LOS ANGELES COUNTY
COMMISSION ON HIV

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Aging Caucus
Virtual Meeting
Tuesday, October 1, 2024
1:00pm-2:00pm (PST)

Collaboration in Care Conference: Empowered Aging, Thriving Beyond HIV | Key Takeaways

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

JOIN BY WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mc8dbc3a7df0c661d7f9ca54c876df421

Meeting number/Access Code: 2537 504 0665
Password: AGING
Join by phone
+1-213-306-3065 United States Toll (Los Angeles)

The Aging Caucus is committed to addressing aging across the lifespan. We welcome your ideas and feedback. If you are unable to attend the meeting, you may still share your thoughts by emailing them to hivcomm@lachiv.org.

Click HERE for information on the Aging Caucus' Recommendations and Care Framework for PLWH over 50 and long-term survivors.

together.

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AGING CAUCUS
VIRTUAL MEETING AGENDA
TUESDAY, OCTOBER 1, 2024
1:00 PM – 2:00 PM

JOIN BY WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mc8dbc3a7df0c661d7f9ca54c876df421
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1	**Welcome & Introductions**	1:00pm-1:10pm
2	**Co-Chairs' Report** a. Addressing Social Isolation and Loneliness in BIPOC Women 50+ Event Debrief b. Introductory Partnership Virtual Meeting with Dr. Gary Tsai, Director, Substance Abuse Prevention and Control (SAPC), Los Angeles County Department of Public Health	1:10pm-1:20pm
3	**Collaboration in Care Conference: Empowered Aging, Thriving Beyond HIV | Key Takeaways**	1:20pm-1:35pm
4	**Division of HIV and STD Programs (DHSP) Report**	1:35pm-1:45pm
5	**Executive Director/Staff Report** **a.** Annual Conference | November 14, 2024 9am to 4pm @ 12021 Wilmington Ave., Los Angeles, CA 90059	1:45pm-1:50pm
6	**Next Steps and Agenda Development for Next Meeting**	1:50pm-1:55pm
7	**Public Comments & Announcements**	1:55pm-2:00pm
8	**Adjournment**	2:00pm

Next Meeting: December 3, 2024

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AGING CAUCUS (AC) VIRTUAL MEETING SUMMARY
TUESDAY, AUGUST 6, 2024
MEETING PACKET: CLICK HERE.

Attendees: Kevin Donnelly (Co-Chair), Paul Nash (Co-Chair), A. Burton, C. Barrit, A. Frames, Dr. M. Green, Andres Herrera, L. Kochems, L. Martinez, Philip, K. Nelson, P. Ogata, and virtual attendees at the LA LGBT Center.

I. Co-Chairs' Report

a. **Collaboration with Women's Caucus -** Co-Chairs P. Nash and K. Donnelly met with the Co-Chairs of the Women's Caucus to discuss collaborating on a joint educational event about addressing social isolation/loneliness/promoting mental health in September in commemoration of National HIV/AIDS and Aging Awareness Day (Sept. 18). September 23 is on hold pending room reservation confirmations. The event theme is "Overcoming social isolation and building community for BIPOC Women ages 50 and over." The Aging Caucus will review initial ideas discussed with the Women's Caucus Co-Chairs and do a deeper dive with event planning at the August meeting. P. Nash reminded the group can show support by allowing women to drive the conversation and focus of the event.

II. Division of HIV and STD Programs (DHSP) Report

a. **Solicitations –** Dr. M. Green noted that DHSP anticipates releasing the Ambulatory Outpatient Medical/Medical Care Coordination/Patient Support RFP in the fall. They are also planning to release an RFP for prevention services in an effort to be more strategic and impactful in the way to fund HIV/STD prevention services in the County.

b. **Discussion: Revisiting Priorities and Directives –** Refer to page 7 of the packet.

Pamela Ogata went over the 4 key goals and activities created by the Aging Caucus in 2022. She offered the following feedback:

Goal 1: Housing for All Stages and Ages
Activity: Examine housing inventory to ensure that it provides safe and welcoming environments for seniors - *examine this activity with DHSP and perhaps work with HOPWA and other housing partners to create an inventory of housing for seniors. K. Donnelly noted that he will appeal to the Housing Task Force to prioritize PLWH over 50.*

Goal Two: Health Reimagined
Activity: Add gerontology training to Ambulatory Outpatient Medical, Oral Health, Medical Care Coordination and Mental Health services providers to improve awareness and understanding of age-related inequities in care and treatment – *DHSP has implemented program changes and the anticipated new AOM/MCC RFP will support this activity.*

Goal Three: Inclusion and Equity, Not Isolation
Activity: Acknowledge and support nontraditional family relationships that nurture well-being and social connection – *this goal is weak, unclear and lacks direction.*

K. Donnelly noted the importance of thinking of how services can be co-located to offer comprehensive services (housing, mental health, food, etc.).

P. Ogata suggested having a conversation with the Substance Abuse Prevention and Control Program (SAPC) and the Department of Mental Health (DMH) regarding loneliness and isolation among people over 50; how is isolation and loneliness manifesting in people with substance use and mental health conditions. Are they doing anything to address the issue? She also suggested doing more grassroots efforts, education, and raising awareness among community and providers. Don't do events, go to people instead.

Examples of resources offered by the group include working with the local area of aging; shiphelp.org (State Health Insurance Assistance Program)

Arlene Frames noted that people do not know how to ask for help on how to deal with loneliness because of stigma. Loneliness is further exacerbated for some Black women. There needs to be more information and community education.

Dr. Nash noted that screening is not just about who is lonely, but about preventing loneliness and identifying those precipitating factors that put them at risk for loneliness; folks may not disclose or have the language to describe how they are feeling. It is really important to get input of providers and clients. There are creative and powerful campaigns to address loneliness around the world but it is also to address stigma, racism, and homophobia. We have to normalize talking about mental health, loneliness and isolation. But we also have to be mindful that one size does not fit all.

K. Donnelly noted that he will reach out to APLA (Brian Risley) if they can help with community education via their Women Together program.

III. **Executive Director/Staff Report:** C. Barrit reminded attendees about the August full Commission meeting which will focus on revisiting the Comprehensive HIV Plan. She referred to various training, programs and resources for older adults in the packet. She encouraged participation in the priority setting and resource allocation exercise that will occur at the August 27th meeting of the Planning, Priorities and Allocations Committee.

IV. **Announcements and Public Comments –** Dr. Nash mentioned the UCLA CDU CFAR 2nd Annual Community Partnered Participatory Research Symposium; will be held at MLK Behavioral Center 12021 Wilmington Ave, Los Angeles, CA 90059.

V. Next Steps and Agenda Development for Next Meeting

- Next Meeting: October 1, 2024 @ 1pm to 2:30pm to be held virtually via WebEx.
- September educational event debrief.
- Continue discussion on developing programs or resources for PLWH 50+ on isolation and loneliness.
- Reach out to SAPC and DMH

Meeting was adjourned at 2:30pm.

CHCF

Road Map to Better Care

Preparing California Health Centers to Serve Older Adults

Developed by the Strategies for Older Adult Services Task Force, Convened and Supported by the California Health Care Foundation

JULY 2024

AUTHOR:
Rafael A. Gomez, MPP, El Cambio Consulting

About the Author

Rafael A. Gomez, MPP, founder and owner of El Cambio Consulting, is a health care consultant with over 13 years of experience providing strategic planning, program development, policy evaluation, and operations planning support to California safety-net health care organizations, including community clinics and health centers, managed care organizations, health-related foundations, and county agencies, among others.

About the Foundation

The **California Health Care Foundation** is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

Executive Summary

California is on the cusp of a demographic shift that will see its older adult population grow and diversify significantly over the next 10 years. This burgeoning demographic, in parallel with a noticeable aging of patients served by safety-net health care providers and policy transformations related to the care for California residents dually eligible for Medi-Cal and Medicare ("dually eligible enrollees"), underscores the need for health care providers and stakeholders to prepare their systems to care for this growing population.

California health centers, with their deep-rooted history of providing comprehensive and culturally competent care to diverse communities and their responsibility as essential primary care providers to Medi-Cal enrollees and the uninsured, will likely play a pivotal role in ensuring that older adults with low incomes in California receive the holistic, integrated, and person-centered care they deserve.

In November 2023, the California Health Care Foundation (CHCF) launched a seven-month effort that convened health center thought leaders and innovators to explore the role of California health centers in serving older adults with low incomes. The Strategies for Older Adult Services Task Force membership included health center leaders representing the diversity of California geography and organizational size, and representatives from clinically integrated networks and health center–led risk-bearing organizations (e.g., independent practice associations) and regional consortia, with additional support and participation by the California Primary Care Association (CPCA) and CHCF, and facilitation by El Cambio Consulting and JSI Research & Training Institute.[1]

Through a series of interactive sessions, the task force articulated a 10-year vision for a sustainable role for California health centers in caring for older adults with low incomes, as well as a road map describing strategies and steps to advance the vision.

The resulting vision and road map are intended to inform planning and collaboration among California health center and regional consortia leaders, Medi-Cal managed care plan partners, California health and aging state agencies, and other older adult stakeholders committed to improving the care and health outcomes of California's older adults with low incomes.

Rationale for Defining a Vision for the Role of Health Centers in Serving Older Adults

- California's older adult population is growing and diversifying rapidly, with an estimated one in three California residents expected to be age 60 or older in 2030 (half of whom will be people of color).[2]
- Older adults represent a rapidly growing proportion of health center patients, with more than 1.15 million current California Federally Qualified Health Center (FQHC) patients age 55 or older and a growing aging patient base on the horizon.[3]
- Health centers' comprehensive service models, cultural competence, and existing Medi-Cal primary care relationships underscore the unique capabilities they can bring to care for older adults with low incomes.
- As the primary care home for thousands of dually eligible enrollees and more than one in three California Medi-Cal managed care enrollees overall, health centers will likely be critical partners to health plans and the state in meeting their goals related to Dual Eligible Special Needs Plans (D-SNPs).[4]

Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan specifically for people eligible for and enrolled in both Medicare and Medi-Cal (dually eligible enrollees). California is in the process of rolling out a requirement that each Medi-Cal managed care plan organization also provide an aligned D-SNP product, known as a Medicare Medi-Cal Plan, by 2026. These aligned D-SNPs are already in place in 12 counties.[5]

Risk-bearing organizations (RBOs) are organizations that contract directly with health plans to assume financial responsibility and risk for a defined set of benefits. Health center–led RBOs in California may be nonprofit or for-profit organizations controlled by individual health centers or by a group of health centers. These organizations may function as clinically integrated networks, independent practice associations, or limited Knox-Keene health plans.

Key Factors to Consider in Defining a Vision and Road Map

- Local Medicare market factors related to the presence of managed care and the extent of market reliance on health centers vary widely by region and impact the strategies different providers and communities will pursue. One size will not fit all.
- While most California health centers have awakened to the need to develop capacity to care for older adults, sophistication and organizational readiness vary widely.
- The traditional FQHC payment system, including the prospective payment system (PPS) fee-for-service model, may not always align with optimal models of care or sustain the cost of caring for an aging and complex population.
- The needs of dually eligible enrollees may be well served by new or creative value-based care models and reimbursement arrangements that more explicitly align with appropriate care models for a complex population.
- Health center–led risk-bearing organizations (RBOs) and arrangements are growing their presence in the health center environment and could serve as useful vehicles for sustaining and supporting health center service models for dually eligible enrollees.

Vision for the Role of Health Centers in Serving Older Adults

The Strategies for Older Adult Services Task Force articulated a two-pronged vision for the future role of California health centers in caring for older adults:

1. **Leverage health center competencies to become essential older adult health care providers.** California health centers will leverage their comprehensive service model, cultural competence, and long-standing care for Medi-Cal populations to play an essential role in caring for California's dually eligible enrollees and older adults with Medi-Cal only.

2. **Align payment and incentives to deliver value.** California health centers will promote a system of care that rewards value by advancing their own value-based business models and promoting modernized and innovative reimbursement policies and programs for older adults with Medicare coverage, Medi-Cal coverage, or both.

Road Map to Advance the Vision

The road map identifies five overarching strategies to advance the proposed vision:

1. **Align stakeholders around a shared vision.** Engage delivery system and policy stakeholders, such as the California Department of Health Care Services (DHCS), Medi-Cal managed care

plans, and the Centers for Medicare & Medicaid Services (CMS), in collaborative planning to advance a shared older adult service vision that incorporates the role of health centers, develop aligned policies, and facilitate coordinated strategies to care for older adults with low incomes.

2. **Mature the health center delivery system.** Assist California health centers in expanding older adult services and capabilities through learning from early adopters and delivering educational content and technical assistance on care models with aligned guidance on financial strategy and sustainability.

3. **Build value-based business models and infrastructure.** Position California health centers to sustain their own value-based business arrangements for older adult care by extending the role and reach of health center–led RBOs and cultivating risk/shared savings contractual arrangements for the dually eligible enrollee population.

4. **Align payment and policy.** Promote federal and state policies that facilitate expanded participation in care for older adults by health centers, and advance innovative reimbursement structures for older adults with Medicare coverage, Medi-Cal coverage, or both.

5. **Leverage D-SNPs as a catalyst.** Connect health center leaders, regional consortia, health center–led RBOs, and CPCA with local Medi-Cal managed care plans and state agencies to leverage the D-SNP transition as a catalyst for increased health center capacity and participation in care for older adults.

Importantly, the task force recognized that developing health center capacity and sustainability to care for older adults requires work along two parallel tracks:

- **Build to the now.** For health centers that are early in their journey caring for older adults and those without participation in existing risk-bearing organizations/arrangements, take steps to educate on and incrementally build older adult services, maximize the patchwork of reimbursement levers within the traditional FQHC model, and promote the development of innovative payments/programs that augment and complement the prospective payment system (PPS).
- **Chart the future.** Learn from and support continued advancement by early adopter health centers and health center–led RBOs, encourage an expanded role and reach of health center–led RBOs and risk/shared savings arrangements in care for dually eligible enrollees, and pursue policies that enable health center engagement in value-based business models and infrastructure.

Rationale for Defining a Vision for the Role of Health Centers in Serving Older Adults

Converging demographic, delivery system, and policy factors suggest that there is a growing need and urgency to define a role and road map for health centers to care for older adults with low incomes. The task force considered the trends and issues described below in defining the older adult vision and road map.

Rationale for Defining a Vision

California's older adult population is growing and diversifying rapidly. By 2030 close to one in three California residents will be age 60 or older and will increasingly reflect the ethnic and income diversity of the communities served by health centers. By 2030 the majority of California older adults age 60 or older will be people of color, and more than one in four will identify as Latino/x.[6]

Older adults represent a growing proportion of health center patients. Since 2014, the number of patients age 65 or older receiving care from California FQHCs has more than doubled; these centers now care for nearly 500,000 patients in this age group — of which about 6 in 10 are dually eligible for Medicare and Medi-Cal. Another 650,000 FQHC patients are age 55 to 64 and poised to age into Medicare over the next 10 years.[7]

Health centers are uniquely positioned to deliver comprehensive, integrated, and person-centered care to a diverse older adult population. Core health center assets — including cultural and linguistic competence; comprehensive medical, dental, and behavioral health service models; support for social needs; and deep experience serving Medi-Cal members who will age into Medicare in the next few years — uniquely position health centers to provide high-quality, coordinated care for older adults across payer types.

Health centers could be major assets to achieve California's Dual Eligible Special Needs Plan (D-SNP) goals. Ultimately, the success of the D-SNPs launched by Medi-Cal managed care plan organizations will depend on their ability to attract and retain members and maintain robust and competent networks of care. As the primary care home for a large percentage of existing dually eligible enrollees and Medi-Cal enrollees who will age into Medicare, health centers could play a significant role in driving D-SNP enrollment, network adequacy, and performance in many California regions by successfully retaining and caring for dually eligible enrollees. Further, continued physician burnout and retirement trends among the broader provider community will likely drive increasing reliance on health centers for future network capacity.[8]

Key Factors to Consider in Defining a Vision and Road Map

Local Medicare market environments vary widely, which influences network and financial strategies. Local characteristics significantly influence strategies and opportunities to grow the health center role in caring for older adults. These factors include the extent of Medicare Advantage versus fee-for-service Medicare presence among dually eligible enrollees and community dependence on local health centers as a source of older adult primary care.

In rural Northern California, for example, health centers are often the only provider available for dually eligible enrollees and increasingly looked to for care of Medicare-only enrollees.

Additionally, these communities operate in a largely fee-for-service Medicare environment. In contrast, Los Angeles and San Diego dually eligible enrollees predominantly participate in Medicare Advantage plans, and both health centers and health plans experience higher competition for these members. These health centers are also more likely to be supported by health center–led RBOs.

California health centers present on a spectrum of organizational readiness. Whereas a subset of leading-edge health centers has paved the way in exploring sophisticated care models and sustainability strategies to care for older adults, many more California health centers are in the early stages of building out older adult care models and understanding the financial levers and strategies that drive success. Further, while several communities have existing health center–led RBOs to build upon, many more operate in environments where this infrastructure is not yet present.

Traditional FQHC payment methodologies may not always align with optimal older adult care models or facilitate sustainability of this care. The traditional FQHC payment model is driven by visit volume for a limited set of clinical services at a defined site-based prospective payment system (PPS) reimbursement rate. Effective care for an aging population encompasses modified and multidisciplinary clinical care teams, longer visits, risk-stratified care management, and comprehensive clinical and support services that are often not well aligned with the FQHC PPS model. In a typical FQHC setting, health centers are currently augmenting PPS with varied revenue sources to enable older adult care, including 340B pharmacy, Chronic Care Management (CCM; fee-for-service settings), accountable care organization (ACO) arrangements (fee-for-service settings), and/or Medicare Advantage/D-SNP incentives, among other contributors.

To facilitate meaningful growth in older adult service capacity, health centers will be challenged to master the many revenue levers within the existing model, carve out more avenues for risk/shared savings, and promote the development of innovative payment models for older adults with Medicare coverage, Medi-Cal coverage, or both that augment PPS and incentivize the development of care management functions.

The needs of dually eligible enrollees may be well served by new or innovative value-based care models and reimbursement arrangements. Dually eligible enrollees experience a significantly higher burden of chronic disease and disability than the aging population at large. Not only do dually eligible enrollees require more frequent and complex medical care, but their health conditions also result in functional deficits that demand the assistance of supportive services to allow them to carry out the activities of daily living.

Delegated and/or value-based reimbursement arrangements could create the opportunity to both improve the management of care for this population and more efficiently use care dollars, resulting in both health plan savings and the possibility of shared financial returns by delivery systems. Health centers are uniquely positioned to provide comprehensive care management to assist dually eligible enrollees in meeting their medical, functional, and social needs. However, as health centers work to meet those complex needs, they will benefit from an openness by health plans, policymakers, and state/federal agencies to innovative and value-based payment arrangements that recognize the intensity and type of services required to meet complex needs and reward value.

Health center–led risk-bearing organizations (RBOs) and arrangements are increasingly sophisticated and garnering interest as vehicles for value-based care. The traditional FQHC PPS is a visit volume–driven reimbursement model that does not always sustain or reward the optimal service components for older adult populations. Several health center–owned and –led RBOs (e.g., independent practice associations, limited Knox-Keene plans, other networks) operate in California, with a membership exceeding 1.2 million assigned lives.[9] The most advanced of these systems have already prioritized D-SNP/Medicare Advantage lines of business for continued growth and have developed sophisticated managed care infrastructure for risk stratification, care management, and quality performance.

More broadly, California health centers are increasingly leaning into health center–led RBOs as valuable entities to house population health and care management infrastructure, and as mechanisms for financial diversification and flexibility. Beyond health center–led RBOs, health centers throughout California are actively exploring and participating in Medicare ACOs and CCM as initial steps to provide older adult care management, incorporate diversified revenue sources, and test risk/shared savings arrangements.

Vision for the Role of Health Centers in Serving Older Adults

Through collective visioning and discussion, the Strategies for Older Adult Services Task Force articulated a long-term vision for health centers to sustainably serve California older adults with low incomes. The vision encompasses two major pillars:

1. **Leverage health center competencies to become essential older adult health care providers.** California health centers will leverage their comprehensive service model, cultural competence, and long-standing care for Medi-Cal populations to play an essential role in caring for California's dually eligible enrollees and older adults with Medi-Cal only.

Health centers come to the table with many of the essential ingredients to care for a racially/ethnically diverse population of older adults with low incomes, including deep cultural and linguistic competence; comprehensive medical, dental, behavioral health, and support service models; and long-standing primary care relationships with Medi-Cal and dually eligible enrollees.

Moving forward, California health centers can develop older adult care models and clinical capacity that incorporate adapted primary care teams, wraparound clinical and support services, robust care management and coordination, and defined programs to retain patients aging into Medicare.[10] Health centers can do this by learning from early California health center adopters, disseminating technical assistance and care model education, and prioritizing aligned learning on financial strategies and levers.

2. **Align payment and incentives to deliver value.** California health centers will promote a system of care that rewards value by advancing their own value-based business models and advocating for modernized and innovative reimbursement policies and programs for older adults with Medicare coverage, Medi-Cal coverage, or both.

To sustainably care for older adults with low incomes, improve patient health outcomes, and reduce program cost, health center business models

and payment mechanisms will need to evolve. A future value-driven financial model can be achieved through two paths.

First, health centers can be supported to expand the role and participation of health center–owned RBOs (e.g., limited Knox-Keene plans, independent practice associations, health center networks) and arrangements (e.g., novel D-SNP contracts, ACO or ACO-like shared savings arrangements) for the dually eligible enrollee population that enable shared savings and risk-based contracting.

Second, health center representatives can promote policies that augment the traditional PPS model with reimbursement models for older adults with Medicare coverage, Medi-Cal coverage, or both that promote comprehensive service models, reward value, and expand flexibility in the care of this population. This could include initiatives that address reimbursement for Medi-Cal-only enrollees, enable comprehensive and integrated services for dually eligible enrollees leveraging both Medi-Cal and Medicare funding, or align and clarify FQHC reimbursement methodologies for older adults, among other policies.

Road Map to Advance the Vision

To advance the proposed vision for the future role and sustainability of health center care for older adults, the Strategies for Older Adult Services Task Force articulated five overarching strategies:

1. **Align stakeholders around a shared vision.** Build an aligned stakeholder vision for the health center role in California older adult care.

2. **Mature the health center delivery system.** Equip health centers to expand and financially sustain older adult care models.

3. **Build value-based business models and infrastructure.** Leverage health center–led risk-bearing organizations (RBOs) and arrangements to build value-based business models.

4. **Align payment and policy.** Innovate and align Medicare/Medi-Cal reimbursement and FQHC policy to maximize optimal care models.

5. **Leverage D-SNPs as a catalyst.** Use the D-SNP transition as a catalyst for an expanded health center role and value-based payment models.

Importantly, the task force recognized that developing health center capacity and sustainability requires work along two parallel tracks.

First, there is work to "build on the now" among California health centers that are early in their journey caring for older adults and do not participate in existing risk-bearing organizations or arrangements. The work ahead includes educating health centers on older adult care models, incrementally building older adult care capacity, maximizing the patchwork of reimbursement levers within the traditional FQHC model, and advocating for innovative payments/programs that augment and complement PPS.

Second, there is an opportunity to "chart the future" by learning from California health center early adopters, encouraging an expanded role and reach of health center–led RBOs and shared savings arrangements in care for dually eligible enrollees, and pursuing policies that enable health center engagement in value-based business models and infrastructure.

The remainder of this section describes in detail the five strategies proposed in the road map. These are also summarized in Figure 1.

Figure 1. Road Map to Advance the Vision for Health Center Role and Sustainability

Align Stakeholders Around a Shared Vision

Collaborative Planning with Older Adult Stakeholders

- California stakeholder planning
- Federal engagement on Medicare and FQHC policy
- Collaboration with D-SNPs aligned with local-initiative Medi-Cal plans

California Health Center Strategic Alignment

- Statewide health center older adult forums
- Health center leadership education and learning
- Strategy discussions on growing health center–owned value-based infrastructure

	Mature the Health Center Delivery System	Build Value-Based Business Models and Infrastructure	Align Payment and Policy
BUILD TO THE NOW	• Health center service model and aligned financial management education/technical assistance • Expert pools on older adult care models, financial management, and contracting • Learning communities and collaboratives	• Novel health center and health center–led RBO D-SNP contracts • Medicare ACOs or Chronic Care Management as a step to build capability and revenue	• Innovative payment programs for older adult services through Medicare, Medi-Cal, or both • Medicare, dually eligible enrollees, and FQHC policy alignment
CHART THE FUTURE	• Forums for field to learn from leading-edge health centers and health center–led RBOs	• Health center–led RBO dually eligible enrollee strategy planning and infrastructure development • Spread of health center–owned managed care infrastructure	• Medi-Cal and FQHC delegated entity policy

Leverage D-SNPs as a Catalyst

- Shared vision for health center network role
- Support for health center readiness
- Mutual understanding of business drivers
- Aligned, innovative contracting strategies
- Policy alignment to encourage health center participation
- Exploration of innovative payment programs

Source: Strategies for Older Adult Services Task Force, 2024.

Notes: *ACO* is accountable care organization; *D-SNP* is Dual Eligible Special Needs Plan; *FQHC* is Federally Qualified Health Center; *RBO* is risk-bearing organization.

1. Align Stakeholders Around a Shared Vision. Build an aligned stakeholder vision for the health center role in California older adult care.

Health center leaders actively engage delivery system and policy stakeholders in collaborative planning to advance the health center vision, develop aligned policy, and facilitate coordinated strategies to care for older adults with low incomes.

Collaborative planning with older adult stakeholders. A first and fundamental step is for California FQHC representatives to engage the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), Medi-Cal managed care plans, the California Department of Aging (CDA), and other aging service partners in collaborative discussion around statewide goals and the future care and sustainability vision for health centers.

Additionally, the California Primary Care Association (CPCA), regional health center consortia, and health center–led RBOs have an opportunity to engage local health plans *early* to define health center market potential and network role, explore contracting options and issues, understand financial drivers, and focus together on strategies to prepare health centers to excel in serving dually eligible enrollees and incrementally expand their capabilities to serve older adults.

At the federal level, California health center representatives can educate the Centers for Medicare & Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) about the future vision and promote forums that address Medicare and FQHC payment rules that inhibit or impact health center care for Medicare and dually eligible enrollees.

California health center strategic alignment. Though conversations about older adult care are percolating among some health centers, there is room to formalize health center forums to solidify the strategic vision; define the role of risk-bearing organizations/arrangements in the health center sustainability and value-based care strategies; and collectively define policy priorities, technical

Stakeholder Alignment Context and Challenges

- Minimal cross-sector, statewide forums focused on older adults with low incomes or dually eligible enrollees exist at the strategic, policy, or implementation levels.
- Most local plans and health center network providers have not yet discussed the health center role in Dual Eligible Special Needs Plan (D-SNP) networks or opportunities for mutual benefit.
- Many California stakeholders have insufficient understanding of health center financial drivers and considerations in care for older adults.
- Limited federal attention or discussion has occurred yet on the extent to which current Medicare policy and Federally Qualified Health Center (FQHC) reimbursement rules inhibit health centers from proactively retaining their aging patients.
- While conversations about the role of health centers in care of older adults are percolating, structured forums at state or local levels do not yet exist.
- Health center–led risk-bearing organizations (RBOs) are on the outside of external stakeholder conversations and internal health center planning. Many health centers and stakeholders have limited understanding of the role or reach of health center–led RBOs.

assistance/education strategies, and stakeholder engagement. Furthermore, health center partners should consider how and where to incorporate health center–led RBOs into health center leadership forums and external partner discussions. In addition, RBOs themselves may benefit from ongoing communication and planning between their peer entities. Continued learning and discussion would facilitate increased alignment and buy-in by health center leaders.

Putting Strategies into Action

This section summarizes potential first steps to engage external and internal stakeholders around a shared vision for the future role of California health centers serving older adults and to advance the delivery system, policy, and business model strategies articulated in the road map.

Collaborative Planning with Older Adult Stakeholders

- **California stakeholder planning.** CPCA, consortia, and FQHCs participate in statewide D-SNP and Medi-Cal planning efforts with DHCS, Medi-Cal managed care plans, and older adult stakeholders.
- **Federal engagement on Medicare and FQHC policy.** Educate CMS and HRSA on the proposed health center role, and address Medicare policies and FQHC payment rules that impact health center participation.
- **Collaboration with D-SNPs aligned with local-initiative Medi-Cal plans.** Health centers, health center–led RBOs, and regional consortia collaborate with plans to develop an aligned vision for FQHCs in D-SNP provider networks.

California Health Center Strategic Alignment

- **Statewide health center older adult forums.** Establish new CPCA and Regional Associations of California (RAC) working groups or committees to refine and advance an aligned older adult strategy.
- **Health center leadership education and learning.** Encourage leadership education sessions and discussion forums for health center, consortia, and health center–led RBO leaders to understand value-based care concepts and business models.
- **Strategy discussions on growing health center–owned value-based infrastructure.** Hold statewide health center leadership discussions to explore strategies to facilitate the spread of risk-bearing organizations, infrastructure, and contractual arrangements among health centers — including incorporating health center–led RBOs into existing or new health center forums.

2. Mature the Health Center Delivery System. Equip health centers to expand and financially sustain older adult care models.

Assist California health centers in expanding older adult services and capabilities through learning from early adopters, disseminating technical assistance on older adult care models, and providing aligned education on financial strategy and sustainability.

Health center education and technical assistance on care models and financial strategies. Early efforts indicate that despite quite sophisticated activities among a few early adopters, there is wide variation in California health center understanding of and experience with structuring older adult service

models, navigating reimbursement levers, and developing an older adult business strategy. Importantly, it is clear that individual health centers will struggle to invest in older adult service models without aligned short- and long-term financial strategies.

To facilitate incremental growth in older adult services among health centers that are early in their journey to care for aging patients, there would be value in providing significantly more education and best-practice forums on older adult primary care models, comprehensive service components, risk stratification and care management programs, and aligned education and technical assistance on how health centers can maximize the patchwork of financial strategies and levers in a traditional PPS setting. Additionally, health centers would benefit from the identification of reliable consultant/technical assistant pools to support implementation of contracting, financial management, and care model strategies.

Education on value-based models. To enable strategic thinking and planning among health center leaders about a future value-based model, there are opportunities for health center leaders to develop deeper familiarity with risk-bearing organizations and models, learn from those health centers pushing the envelope, and better understand the strategic landscape. New forums and educational tracks focused on health center leaders and future strategy would benefit this goal.

Individual California health centers will struggle to incrementally build older adult service models without aligned education on financial strategies.

Support and investments to build health center capacity and capabilities. Structured collaboratives, learning communities, and grant programs from funders, California state agencies, and Medi-Cal managed care plans would serve well the goal of incremental capacity development and learning among California health centers. As noted, it will be essential that any efforts center support for financial model and strategy development along with the development of care models.

Putting Strategies into Action

Recognizing that development of health center clinical capacity and delivery models will occur along two tracks — building on the current model and charting a new model — the Strategies for Older Adult Services Task Force identified the potential strategic steps described below.

Build to the Now

- **Health center service model and aligned financial management education/technical assistance (TA).** Implement health center educational tracks and best-practice forums that address FQHC reimbursement and financial strategies in a traditional PPS setting, and clinical service model development (including risk stratification and care management).
- **Expert pools on older adult care models, financial management, and contracting.** Establish consultant/TA pools to assist health centers with contracting, financial management, and care model development.
- **Learning communities and collaboratives.** Seek and support collaboratives, learning communities, and grants to build incremental service and financial capacity.

Chart the Future

- **Forums for field to learn from leading-edge health centers and health center–led RBOs.** Provide forums for leading-edge health centers and health center–led RBOs to share strategic directions and best practices with the field.

3. Build Value-Based Business Models and Infrastructure. Leverage health center–led risk-bearing organizations (RBOs) and arrangements to build value-based business models.

Position California health centers to sustain their own value-based business arrangements for older adult care by extending the role and reach of health center–led RBOs and cultivating risk/shared savings contractual arrangements for the dually eligible enrollee population.

Extended role, reach, and capabilities of health center–led risk-bearing organizations. Growing the reach of health center–led organizations that can take and manage risk presents one, though not the only, valuable pathway to facilitate financial sustainability and promote value-based care models in the care for older adults. Looking ahead, the role, reach, and capabilities of health center–led RBOs can be extended through a couple of key strategies.

First, existing health center–led RBOs can take purposeful steps to expand their role, contractual arrangements, and capabilities specific to dually eligible enrollees. There are a surprising number of health center–led RBOs in California (e.g., independent practice associations, limited Knox-Keene plans, networks), though few have a mature strategy or infrastructure to care for the dually eligible enrollee population — with a couple of exceptions. The D-SNP transition presents a natural opportunity for these organizations to conduct internal planning, engage local Medi-Cal and D-SNP plans, define long-term strategies for dually eligible enrollees, and develop organizational infrastructure to deliver value for this population. Importantly, this role (and associated infrastructure) could develop incrementally over time rather than radically overnight. Potential pathways brainstormed by the task force included the following:

- Structured planning to develop goals for the Medicare Advantage (including D-SNPs) line of business, strategies to grow membership, and infrastructure
- D-SNP collaborative planning and contracting with managed care plan partners
- Grants or plan investments to build centralized functions in RBOs that can facilitate health center performance and future risk-based contracts (e.g., care management, risk coding, age-in retention)
- Medicare ACO or ACO-like programs as a path to build infrastructure and experience with this population

Second, health centers can explore options to build or extend health center–owned managed care infrastructure to new communities. This could include innovative contracts between health center–led RBOs and health centers or health center networks in other communities to provide management services or functions, regional expansion of existing health center–led RBOs to include more health centers and communities, or even the development of new health center–led RBOs either regionally or statewide.

Novel plan contracts and/or ACOs as a step into risk. Pursuing the development of full-blown independent practice associations, limited Knox-Keene plans, or other health center–led RBOs may not be desired by or feasible for many California health centers. Given that, health centers can pursue other paths to enable flexibility to deliver the right kind of care and generate new, flexible revenue. This could include development of their own

or participation in existing Medicare ACOs and/or pursuit of novel D-SNP contracts that provide risk sharing/shared savings, performance incentives, or other revenue for services or outcomes desired by contracted plans.

Examples of novel D-SNP contracts could include contracts with individual health centers, consortia, or clinic networks for defined functions (e.g., care management) or targeting specific health plan goals (e.g., reducing long-term care costs, improved risk coding, targeted quality or access outcomes). Progress in each of these areas requires thoughtful exploration, planning, and collaboration with health plan partners.

Putting Strategies into Action

The strategies described below highlight potential first steps to actively advance the growth of value- and risk-based arrangements and infrastructure among California health centers, within both fee-for-service Medicare and D-SNPs.

Build to the Now

- **Novel health center and health center–led RBO D-SNP contracts.** Promote exploration of ACO-like or other novel D-SNP contracts with health centers, health center networks, and health center–led RBOs.
- **Medicare ACOs or Chronic Care Management as a step to build capability and revenue.** Support education, exploration, vetting, and development of Medicare ACO or Medicare Chronic Care Management participation by interested health centers as a first step to build capability to serve older adults.

Chart the Future

- **Health center–led RBO dually eligible enrollee strategy planning and infrastructure development.** Encourage and support health center–led RBO planning, strategy, and infrastructure development for serving dually eligible enrollees.
- **Spread of health center–owned managed care infrastructure.** Activate evaluation and development of value-based managed care infrastructure among more California health centers.

Considering How Medicare ACOs and ACO-Like Arrangements Fit In

- In most health center settings, it is likely that enrollment of patients into Dual Eligible Special Needs Plans (D-SNPs) will not be an immediate large-scale shift, but a gradual transition over time for some portion of the population. This means that most health centers will be caring for a mix of fee-for-service Medicare and D-SNP enrollees for an extended period of time (though ratios will vary by community). As part of their strategy for serving fee-for-service Medicare enrollees, some health centers may be participating or considering participation in a Medicare accountable care organization (ACO).
- While Medicare ACOs cannot be used for D-SNP enrollees, they may provide a useful "step into" D-SNP (and revenue sharing) by equipping participating FQHCs with a baseline understanding of the population and increased capacity to serve older adults. Health centers need to evaluate which ACO models and partners are appropriate for them. As an alternative, plans could establish shared savings programs that align with or complement Medicare ACOs for community providers.
- The relative roles of D-SNPs and ACOs also highlight potential value in more deliberate planning between health centers, the California Department of Health Care Services (DHCS), and Medi-Cal managed care plans about the interplay of D-SNPs and Medicare ACOs or ACO-like arrangements.

4. Align Payment and Policy. Innovate and align Medicare/Medi-Cal reimbursement and FQHC policy to maximize optimal care models.

Encourage the development of federal and state policies that spur expanded participation by health centers in care for older adults, and expand innovative reimbursement programs for those with Medicare coverage, Medi-Cal coverage, or both.

Innovative payment programs. There are opportunities to pilot innovative payment programs unrelated to traditional primary care/PPS reimbursement that incentivize the development of care management/coordination support in health center primary care settings. Such programs could enable health centers without RBO infrastructure to appropriately enhance their care models.

This could include creative ideas such as bundled payments for dually eligible enrollees, Medicare-only enrollees, and Medi-Cal-only older adults akin to the Comprehensive Perinatal Services Program (CPSP) for pregnant women; expanded older adult eligibility for Enhanced Care Management; or other bundled payment programs that explicitly address cost drivers among older adult populations.

An important strategy moving forward would be to engage state and federal agencies in exploring innovative bundled payment programs, such as those described above, to augment traditional primary care.

Policy that enables health center risk-based arrangements and aligns PPS and older adult care reimbursement. As the number of older adults served by health centers increases, there is a natural opportunity for stakeholders to consider how Medicare and Medi-Cal reimbursement policies interact with FQHC regulations and the extent to which existing policies align with, encourage, or create barriers to health centers caring for older adults. A valuable future strategy could be to identify policy issues and prioritize solutions that promote health center care for older adults, align program

Preliminary List of FQHC Older Adult Policy Issues for Exploration

- Aligned Dual Eligible Special Needs Plan (D-SNP) enrollment rules, including age-in of those enrolled in the aligned Medi-Cal plan
- D-SNP and Medi-Cal-only older adults provider continuity-of-care rules
- California delegated entity policy for health center–led RBOs
- Relationship between Federally Qualified Health Center (FQHC) payment reconciliation and incentive or augmented payment programs for Medicare-only and dually eligible enrollees
- Role of FQHCs as participants in Medicare payment initiatives
- FQHC Medicare prospective payment system (PPS) rates and California PPS rate methodology for Medi-Cal-only older adults
- PPS productivity screens for older adult populations

Preliminary Innovative Older Adult Payment Ideas

- Comprehensive service model with bundled payment for dually eligible enrollees and Medi-Cal-only older adults (akin to the Comprehensive Perinatal Services Program)
- Expanded Enhanced Care Management eligibility for dually eligible enrollees and Medi-Cal-only older adults
- Expanded telehealth and technology support initiatives for dually eligible enrollees and Medi-Cal-only older adults
- Federal FQHC grants or other funding mechanisms to accelerate older adult care in health centers

and health center reimbursement incentives, and provide regulatory clarity for FQHCs.

Similarly, the road map identifies the potential value of expanded delegation and/or value-based contracting with health centers and health center–led RBOs to care for dually eligible enrollees. To this end, there are opportunities to examine and address California Medi-Cal delegated entity policies that may impact the ability of health center–led RBOs to grow their role as value-based assets to the safety net. Given that the mission, role, and value of health center–led RBOs are fundamentally different from those of commercial delegated entities, an additional future strategy could be to explore and address Medi-Cal delegated entity policy for health center–led RBOs with DHCS and DMHC.

Putting Strategies into Action

Specific steps to advance payment/policy priorities include the following:

Build to the Now

- **Innovative payment programs for older adult coverage programs.** Promote the development of innovative payment programs for older adults with Medicare coverage, Medi-Cal coverage, or both that facilitate optimal care models (e.g., care management), promote desired health and cost outcomes, and complement the traditional FQHC prospective payment system.
- **Medicare, dually eligible enrollees, and FQHC policy alignment.** Engage CMS and HRSA on Medicare policy issues that impact health center participation or reimbursement; collaborate with DHCS in identifying, addressing, and clarifying policy issues related to FQHC reimbursement and appropriate participation by health centers in D-SNPs and care for dually eligible enrollees.

Chart the Future

- **Medi-Cal and FQHC delegated entity policy.** Develop Medi-Cal and health center delegated entity policies that acknowledge the unique value of health center–led RBOs and facilitate an expanded role for these entities.

5. Leverage D-SNPs as a Catalyst. Use the D-SNP transition as a catalyst for an expanded health center role and value-based payment models.

Coordinate and collaborate with the Department of Health Care Services and local Medi-Cal managed care plans to leverage California's D-SNP transition as a catalyst for increased health center capacity and participation in care for older adults.

Though perhaps not immediately, California health centers are poised to play an important role in the long-term success of California's D-SNPs. Between 2024 and 2026, California's intention to establish D-SNPs aligned with Medi-Cal managed care plans statewide presents an impetus for cross-sector planning and collaboration, an incentive for Medi-Cal managed care plans and health center partners to align around shared service and financial goals, and a vehicle to accelerate growth in health centers as reliable network providers for D-SNP enrollees.

Managed care plans and health center leaders would likely benefit from exploring the following strategic questions together as they continue down the path of implementing D-SNPs and advancing the role of health centers as care providers for older adults with low incomes:

Vision and FQHC Network Role

- What is the market reach and potential for health centers serving dually eligible enrollees and Medi-Cal-only older adults?
- What is the optimal role and level of participation by health centers in local D-SNP networks? How might this role shift over time?
- Are there local strategies that can facilitate desired retention and participation in D-SNPs by health center patients aging into Medicare/Medi-Cal eligibility?

FQHC Readiness and Capacity

- What strategies can health centers and Medi-Cal managed care organizations/D-SNPs pursue together to prepare health center network providers for optimal care and performance related to care of dually eligible enrollees (e.g., risk coding, quality goals)?
- Are there opportunities to invest in or facilitate the growth and development of older adult care models and service capacity within health center settings?

Business Models and Financial Alignment

- What are the financial drivers and considerations for health center financial sustainability in a traditional FQHC PPS environment? What are the critical drivers of long-term financial success for Medi-Cal managed care plan organizations advancing D-SNPs? What are the implications for health center contracting and participation?
- How could health center–led risk-bearing organizations and arrangements contribute to expanded health center capacity and sustainability to care for older adults? What are the considerations and factors to keep centered?
- How do fee-for-service Medicare and Medicare ACOs fit into the equation? Is there a role for ACOs to serve as a stepping stone or transitional pathway into D-SNPs and sustainable contract arrangements?
- Are there opportunities for novel D-SNP contractual arrangements that enable flexibility in care models, target cost drivers and health outcome priorities for plans, and provide revenue sharing to health centers that deliver impact?

California Policy

- Are there shared California D-SNP policy recommendations that would facilitate plan and health center goals?
- What are the policy questions, considerations, and opportunities related to participation by health center–led RBOs/delegated entities in D-SNP contracting?
- Are there payment innovations or policies for health center care for dually eligible enrollees

FQHC Older Adult Market Considerations

- California Federally Qualified Health Centers (FQHCs) account for close to one in three Medi-Cal managed care primary care assignments (though these rates vary widely by region).
- FQHCs care for 500,000 seniors age 65 or older and another 650,000 patients age 55–64.
- Health center patients age 65 or older fall into a variety of coverage categories, including fee-for-service Medicare, Medicare Advantage (including Dual Eligible Special Needs Plans), and Medi-Cal only.
- Health center financial sustainability of older adult care relies on a patchwork of payment mechanisms (e.g., prospective payment system, 340B, Chronic Care Management, accountable care organization arrangements, Medicare Advantage incentives).
- Medicare market environments differ greatly by community and impact patient preferences and FQHC financial strategies.

and/or Medi-Cal-only older adults that would facilitate appropriate care delivery by health center providers?

Putting Strategies into Action

As noted, the above questions and opportunities can only be addressed through discussion and collaborative planning between health center representatives, managed care plan leaders, and state policy stakeholders. Included below are potential steps that plans and health centers could take together in the near future to chart a shared vision.

Mature the Health Center Delivery System

- **Shared vision for health center network role.** Assess health center market potential, and define a shared vision for health center network role (both short- and long-term).
- **Support for health center readiness.** Support health center readiness and capacity to serve D-SNP enrollees, incluidng age-in retention, risk coding, quality management, and other essential functions.

Build Value-Based Business Models and Infrastructure

- **Mutual understanding of business drivers.** Educate health plan and health center partners on financial drivers and considerations.
- **Aligned, innovative contracting strategies.** Explore short- and long-term options for health center contracting, including the role of risk sharing, health center–led RBO contracts, and intersection of ACOs (if relevant).

Align Payment and Policy

- **Policy alignment to encourage health center participation.** Identify and, where aligned, prioritize state and federal policies that appropriately encourage health center (and health center–led RBO) participation as providers and contracted entities serving dually eligible enrollees.
- **Exploration of innovative payment programs.** Collaboratively explore innovative payment programs for dually eligible enrollees and Medi-Cal-only older adults.

Conclusion

The evolving demographic landscape of California, marked by a rapidly aging population, underscores an urgent need for a health care system that is both responsive and adaptable to the complex needs of older adults with low incomes. Health centers across the state, with their long-standing commitment to providing comprehensive, culturally competent care, are uniquely positioned to meet this challenge. However, to fully realize their potential in serving this growing demographic, it is imperative that health centers take steps to evolve service models and financial sustainability strategies. It is equally important that their delivery system partners, California health and aging agencies, and other older adult stakeholders engage in collaborative learning and planning — as well as maintain an openness to new strategies and financial models — to increase older adult service capacity within health centers, improve health outcomes, and reduce the cost of care.

While much of the hard work still lies ahead, the vision and road map laid out by the Strategies for Older Adult Services Task Force offers a visionary yet practical guide for California health centers to build care capacity sustainably for older adults with low incomes — and a framework for health centers, managed care plans, state agencies, and other stakeholders to engage collaboratively.

Endnotes

1. Task force member organizations included North East Medical Services, Alameda Health Consortium/Community Health Center Network, Health Care LA, Shasta Community Health Center, San Ysidro Health, and AltaMed Health Services. Guest participants included representatives of the California Health Care Foundation and the California Primary Care Association.
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