT have any sort of stakeholder process or any opportunity for input. However, CPCA did submit unsolicited comments on how to structure the funding and DHCS took some of our key recommendations. The additional funding will be used to bolster the delivery system by improving quality and access to MAT care. The following areas are places we see CHCs being the most competitive:

- $40 million is earmarked for new Medication Assisted Treatment (MAT) access point grants. Primary care sites, including CHCs, can compete for over 200+ new access points to start-up or enhance MAT programs. This was one of our key recommendations.
- Grants are also available for service expansion to special populations (perinatal, NAS, veterans, service members, and youth) are eligible to compete for grants to cover the cost of expansion current or new services.
- Health Centers will be heavily targeted to participate in the Treating Addiction in Primary Care Safety Net program. This is CCI's MAT training program and CPCA serves on the advisory board.

<u>MHSA Update</u>

The Mental Health Services Act (MHSA), a program passed in 2004 by voters as Proposition 63, provides for a 1 percent income tax on individuals earning more than $1 million per year in order to expand existing mental health programs and services, address the stigma and discrimination associated with seeking mental health services, and improve access to underserved groups. CPCA has been working with partners to ensure that MHSA funds are available to CHCs, as well as prioritizing the need to effectively serve culturally diverse communities. The following highlight our recent efforts to improve the functionality of the MHSA.

<u>Mental Health Access to Immigrants and Refugee Communities</u>
The 2018/2019 budget includes funding to the MHSOAC towards improving the mental health services offered to immigrants and refugees, specifically by ensuring advocacy is conducted to help engage this group into services and policy discussions.

Currently the MHSOAC is holding three regional stakeholders meetings to receive input on an RFP that they will be releasing to support advocacy around mental health for immigrants and refugees. We have strongly encouraged health centers to participate in these events to share the work you all are already doing with this population.

To help support the development of the RFP, CPCA completed a survey sent out by the MHSOAC where we highlighted the great work that health centers have been doing to help address fear in immigrant and refugee patients and their arising mental health issues. We are also participating in coalition efforts led by our immigrant partners to ensure the RFP is inclusive as possible and provide funding where it's most needed.

Innovation Funds
CPCA has partnered with Health Access and the California Pan-Ethnic Health Network (CPEHN) to push recommendations to the MHSOAC on how to best shape the innovation incubator and community planning process for PEI and Innovations through an issue brief. CPCA worked to ensure that linkages to CBOs and CHCs was consistently highlighted throughout these recommendations.

The issue brief, which can be found below in the resource section, was shared with MSHOAC during a meeting with the executive director in early August. We hope to have an opportunity to present these recommendations to the council members when they take up this issue at a later date.

Workforce, Education and Training (WET) Funding
The Office of Statewide Health Planning and Development (OSHPD) is currently holding stakeholder meetings to help with the development of the WET 5 year plan. WET funds are used to boost the public mental health workforce and are statutorily allocated for public health providers, and those contracted to provide services on behalf of counties. CPCA has participated in these discussions to advocate for a systems change which prioritizes a more culturally-diverse mental health workforce.

Although, WET funds are in line to sunset in 2019, mental health advocates are likely to conduct a budget push to extend funding. If this were to occur, there may be an opportunity to reshape the program and push to have some of these funds support non-public providers, such as health centers.

Proposition 64 Coalition

With strong encouragement from CPCA members and advocates, staff began participating in a large coalition looking at how California should spend funding from Proposition 64, the California Marijuana Legalization Initiative. These funds are to be made available for SUD education, prevention, intervention, and treatment for youth and will be collected through the Marijuana tax in the state; 60% of which must be allocated to a youth SUD programs after other state entities receive their share.

Through our advocacy efforts, we've been able to promote a more integrated system of care that acknowledges the importance of including all providers who offer primary care and/or SUD services to youth in the funding allocation of Proposition 64. Through these efforts, the coalition has put out principles for the legislature to consider when looking to allocate Prop 64 funding next year. CPCA has successfully included language in these principles to ensure non-profits and CBOs, such as health centers, can have access to this funding.

Although the coalition does not expect to sponsor legislation related to Proposition 64, it will work to oppose legislative bills that contradict or do not follow the principals we've put forth.

IV. Resources

- *Leveraging FQHC's in California's Behavioral Health Care Continuum*
- *California State Opioid Response Grant*
- *Proposition 64 Coalition Principles*

Discussion

Date: September 19, 2018
To: Government Programs Committee
From: Allie Budenz, Associate Director of Quality Improvement
Re: Care Coordination Memo

MEMORANDUM

I. Care Coordination Advisory Committee

DHCS is convening a short-term Care Coordination Advisory Committee to discuss findings of the department's systemic assessment of care coordination services for Medi-Cal Members and formulate future policy recommendations. The Advisory Committee will include Medi-Cal Managed Care Plans (MCPs), counties, providers, sister departments, Medi-Cal member advocates, and internal DHCS stakeholders. After completion of these meetings, DHCS will draft a concept paper of proposed policy changes, vet the proposed changes with stakeholders, and work to implement policy changes. Some changes may require a longer timeframe. This project encompasses the full spectrum of care coordination, including screenings, health assessments, case management, care management (provider and plan driven), data, transitions in care, communication, governance, training, monitoring through meaningful metrics, and other issues.

CPCA has been selected to participate on the advisory committee and will provide input at the four meetings occurring between August and October 2018. We will be vetting questions for member input and providing opportunities to weigh in through the Managed Care Task Force (MCTF). The following are opportunities that we currently see as issues to weigh in on:

> Care Coordination Assessment Library: In general, feedback from stakeholders is that DHCS should redesign assessment requirements as one part of a comprehensive care coordination structure, which will reduce gaps and redundancy by accounting for all scenarios as part of one design process.
>
> CPCA presented the issue of redundant assessments to the MCTF and their feedback was that a number of the assessments used by plans and providers ask redundant questions. But, even if there were a reduction in the number of assessments required, different entities within managed care will perform the same assessment for their records because there is no means to share results across providers. One feasible solution appears to be a HIPAA compliant centralized database where information could be stored and accessed by providers and health plans (which was piloted on a small scale with success in Cal Medi-Connect).

Discussion Questions:

1. Are there any examples of health centers sharing assessment data with MCPs or other providers successfully?

2. Given that the issue appears to be sharing assessment results rather than redundancy, is there value in CPCA staff and the MCTF combing through the assessment library to make a recommendation to the state of which assessments should be removed?

   NCQA Accreditation: Many, but not all, of DCHS' contracted MCPs (18 of 24) are NCQA certified; and as a result, already follow NCQA guidelines with regard to care coordination or population health management. DHCS is considering requiring all Medi-Cal MCPs to be NCQA accredited. In general, feedback from stakeholders is that DHCS should attempt standardization and alignment of any care coordination policy requirements. NCQA has complex case management and population health management requirements already established. If DHCS were to align with those requirements, the expectations and requirements of MCPs could potentially align with other agencies and further reduce redundancies for the MCPs. DHCS is also considering potentially requiring their delegated risk bearing organizations (like IPAs and medical groups) to also become accredited.

   CPCA presented the issue of require RBO's to be accredited to the MCTF and they are skeptical that accreditation would correlate with improved coordination between plans and IPAs. Accreditation is a costly and time consuming endeavor and while it may be valuable in some delegated models, there is no evidence that the requirement would demonstrate statewide improvement. Finally, there is fear that a requirement to become accredited may trickle down to providers, which would be unfavorable.

Discussion Questions:

1. Does CPCA support the requirement that Managed Care Plans (and/or RBO's) be NCQA certified?
2. Why/why not?

II. ACA Section 2703 Health Homes Program

On July 1, 2018, HHP implementation began in San Francisco County for members with eligible chronic physical conditions and substance use disorders. HHP is expected to be fully implemented across 29 counties by January 2020, and will provide services in the following core areas: comprehensive care management; care coordination (physical health, behavioral health, community-based long-term services and supports); health promotion; comprehensive transitional care; individual and family support; and referral to community-based and social support services. DHCS will host a stakeholder update webinar on September 26th, overviewing progress to date.

Given the increased attention on the efficiency and effectiveness of care coordination activities, and the state's assertion that the HHP benefit will only remain in perpetuity if it achieves cost savings, CPCA is deeply invested in ensuring health homes is a success. We have been very clear with DHCS and Harbage Consulting, the state's training and technical assistance contractor, that the trainings produced thus far are insufficient. We've received member feedback that potential CHC Community Benefit Care Management Entities (CB-CME) need more robust training on care management concepts, like: patient engagement and enrollment, standardized care planning, and facilitating coordination between internal and external partners.

To address the unmet need for health center-specific training on the fundamentals of care coordination, CPCA is partnering with the Redwood Community Health Coalition to coordinate a series of peer to peer

learning opportunities for health centers to strategize business plans, care models, and trouble shoot common barriers in order to maximize their chances for success as CB-CMEs. These trainings are scheduled to be delivered in early 2019.

III. DHCS Services that Follow the Patient – SB 456 Response Letter

DHCS has officially confirmed in writing that FQHCs may participate in, and be paid outside of the PPS rate for services under the following programs:

- Whole Person Care pilots under the 1115 Waiver
- Hub and Spoke Services under the Opioid Response Grants
- Medicare Chronic Care Management payments for dual eligible Medi-Medi's
- 2703 Health Homes (also written in SPA).

This guidance should alleviate any concerns that care coordination services reimbursed outside of PPS for these programs may be reconciled. DHCS has also committed to working on final guidance to instruct auditors on the treatment of these funding sources and on the broader issue of pay-for-performance and other similar payments.

This letter came to be as a result of Senator Richard Pan's leadership within the capitol to drive a conversation on the importance of care coordination programs and create clarity for health centers engaging in this space. In 2017, Senator Pan also authored SB 456, as attempt to garner a legislative solution to this issue. In August 2018, Staff from Senator Pan's office, DHCS, and California Health+ Advocates, met to determine and discuss a potential administrative solution. The Senator determined that the timing was right to request written confirmation from DHCS on which programs could be paid for outside of PPS rate. With this written confirmation, Senator Pan has determined that he will no longer move SB 456 on the Assembly floor. We look forward to continuing to work with Senator Pan and the legislature going forward to ensure this letter is honored.

IV. Resources

- DHCS Care Coordination Assessment Project: https://www.dhcs.ca.gov/services/Pages/Care-Coordination-Assessment-Project.aspx
- DHCS Health Homes Program: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
- Letter from DHCS to Senator Pan (re: SB 456)

Informational

Date: September 18, 2018
To: Government Programs Committee
From: Michael Helmick, Senior Policy Analyst
Re: Clinic Lifeline Grant Program

MEMORANDUM

I. Update

CHFFA has undergone the process to amend and readopt the emergency regulations in order to allow for a continuous application process of the remaining Clinic Lifeline Grant funds. The newly adopted regulations became effective on August 22, 2018. Applications can now be filed continuously with CHFAA, and the application will be accepted and reviewed within 60 days of the application submittal.

II. Next Steps

$11,723,690 remains unallocated from the Clinic Lifeline Program fund after the first round of grants, and must be allocated by 2022, as required by statute. CPCA will continue to provide technical assistance to the Treasurer's Office and our member health centers to ensure that the remaining funds are allocated in manner consistent with statute and would allow for health centers and partners to qualify.

III. Background

The Clinic Lifeline Act of 2017 was signed into law by the Governor on July 10th, 2017 and established the Clinic Lifeline Program within the State Treasurer's Health Facilities Financing Authority (CHFFA). The Lifeline Program appropriated $20 million from the Health Expansion Loan Program (HELP) in order to create a grant program with the goal of assisting small health center locations (sites with a budget under $10 million) and rural health facilities that are adversely financially affected by a reduction or elimination of federal government assistance. Applications for grants available under the program were due on March 26th, 2018.

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

On June 28, 2018 CHFFA held their meeting where the first round of Lifeline Grant Awardees were announced. There was a total of 56 grant applications received by CHFFA, however only 42 grants were deemed eligible by CHFFA. FQHCs were awarded 26 grants and received $5,385,066 out of $8,276,310 awarded at this stage. The additional 16 grantees were Planned Parenthood Affiliates. The remaining 13 applicants were deemed either incomplete or ineligible.

Informational

Date: September 20, 2018
To: Government Programs Committee
From: Nenick Vu, Associate Director of Managed Care
Re: Medi-Cal Managed Care Update

MEMORANDUM

I. Overview

CPCA's Managed Care Work has been defined by 4 overarching priorities, developed by the Regional Consortia. While work continues on each of the four priorities, each has begun to interweave with the others and all must be examined in light of the major changes that are underway in the Medi-Cal delivery system, including the soon-to-expire 1115 Waiver and the incoming change of Administration. There are major changes coming to Medi-Cal managed care, and it will take coordination on all levels of the delivery system to ensure that CCHCs are a centerpiece of the Medi-Cal network.

One of the most important elements of the RAC Managed Care priority identification process has been to identify tasks and coordinate between local, regional, and statewide efforts in this area. Each of the four priorities – 1) Educating the new administration; 2) Commercial plan procurement; 3) P4P, HEDIS, and quality alignment; and 4) Enrollment efficiency and default assignment contain elements that need to be addressed at each level of the delivery system. Below, we outline our work in each priority.

II. RAC Managed Care Priorities

Priority 1: Educating the New Administration and Leadership
CPCA has begun collecting data points that can be used to educate the new Administration and Leadership at DHCS about the important role that CCHCs play in the delivery system. Our Government Affairs staff is undergoing a policy prioritization process to identify those priority issues with which we will lead our engagement with new DHCS leadership.

Priority 2: Commercial Plan Procurement
The procurement of new commercial Managed Care contracts is currently scheduled to start in late 2019, according to the DHCS website. Recent news is that the Administration has not yet begun developing the RFP for the Commercial plans to respond to indicates that the procurement timeline may be pushed back. CPCA has retained the services of Athena Chapman, former VP of State Programs for the California Association of Health Plans, to carry this work forward.

Priority 3: P4P, HEDIS, and Quality Alignment
Much of the work in this priority is driven by conversations with DHCS about the potential inclusion of P4P incentive payments in the annual reconciliation. As we begin to arrive at an agreement around P4P incentive guidelines with DHCS, it is our intention to push the industry toward the adoption of best practice measures that have been shown to drive providers toward value-based quality in the commercial market by endorsing IHA's value-based P4P measure set. This set is widely used in the

commercial space but has been adopted in full by only one Medi-Cal managed care plan. During the RAC Staff Day Dolores Yanagihara gave an overview of the history of IHA's standardization of the value-based P4P measure set and how a similar initiative may be replicated in Medi-Cal. The Managed Care Task Force has also begun exploring the variety of P4P measure sets across California to explore with members the need for a standardized measure set.

Priority 4: Enrollment Efficiency and Default Assignment
The goal of this priority is to forward an agenda of modernizing and streamlining the Medi-Cal enrollment system. In line with our work in the P4P, HEDIS, and Quality Alignment priority, this goal seeks to improve and standardize how health centers receive information on assigned members from plans.

III. Merger Undertakings

Earlier this spring, DMHC has announced the acquisition of Davita Health Plan by Optum. As the first of several health plan mergers slated to occur, opportunities are arising to review existing merger undertakings from the Anthem, United, and Centene mergers, as well as influence the development of grants and safety net investment that will be available in the next round of mergers. CHCF has also recently published a report, "Ensuring Health Plan Mergers Benefit the Community" emphasizing a shortage of safety net projects relative to the investment funding that have been made available through previous mergers. CPCA has begun coordinating with DMHC to develop strategies to encourage and expand health center participation to apply for low interest financing for safety net infrastructure investment. Currently, CPCA staff are referring health centers that are interested in applying for financing to DMHC, and are coordinating to develop webinars that will increase health center awareness and utilization of these financing opportunities. Staff are also assessing safety net system for key areas that need investment to improve the access and delivery of care including standardizing P4P quality measures, workforce development, behavioral health integration, and investing in solutions to the opioid epidemic.

IV. Anthem Partnership

CPCA's managed care staff continues to work with Anthem's quality teams to expand health center awareness and participation in Anthem's quality initiatives. Anthem is expanding its quality strategies including adding member access to labs from home, standing orders for labs, the development of P4P incentive programs, and Clinic Days partnerships with health centers. In September, Anthem rolled out a telemedicine option, Live Health Online which will provide urgent care telehealth access to Anthem members. A webinar was held with the Managed Care Task Force to solicit membership feedback and concerns with this initiative, highlighting the need for continuity of care and the sharing of health records.