CPCA
California Primary
Care Association

Health Care Access for All

Comments on the California Section 1115 Comprehensive Demonstration Project Waiver
Department of Health Care Services Implementation Plan
May, 2010

The California Primary Care Association (CPCA) represents more than 800 not-for-profit community clinics and health centers in California that provide comprehensive, quality health care services to primarily low-income, uninsured, and underserved Californians.

Overarching Comments

Safety Net Integration

We commend the State for using the waiver renewal as an opportunity to lay the foundation for effective implementation of federal health care reform in California. Furthermore, we appreciate that a principal element will be to "support the efforts of safety net providers and organized delivery models to better integrate and restructure their financing and delivery models to promote the inclusion of safety net providers in the delivery systems occurring today and contemplated under pending federal reforms" (pg.2).

Executing this waiver in a manner that truly prepares us for health reform will require a new and robust level of safety net integration, both in terms of public and private safety net providers working together, as well as safety net providers strengthening their relationships with the managed care industry. Perhaps terms in the plan like "safety net provider" and "private provider" are intended to be inclusive of community clinics and health centers (CCHCs), but from CPCA's experience, without specific mandates from the State facilitating this kind of collaboration, results will be limited. As described in more detail below, where there is no expectation to work with CCHCs (such as with commercial health plans) or the expectation is encouraged and not required (such as in the current Health Care Coverage Initiative and the Mental Health Services Act) CCHCs face the threat of exclusion. By including mandatory CCHC contracting language in the requirements for health plans and County Alternative Plans that will be serving the SPDs, as well as the Health Care Coverage Initiatives, DHCS can proactively support partnerships and more effectively achieve the goal of collaboration among all local safety net providers.

Medical Homes

Community clinics and health centers have always strived to be comprehensive medical homes for their patients—or as is more descriptive of the broad range of services offered by CCHCs—health care homes. The comprehensive model used by CCHCs has been shown to provide high-quality and cost- effective care that reduces hospitalizations, emergency department visits, and costly care by specialists. Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at health centers are between 11 and 22 percent less likely to be hospitalized for avoidable conditions; 19 percent less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient costs. Together, this amounts to 30-33 percent in total cost savings for each Medicaid beneficiary served in a community health center.[iii]

Unfortunately, the Medi-Cal program does not support many aspects of the medical home model and simply enrolling a beneficiary into a managed care plan or assigning them a primary care provider will not get us there. We will not be able to succeed with our current system of reimbursement that places barriers to effective, integrated care by: not reimbursing health centers for both a mental health visit and a primary care visit on the same day, not reimbursing for the services of

Marriage and Family Therapists when they make up the largest proportion of mental health providers in the state, and limiting primary care providers' ability to reach patients beyond clinic walls. The new waiver is an opportunity to realign reimbursement mechanisms and encourage more effective care for the program's most medically vulnerable by:

- Delivering disease management services within the patient's health care home, rather than fragmenting care by relying on telephonic disease management services outsourced to a contractor.
- Providing adequate funding for comprehensive chronic care services, such as the use of disease registries, group visits, and patient self-management coaching.
- Recognizing the critical work of non-physician members of the treatment team, such as nurses, health educators, and medical social workers.
- Offering community-based case management and outreach to form trusting relationships with patients and help them navigate the complex medical, behavioral health, and social services systems.
- Establishing mechanisms to reward primary care providers for their contributions to keeping patients out of the costly hospital setting.

While the plan clearly outlines the process by which targeted individuals will be enrolled in organized delivery systems, it lacks any substantial strategy for supporting the primary care providers who must be at the core of any reformed delivery system. While the implementation plan states health plan contract requirements will be enhanced with regard to care management and coordination, every effort must be made to ensure those are ultimately functions of medical home providers, not administrative entities.

The Department of Health Care Services and the Legislature should pursue the new state option included in the federal health care reform law, effective January 2011, to provide health homes for enrollees with chronic conditions who designate a provider or a team of providers, as a health home. By pursuing this option, California could draw down additional federal funds for the types of care management and coordination activities already planned under the waiver for complex populations. In this vein, CPCA has released a concept paper, ***Community Clinics and Health Centers: Developing an Enhanced Primary Care Medical Home***, in support of a meaningful and vigorous demonstration of the medical/health home concept in California's next 1115 waiver (***Attachment A***).

Around the country, CCHCs are at the center of many of the existing Medicaid medical home demonstrations, as well as the demonstration announced by CMS at the end of 2009 for federally-qualified health centers (FQHCs) and Medicare. California's CCHCs are one of the logical partners for a medical home demonstration and CPCA believes that the new waiver offers the opportunity to model and refine medical home concepts with existing safety net providers who are the primary providers of services for Medi-Cal beneficiaries. The State should take full advantage of the Medicaid waiver and the health care reform provision mentioned above as opportunities to model medical homes for Medi-Cal beneficiaries with complex chronic conditions.

Seniors and Persons with Disabilities

CPCA commends DHCS for making the commitment, in their March concept paper, to support and integrate current safety net providers into the new delivery systems established through managed care expansion for the SPDs. Currently, only the Local Initiative (LI) health plans are required to issue subcontracts to health centers. Because this requirement does not extend to commercial health plans, our members can face significant challenges when seeking to establish themselves as providers in the networks of commercial health plans. As a proven tool for successfully promoting collaboration between CPCA members and health plans, the mandatory contracting protections already in place with the LIs should be extended to the commercial plans under this expansion.

The degree to which private CCHCs are integrated with and collaborate with county hospital and clinic systems varies greatly throughout the state. Therefore, CPCA is concerned that the County Alternative Option will result in mixed outcomes for our member clinics, as we have already seen with the implementation of the Mental Health Services Act/Prop 63 and the Health Care Coverage Initiative (described below). CPCA requests that any protections contemplated to include safety net providers in the new managed care networks also extend to the County Alternative Option. By including mandatory contracting language in the requirements for counties to develop an alternative model, DHCS can proactively support partnerships and more effectively achieve the goal of collaboration among all local safety net providers.

CPCA shares the concern of many fellow stakeholders that the timeline given in the plan for enrollment is aggressive, and should not be strictly pursued at the cost of thorough plan readiness and network adequacy assessments that may well reveal areas plans need time to improve on before safe enrollment can be accomplished. Lastly, we cannot ignore that currently proposed budget cuts, such as the elimination of Adult Day Health Care, contradict the care improvement goals contemplated for the new waiver. We must preserve and protect the infrastructure that already exists to serve the SPDs if the waiver has any chance of moving us forward.

Health Care Coverage Initiative

Community clinics and health centers have played a significant role in the current Health Care Coverage Initiative (HCCI), serving as medical homes providing preventive and primary care services, as well as dental services, mental health services, chronic disease management, and intensive case management. And as trusted medical homes to many of California's uninsured adults, CCHCs will be vital to providing the increased access necessary to expand the number of slots and counties participating in the program.

The waiver renewal should serve as an opportunity to remedy the uneven track record that counties have of contracting with CCHCs under the current HCCI. One of the underlying challenges of the structure of the HCCI program was requiring counties to manage the program and budget without any guidelines as to how to fairly allocate funds to other safety net providers in the community. Although the HCCI legislation required counties to work with community partners, there was no reward for doing so or consequence for avoiding it. As a result, patients suffered because they did not have a choice of providers and could not select the practice setting in which they preferred to receive care, even if that clinic was the only one near their home. In these situations, the programs failed to strengthen relationships between safety net providers and an opportunity was missed to improve the safety net overall.

For the next waiver, the State should strengthen the enacting HCCI statute to require subcontracts with CCHCs, rather than only require that the program "strengthen and build upon the local health care safety net system". Furthermore, a methodology must be developed to ensure that program enrollment is distributed fairly among the safety net providers who share the responsibility of caring for the uninsured in a given county. For more information on the role of CCHCs in the current HCCI, as well as comments on improving the HCCI under the new waiver, please see ***Recommendations from Community Clinics and Health Centers on California's Health Coverage Initiative***, prepared by Alaina Dall (***Attachment B***).

Persons with Behavioral Health Disorders and/or Substance Abuse

CPCA has been promoting behavioral health integration for many years, so we are pleased to see it as a priority within the waiver. We are concerned, however, that the Department's plan seems to focus on integration at the system/financing level, which does not guarantee the kind of integration at the delivery system level that beneficiaries deserve and need. Encouraging health plans to coordinate with the County Mental Health Plans in serving the SPDs, and bringing County Mental Health agencies to the table in the Health Care Coverage Initiative are important steps, but the most effective integration is achieved at the provider level where seamless care can truly improve outcomes.

As trusted health care homes for many underserved, ethnically and racially diverse individuals and families, CCHCs play a unique role in providing behavioral health services to those who may never seek out or have access to traditional mental health services. While safety net infrastructure differs greatly from community to community across California, in many places, primary care clinics have become the de-facto mental health system for individuals across the entire continuum of mental health need. Unfortunately, similar to CPCA's experience with the HCCI, counties have had an uneven track record of recognizing this critical role through contracting with CCHCs to implement the Mental Health Services Act/Prop 63. Despite Prevention and Early Intervention Component Guidelines emphasizing the importance of partnering with CCHCs, many clinics continue to face barriers to meaningful participation in the county-driven community planning process, including a lack of stakeholder engagement and transparency in decision-making that CPCA has also experienced as an advocacy organization involved with the MHSA at the state level. When clinics are engaged in the local planning process, they are often still unable to secure county subcontracts, despite proven service capacity.

As the State continues to explore the opportunities for better integrating care under the waiver, and specifically when developing the pilot request for proposal which is scheduled to be released in early 2011, DHCS should recognize the critical role of CCHCs as key partners. Community clinics and health centers are recognized leaders in the movement to integrate behavioral health into primary care, but also collaborate with the specialty mental health system to address the comprehensive treatment and supportive services needs of the safety net's most seriously mentally ill. Policy developed under the new waiver should allow for different collaboration models that leverage resources based on the capacity of local safety net providers. Because many collaborative relationships exist between CCHCs and County Mental Health agencies, the waiver should serve as an opportunity to spread best practices and reduce the barriers both parties face to working in a more integrated manner.

For more information on integration within CCHCs and through partnerships with the county mental health system, as well as recommendations for the next waiver based on the discussion of the DHCS Behavioral Health Integration Technical Workgroup, please see CPCA's paper titled ***California's 1115 Medicaid Waiver Renewal: Behavioral Health Integration Opportunities*** (***Attachment C***).

CPCA looks forward to working with the State and fellow stakeholders to maximize the opportunity that this waiver renewal presents to prepare California for successful implementation of federal health care reform and mental health parity. For further information please contact Allison Homewood, Senior Healthcare Analyst, at ahomewood@cpca.org or (916) 440-8170.

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[i] Falik, et al. Comparative Effectiveness of Health Centers as Regular Source of Care (2006) Journal of Ambulatory Care Management. 29(1):24-35.

[ii] Duggar BC, et al. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers. Center for Health Policy Studies, 1994.

Health Care Access for All

Community Clinics and Health Centers:
Developing an Enhanced Primary Care Medical Home

CPCA Concept Paper
March 22, 2010

Background

The medical home is a model of care that is taking root in both public and private payer programs in an effort to improve quality, control costs and increase both patient and provider satisfaction. Since 2006, more than 30 states have been leading efforts to advance medical homes in their Medicaid and Children's Health Insurance Program and several states are leading multi-payer medical home collaboratives to spread this model in the private sector. In addition, in late 2009, the federal Centers for Medicare and Medicaid Services (CMS) announced its intention to implement and evaluate a Medicare Patient-Centered Medical Home demonstration working with federally qualified health centers (FQHCs) as the medical home.

CPCA believes that California's next 1115 Medicaid waiver provides an opportunity to develop, demonstrate and implement the primary care medical home (PCMH), or enhanced PCMH programs. California should propose to use the five years of a new waiver to demonstrate, develop and refine the elements of a community clinic and health center-based patient-centered medical home (CCHC-PCMH) in the Medi-Cal program.[1] CPCA believes that California can and should pilot PCMH models to serve the various Medi-Cal populations covered under the waiver, including seniors and persons with disabilities (SPDs), in different care settings and communities, urban and rural, and in counties with active Medi-Cal managed care programs and in non-managed care counties.

Community Clinics as Primary Care Medical Homes

CCHCs are uniquely experienced to serve as the PCMH for SPDs because of their track record as providers who have always developed the medical and social services necessary to meet the specific needs of the special populations they serve--whether it be low-income women and children, migrant farmworkers, patients with HIV/AIDS, homeless persons, or seniors and disabled persons needing home and community-based services and supports. CCHCs have historically offered cost-effective, patient-centered services that address the health, mental health and social service needs of low-income and vulnerable populations. CCHCs by mission and organizational structure are leaders in designing programs and services that address health disparities, as well as the social and environmental factors that contribute to poor health outcomes, such as homelessness, unemployment, drug and alcohol addiction, poor nutrition, illiteracy, and poverty. CCHCs offer a medical home

[1] Community clinics and health centers are those nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CCHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. Clinics meeting federal requirements and definitions for purposes of Medicaid reimbursement may also be referred to as federally qualified health centers (FQHCs) or FQHC look-alikes.

for the hardest to reach patients by addressing the obstacles that keep them away from care. The CMS announcement of the Medicare medical home demonstration is recognition of the successes demonstrated by CCHCs.

California's CCHCs are well positioned to engage in the development and the implementation of the PCMH concept in California, building on the track record of the CCHC as a community-based, patient-centered delivery system that emphasizes the diverse needs of patients--health, medical and social support.

Defining a Medical Home

A patient-centered primary care medical home, sometimes also referred to as an "enhanced medical home" is a model for care provided in community-based primary care settings. The PCMH provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management – across the lifespan. It seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. Care in a medical home is rewarding for clinical teams to provide and satisfying for patients and families to receive.

Many believe that this comprehensive vision for primary care services through a PCMH is a model of care that holds significant promise for better health care quality, improved involvement of patients in their own care and reduced avoidable costs over time. While there are multiple approaches and models of care, the most commonly defined elements of the PCMH are:

- Assignment of enrollees to a provider of primary care services or PCMH that assumes lead responsibility for the medical and health care needs of the assigned members;
- Identification, assessment, and stratification of the needs of the target population(s) by the PCMH;
- Tailored care interventions to meet the health and medical care needs of subsets of the target population, including those experiencing disparities in care associated with race, ethnicity, language, and literacy;
- Effective care coordination and referral management to link beneficiaries to the specialty providers and community-based services that can assist in addressing complex medical, psychosocial, and social support needs, with an emphasis on focused care coordination and monitoring of high-risk enrollees who might otherwise experience expensive hospitalizations and/or emergency room utilization;
- Use of innovative Health Information Technology (HIT) solutions to share data with providers on the PCMH panel of patients, support practice performance improvement, and expand the use of evidence-based care guidelines;
- Measurement of the PCMH performance to promote accountability and quality improvement; and,
- Financing structured to support the PCMH ability to perform the above functions.

Recognizing Medical Homes Using Measurable Standards

A central feature of the PCMH is the adoption of measurable standards and recognition processes that identify the PCMH as having the systems and the capacity to effectively manage and coordinate health and medical care services across a defined population of enrollees. The most effective models for PCMH standards are emerging and developing in the context of the numerous demonstration programs implemented around the country. No single set of measurable standards has yet been identified as ideal.

One of the preeminent models, the Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) standards and guidelines developed by the National Committee for Quality Assurance (NCQA), is to date one of the most widely used set of standards for demonstration of the PCMH concept. NCQA standards could form the basis of a California demonstration, with appropriate modifications for the Medi-Cal population

to be served, CCHCs and other safety net providers. The NCQA recognition model contemplates three levels of standards with increasing complexity and technology enhancements that improve the ability of the PCMH to track and monitor the care of patients enrolled at the primary care practice. NCQA is currently working on revisions to the medical home standards (expected by January 2011) to specifically address non-physician led practice settings, including safety-net care providers such as CCHCs.

California can and should also look to new and emerging approaches which have built on and refined the NCQA standards. The model CMS selects for implementation of the FQHC PCMH in Medicare may be a good starting point. CMS may choose to implement the elements of a PCMH developed in 2008 for CMS by Mathematica. The Mathematica approach incorporates a two-tier model that reflects standards to be met by the PCMH, but also adds an illness severity score for patients with chronic and complex health conditions permitting risk-adjusted and tiered reimbursement based on the anticipated care needs of the patients. The Center for Medical Home Improvement's Medical Home Index Criteria focuses on the PCMHs organizational capacity, management of chronic conditions, care coordination, community outreach, quality improvement and data management. To the extent that appropriate medical home standards are incorporated into already existing accreditation and certification programs, such as the Joint Commission and the Accreditation Association for Ambulatory Health Care, these methods of recognition should also be acknowledged.

Regardless of the specific model(s) adopted, CPCA believes that the waiver should include a PCMH demonstration that meets the following standards:

- Multiple levels of PCMHs based on the capacities of the PCMH and the standards to be met to ensure maximum participation by the full range of safety net primary care providers now serving Medi-Cal patients;
- Standards and expectations that emphasize a team-based approach to care, active care coordination and care monitoring, chronic disease management and linkages to specialists and community-based social support services;
- Phase-in of the standards and the opportunity for technical assistance / support in the development and expansion of the PCMH's capacity to manage, track and measure care delivered; and,
- Reimbursement structures and care management fees that acknowledge both the level of standards required and the specific needs of patients at different levels of risk and costs.

Care Management Fees

Once a primary care practice has been designated a medical home, the goal of the new standards programs is to provide to the PCMH a supplemental reimbursement called a *care management fee*. This fee recognizes the added value provided to patients by the PCMH and the additional costs associated with enhanced responsibilities for the primary care providers involved in their care.

- The *care management fee* is generally paid based on a per member per month (PMPM) amount for each patient linked to the PCMH and represents an additional and separate payment in addition to payments for health care services provided and reimbursed. However, in some states, payers have made lump sum payments up front to fund the additional costs for care coordinators and HIT improvements.

- The *care management fee* amount can and should vary for the levels of risk associated with various patient types and would also vary by the standard-based levels achieved by the CCHC. CPCA believes that the care management fee should be adjusted based on the severity of illness and burden to the clinic similar in concept to the Mathematica model developed for CMS.

As in other medical home demonstration projects involving CCHCs around the country, FQHCs and FQHC look-alikes would continue to receive the federally required Medi-Cal FQHC rates, but would also receive additional monthly care coordination fees for the members enrolled at CCHC primary care sites. The payment would be for levels of case management and care coordination beyond the case management services contemplated under the federal rules for FQHC reimbursement and allowable as FQHC costs. For example, in a three-tier model, all CCHC-PCMHs would receive graduated care coordination fees for three levels of PCMH. FQHCs and FQHC look-alikes might receive the enhanced payments at levels two and three, depending on the services delineated at each.

Delivery System Support

The PCMH model needs to be integrated into the overall Medi-Cal delivery system in both managed care and non-managed care counties. In counties where the PCMH demonstration is implemented, any and all managed care organizations or administrative entity engaged in the medical home demonstration should be required to include in the Medi-Cal PCMH delivery system all safety net providers who meet the standards, including qualified CCHCs.

Managed Care Counties: In Medi-Cal managed care counties, the PCMH and the managed care plan or plans engaged in the demonstration should engage in a partnership to develop the PCMH program and to coordinate service delivery with the other providers in the system, including specialists and hospital providers. Medi-Cal managed care plans should do the following:

- Contract with PCMHs and implement care management fees, quality reward payments and shared savings arrangements to enhance primary care reimbursement and to reflect the care coordination and service needs of the specific covered populations;
- Identify and assign enrollees based on enrollee choice of primary care provider and provide PCMH partners with the results of an initial health risk assessment at enrollment and with ongoing utilization data and support, including hospitalization, emergency room use and discharge planning support;
- Collect and disseminate claims and encounter data;
- Develop outcomes data and reporting for internal quality improvement and state compliance;
- Provide grants and technical assistance to PCMHs, to helping meeting and monitor their compliance with PCMH core standards;
- Provide required IT and ongoing enhancements; and,
- Offer stop-loss, risk management or other related financial support depending on the reimbursement and risk model(s) adopted.

Non-managed Care Counties: In non-managed care counties, including rural counties, the PCMH demonstration could also be developed. Any administering entity or entities selected by the state to manage the project in those counties would engage in the partnership to develop the PCMH program and to coordinate service delivery with the other providers in the system.

Recommendations from Community Clinics and Health Centers on California's Health Coverage Initiative

Prepared for the California Primary Care Association
By Alaina Dall, M.A., AGD Consulting
September 10, 2009

In August 2005, California was granted a Medicaid waiver, which gave the state the flexibility to implement innovative pilot or demonstration projects promoting the objectives of Medicaid. California was allocated $180 million per year in federal matching funds for the last three years of a five-year demonstration for health coverage expansion (September 1, 2007 through August 31, 2010). Senate Bill 1448 (Stats. 2006, ch. 76) was enacted to provide the statutory framework for the development and implementation of the Health Care Coverage Initiative (CI). Funding for the CI was to be used to provide health care coverage to uninsured individuals who are not eligible for Medi-Cal, Healthy Families or the Access for Infants and Mothers program. As described in the bill [Section 15903(a)-(d)], the CI was intended to achieve the following outcomes:

(a) Expand the number of Californians who have health care coverage.
(b) Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics and community clinics.
(c) Improve access to high quality health care and health outcomes for individuals.
(d) Create efficiencies in the delivery of health care services that could lead to savings in health care costs.

In addition, the bill also described preferences for programs that designated a **medical home** for the uninsured individual; had a benefit package that included **preventive and primary care services**, as well as **care management services** to treat patients with chronic care conditions or mental illness; had **quality monitoring** processes to assess health care outcomes; and promoted the **viability of the existing health safety net** [Section 15904(d)(1)-(11)].

Strengthening the Safety Net

The safety net looks different in every county, but generally consists of a combination of federally-qualified health centers, community and free clinics licensed under Section 1204 of the California Health and Safety Code, county clinics, public hospitals and their affiliated clinics, and disproportionate share hospitals. An uninsured or low income patient needing health care services may enter through any door depending on their medical needs, their insurance coverage, and their understanding of where and how to access health care services. Wherever the encounter takes place, the patient preferably will become established at a medical home, and will access health care before it becomes an emergency.

Increasing access to health care for low income and uninsured individuals requires cooperation and collaboration between all safety net entities. Such cooperation will result in improved health outcomes for the patient, as well as the most cost effective care possible as patients receive health services at the most appropriate level. The CI acknowledged the importance of such cooperation when it required applicants for CI funds to *"strengthen and build upon the local health care safety net system."*

Community clinics and health centers deliver the following services:

- Primary health care services including family medicine, internal medicine, pediatrics and ob/gyn
- Diagnostic laboratory and radiologic services
- Preventive health services such as prenatal care, cancer screenings, well child services, immunizations, pediatric vision and hearing screenings, and preventive dental services
- Referrals to specialists and other health-related services such as substance abuse and mental health services
- Patient case management services including counseling, referral and follow-up services
- Services to help eligible patients gain access to health coverage programs, and to provide linkages to social services, housing, educational and other services
- Outreach and transportation services, as well as translation services
- Patient education about the availability and proper use of health services.

Community Clinics and Health Centers

Community clinics and health centers (CCHCs) have evolved from grassroots health care organizations run by volunteer physicians in the 1960s, to sophisticated clinics staffed by board certified physicians and other staff who are committed to making a difference in their communities. As one of the few providers who open their doors to anyone regardless of their ability to pay, not-for-profit CCHCs play a critical role in assuring access to health care services in California, serving over four million patients each year. Nearly two-thirds of their patients have incomes below the federal poverty line, 83% live below 200 percent of poverty, and 49% speak a primary language other than English.[1]

In addition to primary and preventive care, CCHCs offer a comprehensive continuum of care to their patients that includes access to essential services on-site or by referral including oral health, behavioral health, substance use, and specialty care. These services are supplemented by a broad range of enhanced services that together ensure access to truly patient-centered care including outreach, case management, patient education, translation and interpretation, child care, transportation vouchers, and assistance applying for health insurance coverage.

The comprehensive model used by CCHCs has been shown to provide high-quality and cost-effective care that reduces hospitalizations, emergency department visits, and costly care by specialists. Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at health

centers are between 11% and 22% less likely to be hospitalized for avoidable conditions; 19% less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient costs. Together, this amounts to 30-33% in total cost savings for each Medicaid beneficiary served in a community health center.[2,3]

Health centers are funded through government and private funding. In California, Medicaid accounts for about 40% of health center funding. Additional revenue comes from other public sources such as Healthy Families or Medicare; federal, state or county grants or contracts; county indigent care programs; and patient cash payments. About 95% of all patients have incomes below 200% of the federal poverty level. In some communities, CCHCs are the only providers for low income and uninsured people.

In addition, CCHCs:

- Have strong positive relationships with their community. Health center staff are culturally sensitive, and services are offered in many languages. Translation is provided as needed.
- Are in the process of implementing or have implemented electronic health record (E.H.R.) systems, and some are already using disease registries to track health outcomes.
- Monitor and report key health outcome measures for their patient population by gathering data through chart audits, practice management systems and E.H.R.
- Have dispensaries or pharmacies, offer low cost pharmaceuticals with access to 340b discount pricing programs, and help patients access pharmacy assistance programs for free or low cost medication.
- Reach out to the community through mobile units and health fairs, and provide health/dental screenings in schools.

CCHC Roles in the Health Coverage Initiative

Ten counties were awarded CI funding. **Attachment 1** shows the list of awarded counties, target vs. enrollment numbers as of February 28, 2009, as well as the number of clinic subcontractors. Seven counties contracted with a total of 80 CCHCs to provide CI services. CCHCs provided a variety of services depending on how their contract was structured. Some clinics performed **outreach and enrollment services** to link eligible patients with CI covered benefits. Health centers served as **medical homes,** and provided **preventive and primary health care** services, as well as **dental** and **mental health** services. Clinicas del Camino Real in Ventura County reported that many patients received dental care for the first time ever because of the CI. Other patients with diabetes and/or hypertension received **chronic disease management** services in which they obtained medical care and participated in monthly group education classes to help them manage their condition. CCHCs also offered intensive **case management** to assure CI patients were completing their appointments and following through with referrals to specialists.

Partnerships Strengthen the Healthcare Safety Net

While most counties have or will soon meet their CI target numbers, the real value has been in the counties' ability to strengthen the safety net, and to enhance partnerships between safety net providers. The greatest success stories for increasing access to care and improving health outcomes were in counties where public and private clinic organizations worked together collaboratively during all phases of the CI. CCHCs in several counties reported their relationships were enhanced with county staff and other partners, such as hospitals or community-based programs. The partners recognized a higher level of trust of one another, and they saw the benefits of closer working relationships extend to other health programs where communication and problem solving also improved. For example:

- A few counties initiated **clinician meetings** to gain consistency in the way they were managing patients, particularly with chronic diseases. In Alameda County, a clinician meeting was established for the first time for physicians from private and county health centers. Though their charge was to review medical issues related to the CI, the broader value has been a cross-system clinician's group. They developed common standards of care for patients with diabetes, and they are implementing panel management strategies. Clinician meetings also took place in San Diego County for the first time for CI patients with diabetes and/or hypertension, and again, the value has extended beyond the scope of the CI program.

- CCHCs in Orange County reported that **disease management and care coordination** has improved for all patients as a result of the CI because partners have become more adept at working together.

- Funds from the CI allowed the Los Angeles Department of Public Health to pilot a **centralized database** for all Public Private Partnership (PPP) program patients, which will allow any PPP provider to access patient health information. San Francisco General Hospital has developed a similar database.

- **Data exchange** has been enhanced. In Alameda County, the community clinics have reported information on the number of diabetics and asthmatics in their patient population to the county, and the county has reported on patient characteristics of their County Medical Services Program (CMSP). This patient-specific information has resulted in a better understanding of patient needs, which has helped outreach and enrollment strategies as well as patient care.

- Some counties and clinics who worked closely together to develop and implement the program, **strengthened their working relationships** in the process. **Contra Costa** reported that health centers had several joint meetings with county staff to troubleshoot challenges in CI enrollment. After implementing a number of solutions, the approval rate for applications increased. The result was enhanced communication between community clinics and the county. In **San Diego** County, multiple public and private stakeholders were at the table for the CI program. In both cases there was an extended benefit to programs other than the CI.

Any future CI should support partnerships and encourage all safety net providers to work collaboratively to address the health care needs of low income and uninsured individuals rather than in isolated silos. CCHCs have been involved recently in a number of initiatives involving multiple safety net providers which have resulted from the need to tackle issues collaboratively. For example, implementation of **One-e-App** has helped to develop a uniform approach for streamlining enrollment and retention for state and local health coverage programs in some counties at multiple patient entry points. A number of efforts are underway statewide, such as the California Regional Health Information Organizations (RHIOs), to increase physician access to **patient health information**, whether that patient is seen in a primary care setting or in an emergency room. The statewide **Specialty Care Access Initiative** funded by Kaiser Permanente and the California Healthcare Foundation has resulted in community clinics, county clinics and hospitals, and private hospitals working together to streamline the specialty referral process, develop and implement practice guidelines for specialty care, and identify specialists willing to donate their time for services to low income and uninsured patients. The safety net works together in numerous ways, and needs to continue to do so.

Challenges

The effectiveness of the CI was impaired in some counties where CI funds were not used to strengthen and build upon the safety net as a whole. One of the underlying challenges of the structure of the CI program was requiring health departments to manage the program and budget without any guidelines as to how to fairly allocate funds to other safety net providers. Many if not most health departments face significant budget deficits or inadequate funding for indigent care. The CI was viewed by some counties as a cash infusion that could help to offset these deficits, so funding was targeted as much as possible to their own public clinics and patients. Although the CI legislation required counties to work with community partners, there was no reward for doing so or consequence for avoiding it. As a result, patients suffered because they did not have a choice of providers and could not select the practice setting in which they preferred to receive care, even if that clinic was the only one near their home or workplace. In these situations, relationships were not strengthened, and an opportunity was missed to improve the safety net overall.

Recommendations

At the time this report was written, President Obama had just addressed a joint session of Congress describing his proposal for **health care reform**, and pressing Congress to reach consensus on legislation in support of it. Various proposals have been presented by the House and Senate, including provisions to expand Medicaid income eligibility requirements so more uninsured people are covered, as well as to require prevention and wellness programs. Also referenced in the bills are the requirements to contract with essential community providers such as CCHCs, and for insurers to implement reimbursement structures for care coordination. One version requires a medical home pilot program to evaluate the feasibility of reimbursing health centers and others for providing medical homes. CCHCs support a comprehensive approach to national health care reform that reduces the number of uninsured individuals, and incorporates many of the principles of the California CI as described here.

However if national health care reform does not reach fruition, and California has the opportunity to secure another Medicaid waiver, CCHCs have three recommendations for any future CI. These suggestions are very specific to CCHCs, and they should be taken in a larger context along with recommendations offered more broadly by other organizations. Any future CI or Medicaid waiver should support a coordinated system of care in which all safety net partners work together to improve care to low income and uninsured patients. They should also support innovative programs with demonstrated success in improving quality or reducing cost. The reimbursement structure should match this coordinated system of care. Keeping these broad concepts in mind, CCHCs offer the following clinic-specific recommendations for any future CI or Medicaid waiver, while also supporting recommendations made by other organizations.

CCHC Recommendations

1. Require counties to issue subcontracts to CCHCs and other safety net partners, and develop a methodology to fairly distribute dollars.

The State of California has created incentives in other health coverage programs to support health centers through increased patient flow and reimbursement.[4] For example, all health plans with Medi-Cal managed care contracts are required to provide access to all FQHC services (see sidebar on Page 2). Medi-Cal local initiative plans are required to offer subcontracts to FQHCs, as well as community and free clinics. These requirements help CCHCs in negotiating reasonable reimbursement rates. In any future CI, the state should strengthen the bill language to require ***subcontracts*** with CCHCs, rather than only require that the program *"strengthen and build upon the local health care safety net system."* This requirement would bolster the CCHCs' ability to negotiate a reasonable contract and rates with the county.

To go a step further, the distribution of dollars should be allocated based on several factors including which clinics have capacity to serve patients. CCHCs might also receive funding from the CI in proportion to the relative size of their patient population or the proportion of uninsured served. Either guideline or a combination could be used to help determine the fair distribution of funds by counties.

2. Require counties to submit their CI applications with signatures from representatives of CCHCs and other safety net partners in support of the final proposal.

When counties submit any future applications, the Department of Health Care Services should require a signature not only from a county representative, but also from a representative of other safety net providers in the community, including a clinic association and a hospital association. This process was used on applications submitted by counties to the State of California for hospital bioterrorism preparedness and planning. As a result, counties worked more closely with clinic and hospital leadership during the planning process, and had a better understanding of budgetary implications for program implementation. A similar process should be followed for the next CI.

3. Allocate reasonable funding to CCHCs for start-up activities and direct services.

Assurances need to be put in place not only for subcontracts to be awarded to private CCHCs, but also for those contracts to provide reasonable reimbursement for the required scope of services. The starting point for reimbursement should be the health center's current reimbursement rate for patient visits, the federally determined FQHC rate. If a CI program targets patients with the most challenging conditions, such as diabetes or hypertension, the reimbursement rate should be increased depending on the full scope of services provided. In some counties, health centers were also paid a certain fee for every completed application. In other counties they were paid a monthly flat fee to provide case management services to the target population. Other providers were paid a per-member-per-month rate for case management. Still other counties funded care coordination staff or certified application assistors. Health centers in one county received payment equal to Medicare rates to cover the cost of specialty care.

Administrative dollars should also be provided to all partners for start-up and ongoing programmatic costs such as training, data collection and evaluation. CCHCs operate on a very narrow margin and do not have capacity to add a scope of work without also hiring additional staff or re-assigning existing staff. Reasonable reimbursement is necessary to support CCHCs in providing quality care to diverse patient populations.

Recommendations from Other Organizations

Expand the role of the medical home to include a full scope of services. A UCLA Health Policy Research Brief (June 2009)[5] reported that participating counties fulfilled the statutory requirements of the CI to link patients with a medical home, which the legislation defined as *"a single provider or facility that maintains all of an individual's medical information"* [Section 15904(d)(3)]. All participating county and clinic providers met this narrow definition of providing a medical home, and also offered some level of care coordination and chronic disease management (see the California Association of Public Hospitals and Health Systems' Policy Brief, April 2009).[6]

However as pointed out in the UCLA paper, the medical home should serve a much more extensive and involved role. The *"Joint Principles of the Patient-Centered Medical Home"* agreed upon in 2007 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association add the following additional principles: **coordinated and/or integrated care** facilitated by enhanced communication using information technology and other means; **quality and safety** using evidence-based medicine, information technology, and quality improvement strategies; and **enhanced access** through open scheduling, expanded hours, and other options for communication such as telephone and e-mail. Virtually all CCHCs subscribe to these principles and continue to work toward offering all of these components.

Support a system of care rather than fragmented services. As documented in the report, *"Frequent Users of Emergency Departments: Addressing the Needs of a Vulnerable Population in a Medi-Cal*

Waiver,"[7] the Corporation for Supportive Housing (CSH) emphasized the importance of managing frequent users, a small group of uninsured and Medi-Cal patients who account for a large share of costs. A national study indicated that 3.6% of Medicaid enrollees with annual costs of more than $25,000 each accounted for almost half of Medicaid spending. Emergency departments (EDs) are not equipped to meet their multiple ongoing chronic disease, mental illness, substance abuse, and housing needs.

According to CSH, what is needed is patient centered care using a multidisciplinary approach that addresses all of these issues as well as case management and transportation. Essential to care are community based **case managers** to gain the trust of patients who often face social isolation along with their health problems, and work with them to address their multiple complex needs. The report cites a number of model case management programs that resulted in cost savings by reducing the number of frequent user visits to the emergency room. However, despite this evidence, mechanisms have not been put into place to reimburse providers for these services. The next Medicaid waiver provides an opportunity to realign reimbursement mechanisms to support programs like these that work.

Develop a system of care that creates incentives to reduce costs and encourage innovative service delivery solutions. The Blue Shield Foundation concisely summarized the need to develop such a system in its *"State Medi-Cal Waiver Summary of Preliminary Meetings,"* which was provided in public testimony to the state in April 2009:

> *"The current public health care financing system is unnecessarily fragmented with perverse incentives that needlessly drive costs up and discourage innovation and investments in service delivery reforms, reforms that many believe could result in greater access to care and improvement in health outcomes for the same or less cost."*

Taken together, the clinic-specific recommendations, along with those furnished by UCLA, CSH and the Blue Shield Foundation, speak to concepts that should be included in the next CI or Medicaid waiver. In addition to more specific requirements to include CCHCs, the next iteration should require a more extensive role of the medical home. Also needed are proven innovative models that improve service delivery and reduce costs. Funding mechanisms need to be re-aligned to support these innovative practices and reduce fragmentation in the system.

Conclusion

CCHCs bring unique strengths to the safety net system that bolster access to quality cost-effective care. Like public clinics, CCHCs provide a medical home, offer primary and preventive care, and link patients with an extended network for specialty care services. What distinguishes CCHCs from other providers are their rootedness in the community. Health centers have independent boards with a majority of members from the patient community being served. CCHCs provide culturally competent care in the patient's language of choice. They have strong relationships with schools, migrant education programs, community groups, and social service agencies in large part because of their outreach and referral efforts for a variety of clinic programs. Because of this history they have gained the trust of the

community, whose members view CCHCs as resources not only for health care services, but also for linking them with other needed community services.

When patients are linked with CCHCs as medical homes, they are linked with a complete scope of services. CCHCs offer not only medical care, but dental and mental health services, as well as health education, case management, care coordination, discount pharmaceuticals, and other services. Most CCHCs have more capacity than county clinics to see patients, getting them into appointments sooner, offering evening and weekend hours, and offering services at multiple sites throughout an area, including in remote areas where they are the only source of care. As private, independent, 501(c)(3) organizations, they can respond quickly to creative opportunities without the burden of bureaucratic hurdles. Their work in increasing access to specialty care services for their patients is evidence of this creativity and flexibility. CCHC use of health information technology such as electronic data collection and reporting, and most recently implementation of electronic health record with funding from the American Recovery and Reinvestment Act, also reflect the progressiveness of health centers.

In the future, CCHCs hope to see national health care reform that increases coverage and offers many of the same benefits as were offered by the CI. At the same time, discussions are underway at the state level about how to structure the next Medicaid waiver once the current one ends on August 31, 2010 if national health care reform does not pass. While CCHC reaction was mixed to the current CI, some key recommendations have emerged for any future program whose purpose is to increase access to health care for uninsured people. First, require counties to contract with CCHCs and other safety net partners, and distribute dollars fairly based on capacity or proportion of the population served. Second, require clinic and hospital association representatives in each county to sign off on any application submitted on behalf of the safety net to assure they support the final proposal. Third, put mechanisms into place to assure that CCHC subcontracts provide for reasonable reimbursement for the required scope of services. Following these recommendations will help to build up the entire safety net, support collaboration, and maximize access to high quality health care services for diverse patient populations.

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[1] California Primary Care Association (2009, April). Profile of California's Community Clinics and Health Centers.
[2] Falik, et al. (2006). Comparative Effectiveness of Health Centers as Regular Source of Care. *Journal of Ambulatory Care Management*. 29(1):24-35.
[3] Duggar BC, et al. (1994). *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*. Center for Health Policy Studies.
[4] California Healthcare Foundation (2009, July). Issue Brief: Federally Qualified Health Centers and State Health Policy: A Primer for California.
[5] Pourat N, Reifman C, Roby DH, Meng YY, Diamant AL and Kominski GF (2009, June). Health coverage in the safety net: How California's Coverage Initiative is providing a medical home to low-income uninsured adults in ten counties, interim findings. Los Angeles, CA: UCLA Center for Health Policy Research.
[6] California Association of Public Hospitals and Health Systems (2009, April). California public hospitals and the Health Care Coverage Initiatives: A model for health care reform, Policy Brief.
[7] Corporation for Supportive Housing (2009, April). Frequent users of emergency departments: Addressing the needs of a vulnerable population in a Medi-Cal waiver.

Attachment 1: Coverage Initiatives and Target vs. Enrollment Numbers as of February 28, 2009

County	Initiative	Model	Annual Award*	Yr 1 Target Enrollment	Yr 1 Actual (Percent of Target)	Yr 2 Target Enrollment	Yr 2 Actual for 6 months**	# Clinics with CI Contracts	Notes
Santa Clara	Valley Care Coverage Initiative (VC)	A new program to be administered by the existing Valley Health Plan	$15,250,000	8,300	10,885 (131%)	8,600	17,048 (198%)	10	
Orange	Health Care Coverage Initiative (CI)	Expansion of the Medical Services for the Indigent (MSI) program	$16,871,578	17,300	20,046 (116%)	17,300	25,036 (145%)	13	
Kern	Kern County Camino de Salud Network (CDSN)	Development of a Public Private Partnership (PPP) as previously implemented in Los Angeles	$10,000,000	3,500	3,923 (112%)	3,500	4,393 (126%)	0	Breakdown in county/clinic negotiations.
Contra Costa	Contra Costa Health Care Coverage Initiative (HCI)	Expansion of Basic Health Care, a County managed care program	$15,250,000	8,300	7,118 (86%)	8,600	9,690 (113%)	2	Due to administrative county delays, CCHCs did not begin enrollment until May 2008. As of Feb 2009 only 41 individuals were enrolled at CCHCs.
San Diego	Health Coverage Initiative (CI)	Expansion of the County Medical Services (CMS) indigent care program	$13,040,000	3,260	1,625 (50%)	3,260	3,545 (109%)	5	
Alameda	Alameda County for Excellence (ACE)	Expansion of the County Medical Services Program (CMSP)	$8,204,250	4,500	3,805 (85%)	5,000	5,268 (105%)	10	
San Francisco	Healthy San Francisco (formerly Health Access Program)	Expansion of the Healthy San Francisco program	$24,370,000	10,000	5,674 (57%)	10,000	9,148 (91%)	0	The first year the county drew down $9 million out of $16 million available. In Year 2 they drew down $19 million out of $25 million as of Feb. 2009.

County	Initiative	Model	Annual Award*	Yr 1 Target Enrollment	Yr 1 Actual (Percent of Target)	Yr 2 Target Enrollment	Yr 2 Actual for 6 months**	# Clinics with CI Contracts	Notes
Ventura	Access Coverage Enrollment Program (ACE)	A new program to expand health coverage	$10,000,000	12,500	8,465 (69%)	12,500	9,410 (75%)	9	Clinics are capped at 1,250 patients per year (10% of total).
Los Angeles	Healthy Way L.A. (HWLA)	Expansion of the Public Private Partnership (PPP)	$54,000,000	94,000	17,543	94,000	26,313 (28%)	31	County does not have an executed CI contract with the state, but they are offering CI benefits.

Source of target and enrollment numbers, as well as clinic participation: April 2009 CPCA report.
* Annual award for three years between September 1, 2007 and August 31, 2010.
** Actual enrollment for six months between September 2008 and February 2009
Note: Although San Mateo County received funding they are not included in this analysis.

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CPCA
California Primary
Care Association

Health Care Access for All

California's 1115 Medicaid Waiver Renewal
Behavioral Health Integration Opportunities
April 2010

The California Primary Care Association (CPCA) represents more than 800 not-for-profit community clinics and health centers[1] in California that provide comprehensive, quality health care services to primarily low-income, uninsured, and underserved Californians. As one of the few providers who open their doors to anyone regardless of their ability to pay, community clinics and health centers (CCHCs) play a critical role in assuring access to health care services in California, serving over four million patients each year. Nearly two-thirds of their patients have incomes below the federal poverty line, 83 percent live below 200 percent of poverty, and 49 percent speak a primary language other than English.

Community Clinics and Integration

As trusted health care homes for many underserved, ethnically and racially diverse individuals and families, CCHCs play a unique role in providing mental health services to those who may never seek out or have access to traditional mental health services. While safety net infrastructure differs greatly from community to community across California, in many places, primary care clinics have become the de-facto mental health system for individuals across the entire continuum of mental health need.

Individuals with acute mental health needs requiring short-term therapeutic or other interventions are often unable to access services through traditional mental health providers because they do not meet the eligibility requirements, so CCHCs have expanded their services to fill this unmet need. Other individuals may meet the criteria for care within the specialty mental health system, but due to capacity constraints are denied entry into the system. When services are available within the specialty mental health system, some individuals choose not to access them based on perceived stigma. For many minority communities there exists significant mistrust and fear of mental health treatment, as well as taboos and stigma around mental illness. Fortunately, stigma in seeing your primary care provider is practically non-existent, and when receiving care at a CCHC, you can expect the cultural diversity of the local community to be reflected in the staff.

For all of these reasons, and because many visits to primary care have psychosocial drivers, CCHCs have adopted the Integrated Behavioral Health Care Model, which seeks to most effectively care for patients' needs and support primary care providers by including behavioral health providers, such as psychologists and clinical social workers, as part of an interdisciplinary health care team. Keeping individuals in one system of care has been shown to improve health outcomes, especially for patients with chronic health conditions such as diabetes and hypertension.

Integration and the Health Care Home

Community clinics and health centers have always strived to be comprehensive health care homes for their patients and offering behavioral health services is part of this whole-person approach to care. In addition to primary and preventive care, CCHCs offer a comprehensive continuum of care to their patients that includes access to essential services on-site or by referral including oral health, behavioral health, substance use, and specialty care. These services are supplemented by a broad range of enhanced services that together ensure access to truly patient-centered care including outreach, case management, patient education, translation and interpretation, childcare, transportation vouchers, and assistance applying for health insurance coverage.

The comprehensive model used by CCHCs has been shown to provide high-quality and cost-effective care that reduces hospitalizations, emergency department visits, and costly care by specialists. Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at health centers are between 11 and 22 percent less likely to be hospitalized for avoidable conditions; 19 percent less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient costs. Together, this amounts to 30-33 percent in total cost savings for each Medicaid beneficiary served in a community health center.[23]

Unfortunately, the Medi-Cal program does not support many aspects of the health care home model. We will not be able to succeed with the current system of reimbursement which places barriers to integrated care by: not reimbursing health centers for both a mental health visit and a primary care visit on the same day, not reimbursing for the services of Marriage and Family Therapists (MFTs) when they make up the largest proportion of mental health providers in the state, denying coverage for the cost of case management services for our most complex patients, and limiting primary care providers' ability to reach patients beyond clinic walls, for example for outreach purposes or to work collaboratively and co-locate within County Mental Health settings.

There must be incentives that encourage care coordination and case management that can be delivered by a variety of appropriate staff to promote team-based care. In the CCHC setting, disease management and care coordination activities utilize a range of providers, from physicians and nurses, to health educators and medical social workers. However, provider organizations are generally not paid for non-physician caregivers to provide chronic care, preventing clinics from being able to properly support the critical work performed by other members of the multidisciplinary treatment team. Primary care physicians are often too busy to perform all chronic care functions themselves, fortunately many of these tasks can be well performed by non-physician members of a practice team, with the support of protocols, standing orders, oversight, and training. In fact, some aspects of chronic care—particularly monitoring and education—may be better performed by other team members if they have special skills or experience, such as language proficiency or other cultural sensitivity, or personal experience of the disease.

Some of the best practices in primary care based chronic care are not currently reimbursable at CCHCs. Medi-Cal should pay for components of the Chronic Care Model that have been shown by the research literature to be effective not only in improving health outcomes, but also in reducing non-ambulatory costs, such as hospitalization. Examples include: group visits, and

time spent entering data into and using disease registries for population management or preparing to maximize the value of an individual visit. Reimbursement for patient self-management training is especially critical. For chronic conditions, substantial segments of management are under direct control of the patient (such as diet and medication use). Self-management support involves helping patients and their families acquire the skills, confidence, and problem-solving techniques to manage their chronic illness. Through self-management coaching, patients become active participants in their treatment by setting realistic goals with their care providers for the day-to-day management of their disease.

Integration through Partnerships

As California's CCHCs continue to enhance their internal behavioral health capabilities to better serve their patients, there is still a need for strong partnerships and referral arrangements with the specialty mental health system to address the needs of individuals whose mental health conditions are not adequately addressed in all primary care settings. While growing, the Integrated Behavioral Health Care movement within primary care does not replace the role of the specialty mental health system in providing comprehensive treatment and supportive services for the most seriously mentally ill.

We must continue to look for opportunities to partner and leverage resources to best meet the needs of all individuals and families with behavioral health needs. Policy developed under the new waiver should allow for different collaboration models that leverage resources based on the capacity of local safety net providers. Many collaborative relationships exist between CCHCs and County Mental Health Departments; the waiver should serve as an opportunity to spread the best practices exhibited by successful CCHC/County Mental Health partnerships, and to reduce the barriers both parties face to working in a more integrated manner.

The Integrated Behavioral Health Project recently published the *Partners in Health: Primary Care / County Mental Health Tool Kit*, which lists various collaboration models in use in California for the State and stakeholders to consider:

- The county mental health agency out-stations mental health workers at primary care sites and/or county mental health agency contracts with select primary care providers to deliver health screening and basic services at mental health facilities.

- A county-run mental health clinic has a collaborative arrangement with a primary care clinic to provide health services for their clientele.

- County mental health makes assessment and triage services available to primary care providers.

- County mental health enters into an agreement with primary care providers to deliver services to stabilized clients with serious mental illness and, in return, offers support services, consultation and ease in transitioning the client back to the mental health system when needed.

Behavioral Health Integration Technical Workgroup Pilot Proposal

On Target Population

Due to the focus on achieving cost savings under the new waiver, there has understandably been a major focus at the technical workgroup on addressing the needs of individuals who fall into quadrants two and four of the National Council for Community Behavioral Healthcare's Four Quadrant Model. However, as safety net providers who see anyone that walks in the door, CCHC patients live in all four quadrants and the lines are not easily defined. While the State has expressed an interest in focusing on individuals with serious mental illness, many individuals end up progressing to serious illness due to the sizeable unmet need when a person falls into the gap between what primary care can offer and the threshold to enter the specialty mental health system. Even if the threshold is met, the capacity of the specialty mental health system to enroll more people is in many communities severely limited.

New resources made available under the next waiver for behavioral health integration efforts should be invested where there is the greatest opportunity for return on investment for the Medi-Cal program. While level of behavioral health need may be in some instances correlated with patterns of expensive and avoidable health care utilization, it would be irresponsible to assume all individuals with high behavioral health needs also require extensive medical care management, and/or ignore those with lower behavioral health needs who actually do.

As the data presented to the technical workgroup by JEN Associates on *Prioritizing High-Risk SMI Patients for Case Management/Care Coordination* demonstrates, there is a small subset of the SMI Medi-Cal population driving most of the costs. In their analysis of savings opportunities, it should be noted a key factor leading to recovery versus relapse was a higher ratio of physical to mental health expenditures, and for the low risk SMI population, a major indicator of continued health was access to the kind of preventive primary care and chronic disease management that is a forte of CCHCs.

On Aligning Incentives and Addressing Frequent Users

To achieve budget neutrality, care coordination under the waiver must correct the costly utilization pattern of patients seeking care in the hospital setting for conditions that could be treated more economically in primary care. However, programs delivering the kinds of services that proactively keep patients out of the hospital are rarely funded from the same budgets that pay for hospital care, making it difficult to incentivize a shift to outpatient, community-based care. Mechanisms should be established to recognize and reward health care homes for the hospital savings they produce. Integrated systems that encourage local safety net partnerships can help CCHCs and others to develop and achieve shared financial risk, resources, and financial accountability, as well as common medical records and quality standards.

On Substance Use

CPCA understands the technical workgroup has prioritized the practice of substance use screening and treatment in primary care settings, and agrees there is significant unmet need for

these types of services within the safety net. Many CCHCs already have some screening capability built into the primary care provider encounters that patients seek out to address other needs, but once identified there are often no treatment services offered within the community to refer patients for help. As SBIRT (Screening, Brief Intervention, and Referral to Treatment) programs have demonstrated, there are substance use interventions appropriately delivered within primary care, but current reimbursement streams do not support primary care practices in offering these critical services.

Given the implementation of federal mental health parity and health care reform looming, California could use the waiver as an opportunity to explore models of delivering substance use services within primary care that once proven could be instituted statewide. According to the Obama Administration's National Drug Control Strategy released in February 2010, enhancing substance use care in the primary care safety net will be a federal priority in the coming year, with $25 million in FY 2011 dedicated to adding trained behavioral health counselors and other addiction specialists into federally qualified health centers (FQHCs). As with other funding opportunities available through the HRSA-run FQHC program, accessing these resources will likely be via competitive process. Through pilots in the new waiver, it may be possible to leverage this opportunity, positioning California to maximize the federal funds coming to the state for these purposes.

On the Health Care Coverage Initiative

On the topic of extending and expanding the Health Care Coverage Initiative (HCCI), CPCA has released a report, *Recommendations from Community Clinics and Health Centers on California's Health Care Coverage Initiative*, prepared by Alaina Dall, which provides an overview of the value of including CCHCs as strong partners in the HCCI as well as recommendations for increasing and securing the CCHC role. Community clinics and health centers will be vital to providing the increased access necessary to expand the program, so the waiver renewal should serve as an opportunity to remedy the uneven track record that counties have of contracting with CCHCs. One of the underlying challenges of the structure of the program was requiring counties to manage the program and budget without any guidelines as to how to involve other safety net providers in the community. As a result, patients suffer because they do not have a choice of providers and cannot select the practice setting in which they prefer to receive care, even if that clinic is the only one near their home. In these situations, the programs fail to strengthen relationships between safety net providers and an opportunity is missed to improve the safety net overall.

Assuming additional federal funds are made available under a next iteration of the HCCI, adding mental health and substance use services into the standard benefit package of the HCCI could strengthen the program in terms of responding to the diverse needs of medically indigent adults (MIAs). But resources will remain greatly limited with respect to need, and ultimately trade-offs will need to be made between expanding enrollment and enhancing services for enrollees. While county MIA spending will serve as the state match, to truly achieve the goal of extending coverage to as many MIAs as possible, current patterns of spending should not preclude the

funds acquired via federal match from benefiting MIA populations who currently do not access services or receive services outside the county health system.

Looking Ahead

CPCA looks forward to working with the State and fellow stakeholders to maximize the opportunity that this waiver renewal presents to prepare California for successful implementation of federal health care reform and mental health parity. CPCA encourages the Department of Health Care Services and the Legislature to explore how California can take advantage of the new state option included in the federal health care reform law, effective January 2011, to provide health homes for enrollees with chronic conditions who designate a provider or a team of providers, as a health home.

In this vein, CPCA has released a concept paper, *Community Clinics and Health Centers: Developing an Enhanced Primary Care Medical Home*, in support of a meaningful and vigorous demonstration of the medical/health home concept in California's next 1115 waiver. Around the country, CCHCs are at the center of many of the existing medical home demonstrations, including the demonstration announced by CMS at the end of 2009 for FQHCs and Medicare. California's CCHCs are one of the logical partners for a medical home demonstration and CPCA believes that the new waiver offers the opportunity to model and refine medical home concepts with existing safety net providers who are the primary providers of services for Medi-Cal beneficiaries. The Medicaid waiver and the health care reform provision mentioned above are opportunities to model medical homes that reflect the specific and diverse needs of subgroups of the Medi-Cal population, including the various categories of seniors and persons with disabilities with chronic illnesses, behavioral health and other special needs.

For further information, please contact Allison Homewood, Senior Healthcare Analyst, at ahomewood@cpca.org or 916.440.8170.

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[1] Community clinics and health centers are those nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CCHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. Clinics meeting federal requirements and definitions for purposes of Medicaid reimbursement may also be referred to as federally qualified health centers (FQHCs) or FQHC look-alikes.

[2] Falik, et al. Comparative Effectiveness of Health Centers as Regular Source of Care (2006) Journal of Ambulatory Care Management. 29(1):24-35.

[3] Duggar BC, et al. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers. Center for Health Policy Studies, 1994.