CPCA
California Primary Care Association

Health Care Access for All

November 14, 2014

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: CPCA Proposal for California's 1115 Medicaid Waiver Renewal

Dear Director Douglas,

The California Primary Care Association (CPCA) appreciates the opportunity to provide input on the Department of Health Care Services (DHCS) 1115 Waiver proposal. We fully support DHCS in your efforts to meet the Triple Aim through the use of the 1115 Waiver process, a goal that is especially important after expanding coverage to more than 3 million Californians under the Affordable Care Act (ACA). We thank DHCS for your ongoing commitment to Medi-Cal enrollees, and look forward to working with DHCS and other stakeholders to leverage the 1115 Waiver opportunity to incentivize quality, efficiency, patient satisfaction, and comprehensive care for all Californians.

CPCA writes this letter on behalf of more than 1,000 not-for-profit community clinics and health centers (CCHCs) in California that provide comprehensive, quality health care services to millions of Medi-Cal enrollees and who account for approximately 2/3 of primary care Medi-Cal claims. As an instrumental component of the Medi-Cal primary care network, CCHCs must be a central focus of any efforts to meet the Triple Aim. CPCA and California's CCHCs fully support the State's plan to build on the successes of the 2010 Bridge to Reform Waiver and move forward with a new waiver to care for the newly insured in the most efficient way through delivery and payment system transformation. We see many symbiotic opportunities for California to partner with the Obama Administration to explore innovative, ambitious programs that link quality improvement, outcomes, and financing together in the health care safety net. We are supportive of DHCS taking full advantage of the available programs and leveraging them all to create sustainable, comprehensive reforms for California's safety-net delivery system.

On behalf of our members and in the spirit of true collaboration with DHCS and the rest of the safety-net delivery system in California, we respectfully submit our ideas for California's next 1115 Waiver.

<u>An Opportunity: PCHH Benefit for Beneficiaries with Complex Conditions</u>
Recommendation: Develop a new Medi-Cal benefit for patients with complex conditions.

The Centers for Medicare and Medicaid Services' State Innovation Model (CalSIM) grant, in combination with funding available under Section 2703 of the Affordable Care Act (ACA), and the opportunity for cost savings under the 1115 Waiver, present an unprecedented opportunity for the State of California to take

a leadership role in the transformation of our State's health system. Working together, these three separate programs can position California's safety net to move toward the Triple Aim – the CalSIM providing the resources for technical assistance and preparation, the 2703 building a strong foundation of comprehensive health homes for the state's Medi-Cal population, *and the Waiver affording a new Medi-Cal benefit to California's most complicated Medi-Cal beneficiaries*. The resources to fund the new benefit would be found initially from the savings accrued to the Medi-Cal system during the 2703 pilot and then ongoing from the savings to the system for coordinating care for the sickest and most costly Medi-Cal beneficiaries. CCHCs are eager to partner with DHCS to transform the safety-net delivery system using these three opportunities atop the solid foundation we've already built in the Medi-Cal program.

Because of the critical investments from the Health Resources Services Administration (HRSA), foundations like The California Endowment, and CPCA's Patient Centered Health Home Initiative, California's CCHCs are primed to advance the patient centered health home delivery model. CCHCs have led the way in developing and refining ground-breaking models for care delivery to complex patients, with over 300 CCHC sites already having achieved Patient Centered Medical Home (PCMH) recognition and hundreds more in the process of doing so. Due to their expertise in providing comprehensive care to the Medi-Cal population, CCHCs are in a unique position to build upon their existing PCMH infrastructure to implement this much needed program in California. Currently, health centers are not able to provide the array of services funded in a 2703 because of they are not allowable under the PPS methodology. Creating a PCHH benefit in the Medi-Cal program through the 1115 Waiver provides the additional resources health centers need to deliver these high value services to their patients with complex health conditions. By strategically leveraging available resources to build upon the PCHH infrastructure already existing in CCHCs, California can optimize its ability to reshape the delivery of care and work towards the goals of the Triple Aim.

Safety Net Payment Reforms that Support Coordinated and Cost Effective Care for the Remaining Uninsured

Recommendation: Re-fund the traditional clinic programs to ensure stability for the Medi-Cal Program and its growing patients.

At the same time the State is considering greater flexibility to public hospitals and their clinic systems to care for the remaining uninsured, we urge the State to consider the other critical providers in the safety net, including nonprofit clinics and health centers, all of which serve the remaining uninsured population. Health centers across the state, and especially those serving our rural and frontier communities, are being stretched thinner than ever before as they balance providing care to the newly insured and those that are without a program of coverage.

Using the Waiver, with a General Fund contribution, the State has the opportunity to provide additional resources to the safety net to ensure they have the infrastructure to keep their doors open to any individual who needs care, which is critical to the success of the larger health care system. This strategy is consistent with the 2010 1115 Waiver where, under the Safety Net Care Pool (SNCP), DHCS proposed that federal dollars be drawn down as a match to the Expanded Access to Primary Care (EAPC) program. We encourage the State to consider how funding for the broader Traditional Clinic Programs (TCP) [including the Expanded Access to Primary Care program (EAPC), Seasonal Agricultural Migratory Worker Program (SAMW), Rural Health Services Development Program (RHSD), and the Indian Health Program (IHP)] could be reinstated under the continuation of the SNCP with General Fund contribution as a match. The requisite investment, $52 million at the height of the programs, is a small amount in

comparison to the entire 1115 Waiver, but would provide immeasurable reinforcement to a stretched system.

Similar to the funding being proposed to support the public hospital systems, and building on the precedence established in the 2010 Waiver, reinstating funding to the Traditional Clinic Programs, would allow for comprehensive care to the remaining uninsured that includes primary care in lower cost, outpatient settings. This too could ultimately help achieve reduced emergency and inpatient services, and lower costs to the total system. The Traditional Clinic Program structure allows for more efficient use of funds that would otherwise pay for emergency and inpatient services by redirecting some of these monies to outpatient primary and specialty care

FQHC Payment/Delivery Reform

Recommendation: Share savings from the FQHC Payment Reform demonstration with the providers achieving the savings.

Like the State, CPCA agrees that the FQHC Payment Reform demonstration is a cornerstone effort in California to fundamentally transform care delivery in the safety net. We support the State's commitment to the Alternative Payment Methodology (APM), which affirms that an FQHC would receive no less than they would have received under PPS and that it is a voluntary payment system. This provision is central to the success of the demonstration. CPCA, along with our partners the California Association of Public Hospitals (CAPH), will partner with the State and health plans to develop a demonstration that can be included in the Waiver as well as the requisite legislation and State Plan Amendment.

While we appreciate the State including the demonstration in the 1115 Waiver as a means to capture the savings gained from the expected efficiencies enabled by the APM, we encourage the State to consider sharing the savings back with the FQHCs and plans creating the savings. Creating appropriate incentives to lower the total cost of care to the whole system will only reap larger savings to the system overall, and lead to more valuable care delivery to the patients that need it most.

Payment/Delivery Reform Incentive Payment Programs

Recommendation: Develop a statewide P4P program in Medi-Cal to ensure all primary care providers receive incentives to deliver high quality care.

CPCA recommends that DHCS develop incentive programs for managed care plans and Medi-Cal providers in order to encourage increased care coordination, case management, and patient centered health homes for the Medi-Cal population. We strongly encourage DHCS not to limit this opportunity to health care entities coordinated under a single organization, as is proposed in the State's proposal. While we understand limiting the incentive program would simplify the administrative burden of such a program, most Medi-Cal patients would not be impacted by such a model. Instead, CPCA believes that DHCS would see greater cost savings and Medi-Cal patients would receive greater benefit from an incentive program that focused on incentivizing care transformation at the primary care practices where patients receive most of their care and where health homes are most effective. We encourage DHCS to work with the Integrated Healthcare Association (IHA), Medi-Cal Managed Care Plans, and Medi-Cal providers and the provider associations to develop a standardized value-based pay for performance program in Medi-Cal similar to the value-based P4P program that IHA has successfully operated for years in the commercial sector.

Several Medi-Cal managed care plans have already developed P4P programs for Medi-Cal providers which have made great strides in improving patient care while reducing costs and using those cost savings to invest in further transformation at the primary care level. CPCA encourages DHCS to look at the Medi-Cal P4P programs at Partnership Health Plan, Central California Alliance for Health, and other successful models and consider creating a "best of" P4P program for expansion to the rest of the state.

Medicaid Funded Shelter for Vulnerable Populations

Recommendation: Invest in housing services for vulnerable populations and ensure individuals provided with housing services are supported with dedicated case management.

Among the millions of patients served by CCHCs in California are thousands of homeless individuals and families. While many CCHCs have federal 330(h) grants to support services for homeless individuals, permanent supportive housing is not currently funded. Many state Medicaid programs, including Illinois, Louisiana, Massachusetts, Minnesota, New York, Rhode Island, Texas, and Washington are exploring or have already invested in initiatives to add housing support as a reimbursable service. Chronically homeless individuals are among the most frequent hospital users and investing in a stable environment is often the foundation for redirecting these patients from the emergency room to the primary care setting, with numerous studies showing that investment into housing can significantly improve health outcomes while reducing Medicaid costs.[i]

CPCA strongly supports a State commitment to investment in housing services through the 1115 Waiver, similar to the investment made in other states, as this will be a key component to strengthening the safety net for patients with complex care needs and helping improve the overall health system. A Medi-Cal funded shelter for vulnerable populations is also an example of essential support services that could be more strongly tied to the primary care setting through investment in a Section 2703 Health Home pilot. Providing support for dedicated case management in the primary care setting that works collaboratively with housing services is essential for a successful health home network. However, in order for this initiative to return the savings projected, there needs to be a commitment to fund housing in the Waiver. In New York's housing model, for example, placing homeless individuals who have mental illness in housing caused the average cost of supporting that individual to drop from $40,449 a year to $28,303 per person, even though placement into supportive housing initially increased use of outpatient Medicaid.[ii] Linking housing support to services essential to recovery, such as those available in primary care, will be key to creating a successful program.

Workforce Development

Recommendation: Develop a new Medicaid Graduate Medical Education (GME) pilot program that includes support for a Teaching Health Center Program.

The 1115 Waiver, coupled with the State's commitment to payment reform, 2703, and CalSIM, is a unique opportunity to reshape the workforce that will be needed in a transformed health delivery system and create a mechanism for increasing the overall number of primary care providers committed to serving the Medi-Cal population.

While the malpractice insurance premium incentive program proposed by the State is creative, we do not believe this alone will have the requisite impact to address our present primary care workforce shortage. The unprecedented growth in the number of patients seeking health care due to coverage changes under the ACA is straining the capacity of safety-net networks, and especially impacting access to specialty care for Medi-Cal beneficiaries. CPCA member health centers believe that lack of access –

especially specialty care access - is a driving factor of health reform dissatisfaction and could ultimately lead to poor health outcomes. It is also causing retention challenges with FQHC-based primary care providers because they are frustrated with their inability to secure timely access to referrals for their patients. Resolving the issue of specialty care access is a top priority for California health centers seeking to make health care reform a success and workforce development solutions that address specialty care must be considered side by side with solutions that support primary care.

In addition to the malpractice insurance premium incentive program concept, CPCA recommends the Department consider additional strategies for addressing our State's workforce needs. In particular, we ask the Department to research and consider strategies similar to those that other States are proposing to promote improved access and quality of care for Medicaid beneficiaries. The 1115 Waiver is an opportunity to develop a new Medicaid Graduate Medical Education (GME) pilot program similar to those proposed and/or operating in nearly a dozen other states with the goals of increasing the number of primary care providers, high-demand specialty providers in medically underserved areas, providers trained in patient-centered and population-centered care, and generally providers serving Medicaid beneficiaries.

Consistent with the approach taken by many other state Medicaid programs, CPCA recommends a GME program structure that creates a California Teaching Health Center program (THC) that mirrors HRSA's THC Graduate Medical Education Program and includes incentive-based payments to GME programs for achievement of increasing the number of providers outlined above.

Federal/State Shared Savings Initiative

Recommendation: Use shared savings from Medi-Cal Programs to reinvest in patients and primary care providers.

CPCA is supportive of the State finding ways to capture savings from one part of the system and reinvest it in other programs; however, we are concerned about the impact to patients and providers if it is not done fairly and appropriately. We agree that California's FMAP should be increased, but we do not support any proposal to establish a per capita cap payment structure in Medicaid where fiscal risks and costs would be borne ultimately by the providers and patients they serve. A central concern is that such a financing structure could potentially cause further erosion of Medi-Cal payment rates, which already are the third-lowest rates in the country despite our state having some of the highest medical care costs. California health centers are already experiencing major challenges in finding timely access to specialists for Medi-Cal patients due to inadequate networks caused by these low reimbursement rates. Further, under the proposed Federal/State Shared Savings Initiative we urge the state not to seek waiving the protections in place to safeguard beneficiary access and benefits. Like block grants, per capita cap proposals typically give states greater flexibility to design their Medicaid programs, such as by allowing them to override federal requirements related to premiums or cost-sharing.

In conclusion, CPCA is supportive of programs in the Waiver that strengthen the Medi-Cal program and the ability for providers to deliver better, more coordinated, and higher quality health care to the millions of beneficiaries. Increasing rates to plans in order that they may provide more appropriate rates in Medi-Cal, sharing savings with the primary care providers in order that they be incentivized to achieve certain quality targets, and reinvesting in a permanent PCHH benefit would all be appropriate uses of the Shared Savings approach by the State and supported by CPCA.

We thank the Department for providing CPCA the opportunity to comment on the State's proposal for the 1115 Waiver and offer new ideas for how our state can achieve the Triple Aim. CPCA is committed to the Waiver process and looks forward to engaging more deeply on the any of the above proposed ideas.

Regards,

Originally Signed By,

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President and CEO
California Primary Care Association

cc's: Mari Cantwell, Deputy Director of Health Care Financing, DHCS
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The Honorable Kevin DeLeon, Pro Tem, California State Senate
The Honorable Toni Atkins, Speaker, California State Assembly
The Honorable Mark Leno, Chair, Senate Budget Committee
The Honorable Nancy Skinner, Chair, Assembly Budget Committee
The Honorable Ed Hernandez, Chair, Senate Health Committee
The Honorable Richard Pan, Chair, Assembly Health Committee
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[i] Integrating FQHC Health Care Services with Permanent Supportive Housing in Los Angeles. Available at: http://www.csh.org/wp-content/uploads/2011/11/IntegratingHealthReport_FINAL.pdf

[ii] Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing first for homeless persons with active addiction: are we overreaching?. Milbank Quarterly, 87(2), 495-534.