330 Committee

October 10, 2017
2:00 p.m. – 3:30 p.m.
Corinne Sanchez, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Corinne Sanchez	A
II. Approval of Agenda	• Executive Summary	Corinne Sanchez	A
III. Approval of Minutes	• July 2017	Corinne Sanchez	A
IV. Payment Reform	• Memo: Status Update	Andie Patterson	D
V. Pay-for-Performance	• Memo: Status Update	Meaghan McCamman	A
VI. Proposed State Plan Amendment	• Memo: SPA process update	Ginger Smith	I
VII. A&I Challenges – Progress Update	• Draft standards document	Andie Patterson Ginger Smith	D
VIII. DHCS Update	• Memo: DHCS Update	Ginger Smith	I
IX. HRSA Notes	• Notes from CPCA meeting with HRSA at NACHC CHI	Andie Patterson	D
X. Prop 56	• Memo: Impact on FQHCs	Beth Malinowski	I
XI. Legal Update: Retrospective Dental Claims Litigation	• Memo: Legal Update	Andie Patterson	I
XII. Emergency Preparedness Final Rule	• Memo: EP Final Rule • Compliance Checklist	Emili LaBass	I
XIII. Adjourn		Corinne Sanchez	A

California Primary Care Association

Executive Summary

Date: October 10, 2017
To: 330 Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

Payment Reform

- CMS has informed DHCS that in order to implement the APM we must use the 1115 Waiver as a vehicle because the risk triggers can be approved in the State Plan Amendment.
- While not their first choice, DHCS is willing to use the 1115 Waiver for the APM and will not remove the risk triggers.
- CPCA is researching the legal risk of the 1115 Waiver, but does not want to use the Waiver as the vehicle to implement the APM.
- CPCA continues to explore alternative proposals so that we can implement our APM in a SPA.

P4P

- CPCA formed a small workgroup to develop a series of principles around FQHC exclusion of P4P incentive revenue from the reconciliation process.
- The principles were vetted by CPCA's board and external partners
- The workgroup recommends that CPCA undertake an effort to educate CCHCs and health plans on the principles and share best practices for successful FQHC P4P programs in Medi-Cal managed care

Proposed State Plan Amendment

- DHCS' goal is to submit their proposed SPA changes to CMS on productivity standards, 90-day requirement, Change in Scope of Service Request (CSOSR), and MFTs by the end of 2017 with an effective date of January 1, 2018.
- DHCS provided CPCA with their proposed SPA language on productivity standards and the 90-day requirement and in turn, CPCA had a legal review conducted.
- Proposed edits from the legal review were given to DHCS. Once updated language is available, CPCA will review it with members.
- DHCS provided CPCA with questions/comments on their initial thoughts on SPA changes for the CSOSR.
- CPCA reviewed the questions/comments with members and has started discussing our positions with DHCS. Proposed SPA language on the CSOSR is not available.

A&I Challenges – Progress Update

- Members have requested that something be done to combat Audits and Investigations challenges to FQHCs engaged in rate setting or scope changes.

- CPCA has been working with a small workgroup of CFOs and consultants to develop a strategy.
- A survey of the problem has been completed and the next step is engaging the Department in a discussion about what the "rules" are so that both CFOs and auditors are using the same play book.
- The workgroup has crafted a draft set of rules and standards to commence the discussion with DHCS.

DHCS Update

- A Despite one of the conditions for a qualifying event being the adoption of technology, A&I staff do not believe EHR should be a qualifying event for CSOSR purposes.
- A&I has adopted an unwritten policy only allowing a FQHC to use EHR as the qualifying event on a one-time basis.
- DHCS also takes the position that only an EDR separate from the EHR system may be used as a qualifying event for a separate CSOSR.
- CPCA will discuss the implementation of EHR and EDR as a qualifying event during upcoming conversations with DHCS on their proposed SPA changes with the CSOSR.
- DHCS concurred in 2012 that FQHCs may contract with an off-site private dental provider to render dental services to FQHC patients and bill the PPS rate for the visits.
- The most important key point when contracting with a private dentist is that a patient must be an established patient of the FQHC and the FQHC refers the patient to the private dentist.
- The MEI effective on October 1, 2017 is 1.8%. The MEI rate increase is tentatively scheduled to install in November.

HRSA Notes

- CPCA staff and board members met with Jim Macrae and other staff from the Bureau of Primary Health Care during the NACHC Community Health Institute conference in August.
- Jim shared insights on the new priorities of the Trump Administration and their planning for the fiscal cliff.

Prop 56

- The Budget Act of 2017 included an agreement on a spending plan for the Proposition 56, California Healthcare, Research and Prevention Tobacco Tax Act of 2016.
- FQHCs will be eligible for the supplemental payments for FPACT services.
- FQHCs will not be eligible for any other supplemental payments, including Medi-Cal and/or Denti-Cal fee-for-service or managed care supplemental payments.

Legal Update: Retrospective Dental Claims Litigation

- On August 31, 2017, the State requested a third extension of time, which we opposed.
- The Court granted the State's request for an extension of time on September 5, 2017, but with the statement, "No further time will be granted."
- Accordingly, the State's reply brief is due September 26, 2017.
- Once the reply brief has been filed (or the time to file it has passed), the court will send the parties a notice with the date for oral argument, likely in early 2018. After the case is "submitted" (generally after oral argument is completed unless the court does not grant oral

argument or asks for additional briefing on an issue), the court will have 90 days to decide the appeal.

EP Final Rule

- On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.
- The regulation went into effect on November 16, 2016. Health care providers and suppliers, including FQHCs and RHCs, affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.
- The final CMS Emergency Preparedness Rule was designed to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and man-made disasters.
- In an effort to assist FQHCs, FQHC Look-alikes, and RHCs become compliant with the rule, CPCA has created and disseminated a multitude of resources, training opportunities, and technical assistance over the past 18 months.

CALIFORNIA PRIMARY CARE ASSOCIATION

330 COMMITTEE
July 13, 2017
9:00am – 10:00am

Members: Corinne Sanchez – Chair, Antonio Alatorre, Tanir Ami, Linda Costa, Isabel Becerra, Doreen Bradshaw, Trisha Cooke, Irma Cota, Lynn Dorroh-Watson, Reymundo Espinoza, Ben Flores, Cathy Frey, Alvaro Fuentes, Greg Garrett, Franklin Gonzalez, Britta Guerrero, Haleh Hatami, Steve Heath, Virgina Hedrick, Kerry Hydash, Cathryn Hyde, Tina Jagtiani, David Lavine, Alicia Mardini, Leslie McGowan, Nichole Mosqueda, Justin Preas, Joanne Preece, Carole Press, Tracy Ream, Lucresha Renteria, Tim Rine, Jacqueline Ritacco, Melinda Rivera, Tiffany Robertson, Gary Rotto, Paulo Soares, Terri Lee Stratton, Sabine Talaugon, Vernita Todd, Tony Weber, Paula Wilson

Guests: Jason Vega, Jill Damian, Terri Vise, Dolores Alvarado, Susie Foster, Suzie Shupe, Sergio Bautista, Michael Schaub, Wunna Mine, Becky Lee, Sendy Sanchez, Meryl Schlingheyde

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Meaghan McCamman, Ginger Smith, Nataly Diaz, Mike Witte, Meghan Nousaine, Allie Budenz, Lucy Moreno, Cindy Keltner

I. Call to Order
Corinne Sanchez, Committee Chair, called the meeting to order at 9:06am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (L. McCarthy, M. Lynch)**

III. Approval of Minutes
A motion was made to approve the minutes of May 4th, 2017. **The motion carried. (D. Myers, B. Flores)**

IV. Pay-for-Performance
The 330 Committee asked CPCA to form a small workgroup to refine a series of principles around FQHC exclusion of P4P incentive revenue from the reconciliation process. The workgroup has met 3 times and has developed a white paper.

A motion was made and seconded to move the proposed P4P draft position paper to the Board of Directors for review and approval. **The motion carried.** (I. Cota, M. Lynch).

V. A&I Challenges
In response to CPCA member concerns about rate setting and reconciliation with A&I, CPCA developed a sub-group to help develop a survey about the challenges which was open over the course of three weeks in June. The sub-group identified two solutions to the challenges: 1. Agree with DHCS on the rules, policies and procedures for reconciliations and rate setting and 2. Appropriately train auditors. Next Steps: CPCA staff will consolidate and summarize the information from the 36 survey results and share the summary with the sub-wg to ensure all of the important elements were captured. In August, CPCA will circulate the summary of issues to health center CEOs and CFOs to secure affirmation for the results with the goal of securing as much support for the results from health centers as possible. CPCA will develop a white paper of rules that will be built from the State Plan Amendment regarding PPS, Medicare Cost Principles, Generally Accepted Accounting Principles, DHCS FAQs, and CA PPS rules and begin discussions with DHCS.

VI. Payment Reform
The implementation of the pilot is dependent on CMS approving the concept. The SPA has not yet been drafted as CMS has not yet signed off on the concept. CPCA has been working diligently to try and get the APM approved by CMS.

VII. Proposed State Plan Amendment

The first two topics CPCA is discussing with DHCS regarding their proposed amendments to the Medicaid State Plan are productivity standards and a 90 day requirement for submitting an initial rate setting application. DHCS will revise the productivity levels for MDs and DHCS will require all hours that a provider spends seeing patients or is scheduled to see patients in the productive FTE calculation. DHCS will not include any non-productive time such as paid time off, CME/training/meetings, teaching responsibilities, and administrative time in the productivity FTE calculation as long as a health center can support the non-productive FTE with acceptable documentation. DHCS has developed a FQHC/RHC Minimum Productivity Standards Fact Sheet which CPCA is vetting with members. With CPCA BOD support in May, CPCA informed DHCS that we support their proposed SPA language for a 90 day requirement for submitting an initial rate setting application.

A motion was made and seconded to authorize CPCA staff to support DHCS' proposed language with the State Plan Amendments on productivity standards and 90-day requirement upon approval from the members participating on the SPA webinars and legal review. **The motion carried.** (K. Mattson, M. Lynch).

VIII. Legal Update

The state filed its opening brief on appeal on March 23, 2017. Our attorneys filed the Respondents' brief on May 16, 2017. The state's reply brief is due August 4, 2017. Oral argument will likely be set about six months after the case is fully briefed, so around February 2018. The court will have 90 days to issue a decision after the case is submitted, which is usually the date of the oral argument. If that schedule stands, a final decision should be issued around May 2018.

IX. Adjourn

The meeting was adjourned at 10:10am. **The motion carried. (N. Gupta, T. Pusateri)**

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care Association

DISCUSSION

Date: September 21, 2017

To: 330 Committee

From: Andie Patterson, Director Government Affairs

Re: Status of Payment Reform Work

MEMORANDUM

Status of CA APM

CPCA and CAPH met with DHCS staff Jennifer Kent, DHCS Director, Mari Cantwell, Medi-Cal Director, Lindy Harrington, Deputy Director, and Ryan Witz, Deputy Director in mid-September to discuss the alternative payment methodology (APM) approved by the Governor in October 2015. Mari Cantwell led the meeting and made it clear that while DHCS preferred using the State Plan Amendment (SPA) for the APM, they just were not able to convince legal counsel at CMS that the California APM would work in a SPA. CMS does not believe they can legally approve the California APM with its prospective attestation and risk triggers. They believe that retrospective reconciliation is necessary to ensure health centers are fully compensated for every eligible visit. For DHCS, the risk triggers are the essential element to the APM and they are not willing to adjust the APM to accommodate CMS' concerns. CPCA shared our strong reservations and concerns with waivers, but let DHCS know that, to ensure our due diligence, we have engaged legal counsel (Feldesman Tucker Liefer) to fully understand the risks and opportunities of pursuing an APM in a waiver. This research will take 6 weeks to complete- approximately until October 30.

CPCA has promised to circle back with DHCS after reviewing the research. The next conversation with DHCS will be to let them know if we can or cannot move forward with the waiver. At this point in time, however, CPCA does not intend to move the APM forward using the waiver as a legal vehicle. We do hope that the legal research is an educational opportunity for the association to better understand in more detail the risks and opportunities of waivers, but our review of the political landscape has led us to conclude we cannot use the waiver now. NACHC has essentially said that they will work to stop any waiver that includes PPS, and while we believe we have constructed the right APM for California that doesn't "waive PPS," that is not the view point of the national association. Further the fear and political consequences of California appearing to "waive PPS" are too great for CPCA and members. We do not rule out the possibility that in the future under new federal leadership using an 1115 waiver to further the objectives and mission of health centers may be a necessary tool. However that is not where we are at today.

CPCA remains committed to the APM and payment reform, and we intend to continue developing an alternative proposal where the SPA is the vehicle for the APM. This roadblock may actually be the opportunity we needed to be best positioned for success in a payment reform model.

Next Steps

In advance of the meeting with DHCS, CPCA staff had discussed ways in which we could amend the APM to make it more palatable to the state. CPCA surveyed the Wrap Cap WG members on the possibilities to determine if

there were appetite for alternative approaches. On the whole members were willing to be somewhat flexible in order to move the APM. One idea we reviewed was specifically raised with DHCS at the September meeting. An alternative model with risk is as follows:

> *Today, health centers can enter into contractual arrangements with managed care plans or third party payers to receive "incentives" should they meet certain criteria or objectives. We often refer to these as P4P or pay for performance. These incentives are held outside of reconciliation. While never done, health centers could also voluntarily enter into contractual relationships with managed care plans where they agree to take risk if they do not meet certain criteria. This risk would also be held outside of reconciliation.*
>
> *The new idea we briefly discussed with the Wrap Cap WG and DHCS was for the CA APM to be amended to remove the risk triggers and be implemented through a State Plan Amendment. If we did this, and visits from base year went up for the FQHC, at the end of the year the state and the plans would make the health center "whole." To meet the state's objectives for risk or "having skin in the game" the health center would take on risk with the plans. In this model, if we crafted it so that health centers were penalized for visits going up (as it is in the APM currently) then the health center would pay back the managed care plan. Ultimately we believe the state, who pays the plans, could make up for their additional costs of making the health center whole by figuring subtracting the cost from the next rate with the plan.*

When we pitched this idea to DHCS, Mari said she "intellectually" understood the model but it didn't meet their objectives and Jennifer Kent argued it wouldn't actually help the state's bottom line. Per that conversation we do not believe that the state would consider this model as viable if we further built it out, however, we do believe this alternative model might be appealing to the health plans and to a new administration post the 2018 elections. We intend to identify a few plans to work with on the alternative model over the course of the next year.

We continue to believe the APM will happen, it's just a matter of when. Health centers committed to the APM and who have been engaged in CP3 should continue this forward momentum as they we will be positioned once the APM is implemented.

California Primary Care Association

ACTION

Date: October 10, 2017
To: 330 Committee
From: Meaghan McCamman, Assistant Director of Policy
Re: FQHC P4P Incentives & Reconciliation

MEMORANDUM

Overview

On January 12, 2017, a county health center and hospital in San Mateo lost an appeal before the California Department of Health Care Services (DHCS) relating to whether their P4P incentive payments were properly excluded from their Medi-Cal PPS reconciliation. This decision quickly spread among FQHCs because elements of the San Mateo P4P structure was common in other FQHC P4P arrangements. There was a desire to better understand how P4P programs were structured and to lay a foundation of understanding among FQHCs.

In response, CPCA convened a small workgroup to identify a common set of principles that we believe constitute an FQHC incentive that is justifiably excluded from reconciliation. The common set of principles was formalized in a white paper and disseminated at the July 13, 2017 330 Committee meeting. At the recommendation of the committee, the CPCA Board of Directors authorized CPCA staff to gather feedback on the white paper from strategic partners, including managed care plans and the Integrated Healthcare Association (IHA), and approach DHCS with the support of those key partners to advocate for using those common principles as the basis to advance clear policy for auditors to use during the reconciliation process.

Current Efforts

- *Stakeholder Engagement:* The P4P White Paper has been shared with Medi-Cal managed care plans, plan associations, and with IHA. All stakeholders support the concepts and arguments outlined in the paper.
- *San Mateo Appeal:* The San Mateo health center at issue has hired an attorney to appeal the ALJ's decision. The attorney, Felicia Sze, has requested that CMS weigh in. San Mateo is still awaiting the compilation of the administrative record, which should be done in September. If the record is obtained in September, the hearing will be in December or January, and a final decision is expected by, loosely, February 2018.
- *Health Plan Engagement*: Many health plans have expressed interest in partnering with their FQHC providers to ensure that P4P incentive payments are excludable from reconciliation. At least 2 health plans – Partnership Health Plan and Health Net – have attempted to take their P4P programs to DHCS for sign-off. DHCS has refused to sign off on any Medi-Cal managed care plan P4P programs.
- *Major Concerns:* CPCA has spent the last month exploring the potential impact of approaching DHCS with our P4P position paper. We have an outstanding concern

around the potential exposure of many FQHCs in California to losing some or all of their P4P funds during the reconciliation process, which may be exacerbated if the industry comes forward with a position on what constitutes excludable P4P that not all FQHCs in the state are meeting.

Updated Workgroup Recommendation

As we've begun to understand the extent of the potential exposure to recoupment during the reconciliation process from FQHCs around the state, the workgroup convened to re-evaluate options and consider a revised recommendation to the full 330 Committee and CPCA Board of Directors. The workgroup considered the following options, listed with pros and cons of each:

Option:	Pros and Cons
1. Approach DHCS: This option includes CPCA and/or other industry partners approaching DHCS with our position paper. We would request that DHCS issue regulations that clarify the definition of 'incentives' that FQHCs may exclude from reconciliation in accordance with our proposed policy position.	***Pro:*** Clear guidance from the Department on 'incentives' that can be excluded would prevent the confusion and audit inconsistencies that caused the San Mateo issue. It would also set a precedent for DHCS in issuing regulations that could effectively prevent auditors from creating their own rules during audits – a common and growing problem on many fronts. ***Cons:*** controversy around excludable P4P is just beginning to rise to the forefront. It's our belief that there are some CCHCs around the state who still have open cost reports that may not meet the standards reflected in our P4P white paper. There is some concern that this approach would open clinics up to even more exposure than they experience under the existing system.
2. Await San Mateo Appeal: According to the San Mateo attorney, we should know the outcome of the San Mateo appeal by February 2018.	***Pros:*** The San Mateo position is broader than the position taken by the CPCA board of directors and reflected in our P4P position paper. In essence, San Mateo holds that any payment meant to incentivize the provision of care – even payment for a single instance of service – constitutes an incentive payment if it's part of the health plan incentive program. If San Mateo wins, perhaps A&I auditors will stop pursuing the inclusion of incentive payments in reconciliation. ***Cons***: We have been told that the San Mateo decision, whatever the outcome, is not precedent-setting. A continuation of the status quo means that A&I auditors may, arbitrarily, decide that a variety of incentives excluded by

	FQHCs should be reconciled. This leaves clinics to fight this battle in a piecemeal fashion.
3. ***Ground-level "cleanup":*** CPCA embarks on an education campaign for FQHCs and their managed care plan partners to ensure that all incentive programs are in compliance with the P4P position paper.	***Pro:*** all FQHC incentive programs will meet an easily justifiable standard that should prevent future issues with A&I. ***Con:*** Requires the partnership of health plans and RBOs to be willing to restructure their P4P incentive plans to meet the FQHC standard.
4. ***Health Plan Approval:*** Several health plans have approached DHCS to request that DHCS give a 'seal of approval' to their P4P programs, so that the plans are confident that FQHC recipients can keep incentive funds. In this approach we work with the plans, potentially with IHA and their standardized measure set, and other industry partners to pressure DHCS to approve individual plans, rather than a framework of what's allowed and what's not.	***Pro:*** Rather than drawing attention to FQHCs and our reconciliation process, this places the health plans into a position between FQs and DHCS. ***Con:*** Would require the partnership of all plans, and we would need to work with RBOs under the plans as well.
5. ***Combination Approach:*** This is a combination of options 1, 2, and 3.	***Pro:*** This option would allow FQHCs to partner with plans in completing 'ground level cleanup' (option 3) right away, thereby ensuring that, a few years in the future at the very least, FQHC incentive payments would be relatively safe during the audit process. Once all FQHCs have 'clean' P4P programs according to the standard set forth in our P4P Paper, we can approach DHCS about creating regulations and preventing issues such as the San Mateo lawsuit in the future. ***Con:*** Would require all plans and FQHCs to participate in ground level clean-up. In the meantime, clinics continue to face exposure.

After careful deliberation, the workgroup determined to **recommend *Option 5: the Combination Approach*.** In this approach, CPCA and our members would:

1) Continue to closely monitor the San Mateo appeal, and consider weighing in on the appeal process through an amicus brief.
2) Continue and enhance our efforts at 'ground level cleanup.' This effort would involve a two-pronged effort aimed at reaching every single one of CPCA's member clinics to ensure they understand their own exposure to the change in A&I's positon exemplified by the San Mateo decision, and to encourage each health center to do some internal housekeeping on their P4P incentive contracts. It also includes working with CAHP and LHPC to educate the health plans and provide them technical assistance in ensuring that their P4P quality programs meet the standards promulgated in our P4P paper, which is included in the *resources* section below.
3) Work with the Integrated Healthcare Association (IHA) to ensure that their efforts around a standardized P4P program in Medi-Cal meet the standards promulgated in CPCA's P4P paper.
4) When all CPCA member FQHCs and RHCs feel confident that their P4P incentive programs meet the standard set forth in the CPCA P4P paper, and all outstanding cost reports meet that standard, the 330 Committee could evaluate making a recommendation to the Board of Directors that CPCA approach the Department, in concert with health plans and IHA, to promulgate regulations clarifying the standard for FQHC/RHCs and A&I auditors. Because we would have worked on ground-level cleanup before approaching the department, there would be little to no exposure for FQHCs with outstanding open cost reports who may be subject to the new rules even though their cost reports were filed before the Department promulgated the standards.

Questions to the Committee

- Should CPCA consider writing an amicus brief to support San Mateo's appeal? Considerations: If San Mateo is successful in appealing, arguably the position of all health centers in the state is strengthened as A&I has one (non-precedent setting) definitive decision that FQHCs may exclude all 'bonuses, risk pool payments, and withholds from the reconciliation process. An amicus brief may, however, draw the attention of A&I from San Mateo to CPCA member clinics, and if San Mateo is unsuccessful in the appeal, might strengthen A&I's position that they can evaluate managed care P4P programs to determine whether they are "true" incentives based on unpublished, unclear, and ambiguous standards.

- Should the Committee accept the Workgroup's revised recommendation, does the Committee agree with the proposed steps?

Resources

- CPCA's P4P White Paper

INFORMATIONAL

Date: September 18, 2017

To: 330 Committee

From: Ginger Smith, Director of Health Center Operations

Re: Medicaid State Plan Amendment - Proposed Changes to the Prospective Payment Reimbursement: Productivity Standards, 90-Day Requirement, and Change in Scope of Service Request

MEMORANDUM

I. Background

The Department of Health Care Services (DHCS) is proposing changes to the *Prospective Payment Reimbursement* section of the California Medicaid State Plan. CPCA, along with the California Association of Public Hospitals (CAPH), are meeting with DHCS bi-weekly and sharing and securing input from members after each meeting with DHCS, and then taking back any feedback to DHCS. DHCS has committed to working collaboratively with CPCA until we get through the proposed changes. DHCS' goal is to submit their proposed SPA changes to CMS on productivity standards, 90-day requirement, Change in Scope of Service Request (CSOSR), and MFTs by the end of 2017. This would ensure an effective date of January 1, 2018. DHCS is required to provide a 30 day public comment period in advance of submission to CMS.

II. Issues

Productivity Standards and 90-Day Requirement

DHCS provided CPCA with their proposed SPA language on productivity standards and a 90-day requirement for initial rate setting applications. As requested by the CPCA Board of Directors in July, CPCA had a legal review of the proposed language conducted. Foley & Lardner LLP completed the review on productivity standards and Kathryn Doi with Hanson Bridgett LLP conducted the review on the 90-day requirement. Proposed edits from the legal reviews were sent to DHCS and they are in the process of reviewing the edits. Once updated language is available from DHCS, CPCA will review it with members.

CSOSR

DHCS provided questions/comments for CPCA to review with members regarding their initial thoughts on SPA changes for the CSOSR. CPCA collected member feedback on DHCS' questions and has started discussing our positions with DHCS. Proposed SPA language on CSOSR is not available at this time.

III. Resources

- The SPA notice can be found here: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001_PN.pdf
- When SPA language is available, it will be posted here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx
- Once submitted to CMS, the SPA will be posted in the "Pending" category here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending_2017.aspx

Allowability of Costs for an FQHC
Initial Rate Setting or Change in Scope of Services
September 27, 2017
Version 1

Purpose: To ensure as efficient and clear a process for health center rate setting and scope of service changes the following document was created to confirm the rules and parameters that both health centers and the state must follow.

Basic Rules

- Costs are allowable if the service and costs associated with the service are part of the CMS core services and any additional services in California Medi-Cal program.
- Costs are allowable if the costs meet the definition of reasonableness, if a cost is related to client care and can be expensed under GAAP. The cost is a cost typically incurred by a similar provider type.
- The financial records must be kept such that an experienced auditor can be reasonably assured about the allowability of the expense.
- Allocation methodologies must follow GAAP principles and documented by actual data by the health center.

Definitions

A. Core Services

The core services required of an FQHC clinic are primary health care services, defined[1] as the treatment of acute or chronic medical problems which usually bring a patient to a physician's office. FQHCs must provide these services to all life-cycle ages.

FQHCs are required to provide, either on-site or through arrangement with other providers or service providers[2]:

- Preventive health services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear exams, perinatal services, well child services, immunizations and voluntary family planning services
- Preventive dental services, defined as brief examinations of the teeth and gums with referral to a dentist for prophylaxis and treatment.
- Basic lab services
- Emergency care
- Access to pharmacy services
- Transportation services, as necessary for adequate patient care

[1] From the Health Resources and Services Administration (HRSA) "Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs."
[2] Contracting restrictions for FQHC services is not a part of this paper.

- Case management services, including outreach and translation enabling services
- After hours coverage
- Imaging services
- Diabetes self-management training (added in 2005 to Social Security Act)
- Medical nutrition therapy services (added in 2005 to Social Security Act)
- Chiropractic services[3]
- Podiatric services[4]
- Psychology[5]

B. Allowable Costs

Allowable costs are those costs that result from providing core and FQHC covered services, are reasonable[6] in amount, related to the cost of furnishing such services, and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component of providing the covered services and an allocated portion of overhead.

As per Medicare cost principles, the cost MUST meet the following criteria:

- Reasonable judged by the prudent buyer standard, client related to provision of covered services and Luxury items are not allowable.
- Generally, to put it in the affirmative, a cost that is reasonable, related to client care and can be expensed under GAAP is allowable.

The costs not only need to be "reasonable" but the method used to allocate the costs between costs centers must be reasonable and the method used to allocate step-down costs to the Medi-Cal program must be reasonable and documented in accounting procedures.

Cost topics often discussed and causing much confusion are:

- capital,
- depreciation,
- sales and lease backs,
- disposal of assets,
- interest,
- bond premium,
- funded depreciation,
- bad debts,
- charity allowances,
- cost of educational activities,
- research costs,

[3] Subject to a maximum of two services in any one calendar month, or any combination of two services per month among other specified optional services, if provided by an FQHC or RHC, except as otherwise authorized.

[4] Subject to a maximum of two services in any one calendar month, or any combination of two services per month among other specified optional services, if provided by an FQHC or RHC, except as otherwise authorized.

[5] As of January 1, 2014, psychology services are no longer subject to the two-per-month limit.

[6] Tests of reasonableness as the Secretary prescribes in regulations[6].

- grants and gifts and value of service for volunteers,
- health education
- Transportation
- Outreach
- purchase discounts and allowances and refunds.

C. Non Allowable Costs

If a practice provides a non-covered service, the direct and indirect cost of this service is unallowable and is excluded from the rate calculation.

If an auditor cannot determine the non-allowable costs, he/she can use the revenue as a proxy for the cost. As stated in the FQHC/RHC Medicare cost reporting instructions found in HIM 15-2, Section 2906, Worksheet A-2, (Adjustment to Expenses), "Make these adjustments, which are required under Medicare principles of reimbursement, on the basis of cost or amount received. Enter the total amount received (revenue) ***only if the cost*** (including the direct cost and all applicable overhead) cannot be determined. ***However, if total direct and indirect cost can be determined, enter the cost."*** (emphasis added)

For example, the clinic has received a grant for outreach activities, but clinic documentation does not support the allowability of this cost for rate setting. The grant is for $25K and the cost on the cost report is for the entire cost of the Outreach Worker (salary, fringe benefits). The grant specifically states the intent is to provide services for outreach activities at community events. It is not specific about enrolling in Medi-Cal programs. The auditor could deduct the $25K as a proxy for a disallowed cost against the amount claimed on the cost report. If the clinic had documented through activity logs, job descriptions and timesheets the allowability of these costs there would be no need for a revenue offset.

Another example is the WIC program which is an unallowable cost. All the direct costs of the program and the actual indirect costs of the program are excluded from allowable costs and thus rate setting. The actual indirect costs may be greater than the grant allows and must be excluded at the actual indirect rate.

D. Interaction of Allowable and Non Allowable Costs

- Interest income must offset interest expense (exception to funded depreciation).
- Rebate and Refunds must be deducted from the cost of the item to determine allowable costs.
- Copying of Medical records income should be deducted from the cost of the department.
- Self-insurance rebates should be deducted from the medical expense (fringe benefits).

E. Reasonableness

A cost may be considered reasonable if the nature of the goods or services acquired or applied and the associated dollar amount reflect the action that a prudent person would have taken under the circumstances prevailing when the decision to incur the cost was made. GAAP principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations, whether the organization complied with its established policies in incurring the cost or charge, and

whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the Federal government and the public at large as well as to the organization.

In order to evaluate reasonableness an auditor considers the circumstances of the industry in which the entity operates, its methods of conducting business, and other external factors. The auditor usually concentrates on the following key factors: significance of an accounting estimate, sensitivity to variations, deviations from historical patterns and if the cost is subjective and susceptible to misstatement and bias.

Documentation

A fundamental principal of reasonable cost reimbursement is that the provider has the obligation to maintain adequate records. There is no obligation to pay a clinic for any services absent such records.

The filing of a rate setting requires an organization to do a careful review to ensure that the costs are allowable and can be justified through primary source documents such as job descriptions, invoices, and contractual arrangements. For example, if the job description for your outreach worker does not address the percentage of time spent assisting clients with Medi-Cal applications there is no justification for the expense allocation. The allocation of covered and a non-covered service needs to be based on complete personnel records (Payroll and job descriptions).

Agreed upon rules:

- For rate setting, financial records must be maintained on an accrual basis and meet generally accepted accounting principles (GAAP).
- Allocation statistics must be based on actual data. Depreciation must be based on the American Hospital Association schedule of useful lives.

Appendix A. Regulatory Sources

I. FEDERAL

Social Security Act:

- Title 18, Part E—Miscellaneous Provisions, Section 1861(aa). Rural Health Clinic Services And Federally Qualified Health Center Services
- Title 18, Part E—Miscellaneous Provisions, Section 1833(a)(3). Payment of Benefits
- Title 42, Part E, Section 1395x: title42-chap7-subchapXVIII-partE-sec1395x

Medicare Regulatory Requirements:

- The FQHC must remain in substantial compliance with all of the FQHC regulatory requirements specified in 42 CFR Part 405, Subpart X, and at 42 CFR Part 491, with the exception of § 491.3.
- 42 CFR Section 405.2436 provides that CMS may terminate an agreement with an FQHC if it finds that the FQHC is not in substantial compliance with the Medicare regulatory requirements

Medicaid Statute:

- FQHC Services, as defined in Medicaid Statute: 42 USC §§ 1396a(a)(10)(A) and 1396d(a)(2)(C) and 1396d(l)(2)

Required primary health services for FQHCs:

- 42 USC Section 254b(b)(1)

Federal Cost Principles:

- Publication 15-1: The Provider Reimbursement Manual – Part 1

I. STATE

California State Plan and Related Amendments

- California State Plan
- Approved State Plan Amendments

California Code of Regulations:

- Title 22, Division 3, Subdivision 1. California Medical Assistance Program

Medi-Cal Provider Manual, Part 2:

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

PPS Rate Setting Cost Report:

- DHCS 3090i (Medi-Cal Freestanding PPS Rate Setting Cost Report)

Medi-Cal Provider Bulletin:

- Medi-Cal Update; General Medicine | December 2013 | Bulletin 471; 1. Update to Changes Regarding Optional Benefits Exclusion for FQHCs and RHCs and 7. Psychology Services Expanded

Appendix B. Examples of appropriate allocations of cost by California Department of Audits and Investigations

- FY 15-16 Change in scope rate setting clinic did not abate all investment income against interest expense, only abated interest income. Interest expense is an allowable cost only for the net amount of interest and investment income earned minus interest expense. The department auditors were correct and clinic conceded to auditor's findings.

- FY 13-14 Change in scope rate setting for OB clinic Site clinic did not use the correct depreciation amount for fixed assets. Clinic took too much depreciation expense based on 2008 edition of the "AHA Estimated Useful Lives of Depreciable Hospital Assets". Clinic conceded to auditor's findings.

Appendix C. Examples of Costs INCORRECTLY disallowed

Below are several examples of the confusion over the costs from rate setting audits. In each case the clinic should have been allowed to include these costs in rate setting.

Example 1: Distinction between direct costs, allocated costs and overhead (home office costs) The auditor's primary argument is that these costs are administrative costs and therefore not direct and should be reclassified as indirect and cites Pub. 15-1.

Clinics response to Audit Findings: The reclassification of these costs is not a standard accounting practice by the audit Review and Analysis Section of the Department of Health Care Services Department. Our Home office cost report which is the indirect costs (overhead cost) for the organization has been accepted by the department for other rate settings. An indirect cost is a cost that benefits more than one function in an organization and cannot be reasonable attributed to one function but benefits many functions. The typical examples of an indirect cost are the accounting department, the human resource's department, and information technology department. The example used in the auditor's position statement of a physician with administrative duties is correct. Our chief Medical Officer's time serving as administrator is in our indirect/ overhead costs in our home office cost. But the auditor applied this to other positions and it does not apply. The staff listed in the auditor's Report is directly assigned to this clinic. Payroll records, payroll costs and our general ledger all support this fact as well as the job description. These are directly allocable costs, these are costs that are directly related to patient care. There is no justification in CMS 15-1 to treat these costs as indirect. To treat these costs as indirect would incorrectly burden other sites with this cost.

Example 2: Removal of Behavioral Health Clinician and Fringe Benefits

These costs were disallowed as there are no corresponding visits by this provider. Again, the auditor refers to CMS Publication 15-1, section 2328 in support of the adjustment. These visits were provided by a Licensed Marriage and Family Therapist. Clinic attached a copy of the staff person's license and job description supporting this fact. Therefore, the cost is allowable but the visits are not allowable. Clinic cannot bill for these services as they are not provided by an allowable provider type. The visits are documented in charts in the Integrated Behavioral Health Department. No Fee ticket was created and no data was entered into the Practice Management System because we cannot bill for these services.

The auditors included in their exhibit 12, page 2, the list of the providers for which clinic can bill and are considered allowable provider types. This provider type is not on this list and therefore clinic cannot bill for these services. There would be no visits billed for this provider just as there would be no visits for a Registered Nurse or a Medical Assistant. In the rate per visit calculation the visits used are only for allowable provider types not for unallowable provider types.

The second part of the argument is that these costs are therefore unallowable and have been removed from the rate setting cost report. The argument that reporting expense and omitting visits would lead to a mismatch in costs and visits does not apply in the case of a Marriage and Family Therapist. Upon appeal, the clinic was asked to submit documentation to support its position, as the services were furnished "incident to" services of a qualifying practitioner. The additional documentation was to include, but was not limited to, patient medical records, the name of the supervising practitioner, and the name of the rendering practitioner. When clinic submitted data, audits would only allow 50% of the cost based on the documentation. This example demonstrates a lack of understanding by the auditor in the initial finding.

Example 3: Clinic denied recruitment expense as it is not patient care related and auditor cites CMS Pub 15-1 Section 2102.3.

Nowhere in the below citation does it say specifically recruitment costs. The costs are appropriate, necessary and proper for the operation of patient care facilities and activities and should have been allowed.

CMS Pub 15-1 Section 2102.3.:

2102.3 Costs Not Related to Patient Care. --Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.
Such costs are not allowable in computing reimbursable costs and include, for example:

- *Cost of meals sold to visitors;*
- *Cost of drugs sold to other than patients;*
- *Cost of operation of a gift shop;*
- *Cost of alcoholic beverages furnished to employees or to others regardless of how or where furnished, such as cost of alcoholic beverages furnished at a provider picnic or furnished as a fringe benefit;*
- *Cost of gifts or donations;*
- *Cost of entertainment, including tickets to sporting and other entertainment events;*
- *Cost of personal use of motor vehicles;*
- *Cost of fines or penalties resulting from violations of Federal, State, or local laws;*
- *Cost of educational expenses for spouses or other dependents of providers of services, their employees or contractors, if they are not active employees of the provider or contractor;*
- *Cost of meals served to executives that exceed the cost of meals served to ordinary employees due to the use of separate executive dining facilities (capital and capital-related costs), duplicative or additional food service staff (chef, waiters/waitresses, etc.), upgraded or gourmet menus, etc.; and*
- *Cost of travel incurred in connection with non-patient care related purposes.*

INFORMATIONAL

Date: September 27, 2017

To: 330 Committee

From: Ginger Smith, Director of Health Center Operations

Re: Department of Health Care Services (DHCS) Updates

MEMORANDUM

I. Background

CPCA meets regularly with DHCS to address and potentially resolve the challenges experienced by health centers when working DHCS. Over the last year, our meetings have focused on DHCS' proposed changes to the California Medicaid State Plan. This memo provides an update on other discussed issues.

II. Issues

EHR as Qualifying Event for CSOSR

DHCS recently denied a health center's Change in Scope of Service Request (CSOSR) where the health center used their EHR replacement system as the qualifying event. The health center had submitted a previous CSOSR using EHR as the qualifying event in 2013. Despite one of the conditions for a qualifying event being the adoption of technology, staff at Audits & Investigations (A&I) do not believe EHR should be a qualifying event for CSOSR purposes and has reportedly adopted an unwritten policy only allowing a FQHC to use EHR as the qualifying event on a one-time basis. A&I does not contest; however, a health center's, that already used their one-time EHR CSOSR, ability to include replacement EHR cost when submitting a valid CSOSR so long as the EHR is not the qualifying event.

CPCA is also aware that DHCS takes the position (not in writing) that if an EDR is an add-on to the health center's existing EHR system, the addition does not qualify for a new CSOSR. However, if the health center implements an EDR separate from the EHR system, the EDR implementation may be used as the qualifying event for a separate CSOSR. It is not clear if DHCS still makes this add-on vs. different system distinction. This nuance was gleaned in 2015 when CPCA requested clarification on DHCS' policy of the implementation of electronic dental records (EDRs) as a qualifying event for a new CSOSR if the health center previously submitted and received approval for a CSOSR for EHR implementation as the qualifying event.

CPCA is currently discussing with DHCS their proposed CSOSR changes within the State Plan Amendment (SPA). It is CPCA's position that if all the requirements for CSOSR are met it does not matter the qualifying event- be in the first or fifth time an EHR or EDR or other technology is implemented. CPCA staff will include the implementation of EHR and EDR as a qualifying event in the CSOSR conversation and aim to secure reasonable clarification on how and when health centers can use either as a qualifying event.

Contracting with Private Dental Providers

The Children's Health Program Act of 2009 (CHIPRA) permitted health centers to contract with private dentists for services to their FQHC patients. In 2012, DHCS concurred that FQHCs may contract with an off-site private dental provider to render dental services to their patients and bill the PPS rate for the visits. The dental services provided should be the same if provided on-site at the FQHC. There are three key points that FQHCs must ensure in order to successfully and compliantly implement a dental contracting program:

- There is a contract with the private dentist that includes a provision that the dentist's office will not bill Medi-Cal directly for the same services.
- Dental services are included in the FQHC's federal scope of project.
- The patient **must** be an established patient of the FQHC and the FQHC **refers** the patient to the private dentist.

The intent of this program is to help FQHCs that do not have the capacity to meet the dental needs of their established patients by contracting with a private dentist to provide the care. CPCA does not believe the intent of the program was for a private dentist to refer their patients, who are already receiving dental care from the private dentist, to the FQHC just for billing dental visits at the PPS rate. DHCS has verbally stated to CPCA that a FQHC must be able to demonstrate a patient was established with the FQHC and then referred to the private dentist for their dental care.

2017 MEI Rate Increase

Effective October 1, 2017, the FQHC/RHC PPS rate will receive an annual rate adjustment of 1.8% in accordance with the current Medicare Economic Index (MEI). However, due to the implementation of the FQHC/RHC/IHS-MOA Code Conversion (effective 10/1/17), the MEI rate increase is tentatively scheduled to install in November. DHCS has confirmed that any claims for dates of service from October 1st to the MEI implementation date will be reprocessed and paid at the correct rate through the quarterly FQHC/RHC Retro Rate Erroneous Payment Corrections (EPC). We anticipate DHCS will provide an update in the NewsFlash section of the Medi-Cal website and/or in the Medi-Cal Update in the coming weeks.

III. Resources

- DHCS Memo on Contracting with Private Dentist

Talking Points/ NOTES

NACHC CHI 2017

CPCA Meeting with Jim Macrae, et al, HRSA
With NOTES from 8-26 meeting

I. HRSA – 2017 Direction and Goals

- Uncertainty continues. We have a few questions to better understand the environment you are working within.

⇒ Is there anything you can share on the funding cliff? Plans for health centers not being made whole? Plans for Congress missing the Sept 30 deadline?

⇒ Could you share any information you have about future grant funding, aside from the funding cliff, including capital grants?

⇒ Can you share new developments since March under the new Administration, and how it has or has not changed the direction and goals for HRSA?

⇒ We understand that Secretary Price has identified three priorities: Obesity, telehealth and the opioid epidemic. How is this impacting HRSA? How can health centers better prove their ROI in these three areas?

⇒ If the ACA is not repealed do you have any insights on the flexibility Secretary Price intends to exercise with the states and Medicaid?

Notes

HRSA is making plans to go over the primary care funding cliff
3 scenarios they are planning for

1. No discretionary as of oct 1, no mandatory as of oct 1 (govt shuts down)
    a. Some carry over money to continue basic operations
    b. Won't be able to give health centers money
2. Discretionary money in a continuing resolution with no mandatory funding
    a. Keep basic operations in place
    b. Fund health centers month to month
    c. Will run out of money likely by april, maybe may
3. Mandatory funding, but no discretionary in a continuing resolution
    a. Will likely fund health centers through a certain point of time – depends on how much

Secretary of Health and Human Services, Tom Price, visited a health center during national health center week and wrote a very positive blog
The Administrator of the Health Resources and Services Administration, George Sigounas, is very supportive of health centers. He wants health centers and BPHC to be further recognized for their amazing work. Also interested in expanding the footprint of health centers (at this point not with new money), as well as better understand the value of the investment.

There is a big push on relaxing regulatory requirements, and a desire to increase accountability.

Jim pushed at other meetings during the CHI the importance of health centers being engaged in education and training. If a health center doesn't want to be a teaching health center they should at least be training to "grow their own."
Also a big push for health centers to do a fuller range of services (med/dental/bh/vision/enabling)
With a particular focus on substance abuse (because Secretary Price has this as a priority)

II. 340B

- We faced a very challenging battle in the state budget this year over 340B.
- In the January Governor's proposed budget for 2017-2018 the state sought to impose an acquisition cost plus dispensing fee reimbursement methodology for managed care. Savings, intended to help the safety net do more with less, would instead have accrued to the state.
- Then in May, the revised budget made it just so that contract pharmacies could not be used in Medi-Cal managed care 340B.
- While not as bad, this change would have resulted in a tremendous financial hit to health centers in California.
- We are happy to share however that we effectively stopped both proposals and status quo remains.
- However, we are fully aware the department is upset and wants to see changes.
- Right now we are trying to work collaboratively with them to meet their needs of accurate and appropriate reporting and continue our contracts with contract pharmacies.
- The federal backdrop on 340B casts a shadow on our progress however.
- We are aware of leaked executive orders, proposed legislation, hearings focused on 340B.

⇒ Do you have an update on what will happen with the 340B program? Will HRSA have more of a role to play in accountability for the program and what is done with the savings?
⇒ How can we continue to participate safely?
⇒ Any advice as we continue our negotiations with the state?

NOTES

- Jim shared that there is nothing in the 330 statute that says states can't take all the money for Medicaid drug rebate
- The 340B statute is good but it also doesn't say much and as more and more players realize this its more likely that the savings will be accrued to the states
- Jim said he's been telling health centers no to count on 340B savings in perpetuity
- Jim agreed with us that we need to do a much better job at showing where the benefits are going

III. Workforce

HRSA PATIENT TARGETS

- We know that health centers adjusting patient targets continues to be a focus for HRSA.
- While we appreciate the goals of the Bureau we remain challenged with the strategy. Patient targets may be going down but its not because of demand, but rather external factors outside of the control of health centers.
- The biggest issue is our workforce crisis.
- We still cannot recruit, especially in rural areas.

- And educational health centers that focus on training clinicians to bring into our system, experience a downward effect on productivity, and they are then penalized by the HRSA patient targets.
- With all we are doing to address workforce, we think we can turn this around, but not right away
- Another challenge are the higher no-show rates for immigrant patients created by the culture of fear under the new federal administration.
- It doesn't seem appropriate to penalize health centers with less resources to support their communities under these trying circumstances.

⇒ Lastly, the three priorities of Secretary Price (obesity, telehealth and opioids), are all high intensity visits- and not necessarily supportive of the volume HRSA seeks through the Patient Targets strategy. How can we reconcile the two goals? How can we effectively capture patients through telehealth?

- We maintain the Patient Targets effort is fundamentally flawed and would continue to request that HRSA work with CA on a more nuanced approach to achieve both the health center goals and the Bureau's goals.
- Health centers shouldn't be penalized when things like the culture of fear and the workforce crisis are outside of health centers control.

⇒ The last time we met you shared that you were looking at other ways of capturing what health centers are really doing. Have you come up with any new approaches?

⇒ We want to be partners with HRSA in this undertaking? How can we help?

NOTES

- They hear our concerns.
- Jim shared that the good part is that they made a decision to allow folks to adjust into the future (said it was a pretty generous adjustment).
- But they are not sure what will happen in the future. Its looking like if you don't meet the targets, you don't need as much of the grant.
- They are looking at how to make adjustments when targets are not met. Because they are getting asked a lot of questions.
- BPHC is looking at how to better measure the impact of the program. UDS is great, but it needs to update. Its time. They are looking at creating an advisory council to look at UDS.
    - Suma shared they are discussing opening a place on their website for feedback on UDS which would be reviewed quarterly and changes would be made.
    - They will also be reviewing and proposing changes, and will want to develop a very robust feedback mechanism, perhaps an advisory body as well.

HPSA

- Thank you for the partnership and concerted effort to work alongside NACHC and our partners to reevaluate the HPSA scoring process.
- We have engaged in conversation with NACHC about the proposed changes and are excited that conversations have shifted to prioritize organizational-level auto-facility HPSA scoring over site-level scores, which we advocated for during our conversations last year. We continue to believe this is the best path forward.
    - While health centers strive to keep all of their providers, including NHSC providers, in one site, they need flexibility to transfer providers based on emerging needs.
    - It is unclear if or how part-time, temporary, or mobile sites would be scored, therefore, site-level scoring is inappropriate for non-traditional health center sites.
    - In addition, UDS data is not currently collected at the site level, instead it is gathered at the organizational level.

- In addition, we are happy to see that UDS data is being heavily considered as the predominant data source for several measurements since it accurately captures the patient population we serve.
    - This is critical for appropriate evaluation of poverty and service area measurements.
- We are concerned that calculating poverty measures based on the general population will lower health center's auto-facility HPSA scores and decrease their likelihood of receiving an NHSC provider.
    - We disagree that UDS data overstates poverty.
    - We also continue to disagree with the notion that health centers should not be allowed to use it because other provider types are not required to provide it.
    - If the new data sets used to score facilities do not accurately capture our patient population, it could make it even harder to access resources.
- For these reasons, we encourage continued formal stakeholder engagement through the development process and after the impact analysis is released.

CALIFORNIA'S PROGRESS

- CPCA continues to dedicate increased resources to address the critical workforce needs of our membership.
- REPORT
    - In partnership with Kaiser and UCSF HealthForce, we just released "California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030" - the second in a series of three reports on primary care from Healthforce Center at UCSF
    - Collectively, these reports will enable stakeholders to assess the adequacy of the current primary care workforce, anticipate future gaps in the primary care workforce and identify effective policies for addressing these needs.
    - The 1st report, detailed the state's current supply, characteristics and pipeline of primary care clinicians and trainees, and identified primary care clinician shortages in most California regions compared to national benchmarks.
    - The 2nd report, focuses on workforce forecasting, and is broken down by region.
        - It is believed to be the first report that makes joint projections of supply and demand for primary care physicians, nurse practitioners (NPs) and physician assistants (PAs) in California at the regional level.
    - The team will produce a third and final report later this year focused on strategies being implemented in California and other states to increase the supply.
- CONVENING
    - In March, we shared with you the outcomes of our tremendously successful workforce convening that was born out of recommendations of the 2016 CPCA commissioned report - Horizon 2030: Meeting California's Primary Care Workforce Needs,
    - Our objectives were three fold: (1) Advance promising solutions that increase and diversify the health care workforce to ensure communities across the state benefit from a skilled and culturally competent workforce; (2) Identify potential policy collaboration among participating organizations and their constituents to overcome health care workforce challenges; and (3) Seek ways to test new models that safely broaden scope of practice rules/regulations in the safety net
    - Recognizing the energy in the room, we moved forward with hosting a second half day convening in June, which was attended by representatives of over thirty interests.
    - Coming out of that meeting, there was commitment to establish three sub-committees, all of whom have just held their first meetings. These subcommittees include:
        - Advocacy and Communication

- Pipeline Programs
- Residency Redesign

- FEDERAL ISSUES
  - Lastly, We remain committed to federal advocacy on workforce, including:
    - Increasing resources for Teaching Health Centers
      - We are very excited to see the bills recently introduced in the US Senate and House to support reauthorization and expansion
    - Increasing funding for the National Health Service Corps
    - Supporting our Area Health Education Center partners.
  - ⇒ Thank you for your continued efforts to support these programs.
  - ⇒ Do you have any updates to share on any of these issues?

IV. STATE ISSUES

Budget

- In March, we were very disappointed to share with you that the $100 M we were able to secure last year for residency had been zeroed out in the Governor's proposed budget in January.
- Through heavy advocacy, we are excited to report that the final FY 17-18 Budget for California that took effect on July 1st is a testament to our advocacy and perseverance during challenging times
- The Budget Act of 2017 reflects California's commitment to creating a healthy California.
- In particular, CaliforniaHealth+ Advocates is proud to share that this budget reflects strong support of health centers and the patients we serve. Through successful lobbying and advocacy, and with the tremendous leadership of our health centers and a wide array of advocacy partners, we are excited to share the following news on our top priorities:

- $100 Million Workforce Funding Reinstated: The legislature reinstated $100 million to support primary care residency, including teaching health centers, and loan repayment. The budget act appropriates $33.3 million, the 17-18 portion of those funds. Consistent with the Budget Act of 2016, these are to allocated through Song-Brown in the following manner:
  - Existing Programs: $18,668,000 is available to grant awards for existing primary care residency programs
  - Teaching Health Centers: $5,667,000 is available to fund primary care residency slots for existing teaching health center programs
    - These funds, similar to the existing programs funds, will be dispersed to programs based on the total number of residents incoming in 2018.
  - New Slots: $3,333,000 is available to fund new primary care residency slots at existing primary care residency programs
  - New Programs: $3,333,000 is available to fund newly accredited primary care residency programs
  - Loan Repayment: Of the funds appropriated, $333,000 is available for the State Loan Repayment Program (SLRP)
  - The funds appropriated in this item shall continue to be available for encumbrance or expenditure until June 30, 2023.
  - It is important to note that these funds are in no way a replacement of the necessary federal investments.

- New $20 Million Community Clinic Lifeline Grant Program: Establishes the Community Clinic Lifeline Grant Program within the California Health Facilities Financing Authority (CHFFA) for small and rural health clinics suffering financial losses, and appropriates $20 million from the Health Expansion Loan Program (HELP II) fund one-time for this purpose. CHFFA will develop selection criteria and a process for awarding the grants, which may not exceed $250,000 each, in the coming months.

- 340B Drug Discount Program Untouched: The passed budget includes no changes to contract pharmacies or other provisions relating to the 340B Program.

- Newly Qualified Immigrant (NQI) Wrap No More: The signed budget adopts the Governor's May Revise proposal to halt the implementation of the NQI Affordability and Benefit Program (Wrap), allowing newly qualified immigrants to continue to receive care through the Medi-Cal program.

- MFT Implementation Greenlighted: Delays AB 1863 (Wood, Chapter 610, Statues of 2016) implementation from January 1, 2017 to **no later than** July 1, 2018, allowing FQHCs and RHCs to include MFTs as Medi-Cal billable providers at that time.

STATE LEGISLATION

- In addition to our state budget advocacy, we are also sponsoring two bills – SB 323 and SB 456 – both bills, if passed, will support out health centers in providing quality care
    - SB 323 (Mitchell), a bill we are running in partnership with CCALAC, creates clarity in the law so our health centers and counties can move forward with contracting for specialty mental health and drug Medi-cal services. As trusted behavioral health partners, our health centers want to be able to part with counties to go the extra mile delivering services that go beyond the mild to moderate mental health services that they traditionally provide.
    - SB 456 (Pan) is a bill that also speaks to our commitment to partnership. This bill is focused on allowing our health centers to participate fully in new and innovate programs and pilots happening our state. In particular, if passed, this will would allow us to get paid for "services that follow the patient." And would create clarity regarding our ability to participate in, keep payments we receive, tied to the whole person care initiative and health home program.

STATE PLAN AMENDMENT

- We continue to work through PPS and SPA issues with the state.
- As you may recall, in December the state informed us that they intended to release a SPA that would be effective January 2017
- The SPA we are working through together includes an array of issues including: productivity standards, MFTs as billable providers, change in scope, administrative caps, and executive compensation.
- The process we are working through is one issue at a time, and we've almost made it through Productivity Standards.
- We are happy to report that while we continue to disagree in the use of productivity standards we were able to negotiate the numbers to be more realistic and advantageous for health centers.
- Instead of 4200/ 2100 they are not 3200/ 2600. There was a decrease of 1000 for physicians and an increase of 500 for mid-levels.
- The issue we are dealing with now is CIS.
- Overall the process has been fair and reasonable.

- There is an overarching issue of A&I being very antagonistic with health centers and making up rules left and right, but we are hopeful that through the SPA process and other conversations we can create a clear and consistent set of rules that both health centers and the state agrees to.

PAYMENT REFORM

- In the fall, the state submitted a concept paper to CMS to kick start the APM SPA negotiations
- CMS and DHCS continue conversations but the speed has been slowed by the change in administrations
- At this point, CMS has not signed off on the concept
- It is very important to us that CMS approve the APM so that we can begin transformation in California and ready ourselves for what appear to be major payment changes in the future.
- DHCS remains committed.
- Right now the pilot is set to launch in July 2018.

CP3

- We have completed 75 readiness assessments, the Payment Reform Readiness Checklist, with participating pilot sites and developed implementation plans for each of those sites.
- In September 2017 we will begin to complete reassessments to determine the level progress of sites in preparing for payment reform.
- We will use this new data to inform the development, spread and refinement of training and technical assistance efforts.
- CP3 staff continue to do monthly check ins with sites to review progress, discuss site specific challenges and successes, identify potential opportunities for peer to peer learning within and across organizations, determine potential resources for sites to assist them in moving their process forward.
- We continue to have new sites express an interest in joining the preparedness program and are developing an on-boarding process to bring sites up to speed.
- Population health technical assistance has been provided in both comprehensive and low intensity tracks for select pilot sites.
- We have provided a series of trainings on change management and on finance and operations.
- We have rolled out a series of six training modules and technical assistance on managed care operations and finances in a payment reform environment. We have completed 4 of 6 trainings. All have been well received by pilot sites and other CPCA members who have participated to learn more about the alternative payment model.
- Codes have been finalized for the non-traditional services by our members and we will begin to have conversations with the State and health plans on the best process to test data submission of the codes once training for the pilot sites has been completed.
- Finally, CPCA continues to stay involved with the HRSA sponsored PCA Learning Groups, especially as they relate to Population Health and Quality Improvement – both to learn practices coming out of the field and to share the learnings coming out of the pilot.

DENTAL/ MIP AUDITS

- We have not yet begun working on the MIP audit trainings with DHCS but believe that work will commence shortly.
- We did want to make you aware of and/or ask about your involvement in the Medicaid|Medicare|CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing Medicaid-FQHC Dental Policy Workgroup.

- We have been invited to participate and understand the workgroup is in response to recent FQHC dental services and payment issues that have emerged across state Medicaid programs.
- MSDA is an association open to Medicaid dental programs across the country.
- MSDA will convene the Workgroup specifically to study existing federal and state legislation, regulation, policies and practices as they relate to the delivery and billing of dental services by FQHCs; and develop guidelines for use by state Medicaid dental programs aimed at improving Medicaid-FQHC dental program policy and administration.
- They anticipate that this process will take approximately eighteen months to complete.
- Their plan is to convene a group with representatives from CMS; HRSA; state Medicaid dental programs; NNOHA; NACHC; FQHCs, dental health plans/managed care organizations; national provider organizations; PCAs; and other key experts, who may provide the necessary expertise for the development and future utility of these guidelines.
- The initial Workgroup Meeting is 9/18 held in person in Washington DC.
- Is HRSA aware of this effort? Who will be the HRSA lead?

NOTES- DID NOT RAISE

LICENSING/OSHPD 3 STANDARDS

- California is one of the few states to require that FQHCs receive a license from the State before they can begin operating. Recent re-structuring of the State department responsible for licensing CHCs has contributed to a backlog in applications processing.
- Data collected from a statewide survey of CHCs shows a current licensing delay of 4 – 6 months on average. Some CHCs have been experiencing delays of 9-12 months in simply getting a license approved.
- Additionally, in some parts of California, the State estimates it is taking an additional 6-12 months to conduct a site inspection for the newly approved licensees, which is required to be completed before the site can open full time.
- The survey found that the average cost of these licensing delays is almost $150,000 per impacted site, though for many CHCs, the costs are even higher.
- These licensing delays along with the financial and time challenges of meeting California building codes specific to licensed community health centers, referred to as “OSHPD 3” building code standards, continue to prevent patient access due to their high cost.
- For new construction, application of OSHPD 3 standards increases the project cost by about 30%. To remodel an existing private practice medical office space, (which should be cheap), application of OSHPD 3 standards doubles, and in some cases more than triples, the costs to renovate. These costs are often prohibitively high.
- When we can’t open sites patients can’t be seen and we lose significant resources.

V. Immigration

- During the presidential campaign, negative rhetoric around immigration had a real impact on our patients and unfortunately, since the President’s inauguration, things have gotten worse.
- Since the election, and the new Administration’s focus on immigration reform, the culture of fear has been solidified with the signed and leaked executive orders.

- At the direction of members, California Health+ Advocates has been working diligently to develop materials that provide information on the legal rights of clinics, and their patients, in regards to Immigration enforcement. Just a sampling of what we have done:
    - Created a new Immigration Workgroup
    - Coordinated with NACHC and twelve other PCAs on legal resources, including FAQs that help answer questions regarding health center rights to protect staff and patients during an encounter with immigration officials.
    - Developed six sample policies and procedures to provide clear, detailed and direct policies that can be implemented immediately to help protect immigrant patients while they seek services at your health center. We've worked very closely with our legal counsel, Feldesman Tucker Leifer Fidell LLP (FTLF), the Northwestern PCA and immigration partners, like the National Immigration Law Center (NILC).
    - Partnered with the NWPCA to develop webinar trainings to help health centers implement policies and procedures that help protect staff and immigrant patients. Our trainings will also provide information on how to utilize CHWs to reach decrease the fears in immigrant patients and the impact that our current anti-immigrant climate has had on our patients mental health.
        - -Our first webinar was held on June 27 and provided an overview of the FAQs (had over 140 attendees).

⇒ Any new information around immigration or resources you can share?

NOTES

- Jim shared they haven't heard anything on how Administration might try and close loop holes on legal immigrants. BPHC is not asking questions right now.

VI. Administrative Issues

EHB

- In March we brought wanting to make small changes, like address modifications, through the Scope Alignment Validation (SAV) process.
- We would like to have a simple process to make small changes rather than having to do a more formal scope change.
- Have you considered our request?

NOTES- DID NOT RAISE THIS ISSUE AS MEMBERS THOUGHT THE ISSUE HAD BEEN RESOLVED.

CONSORTIA STANDING & HEALTH CENTER TA

- In California, because we are so big, we have the unique structure of a statewide PCA, and in essence regional PCAs.
- Health centers locally depend heavily on their local consortia for support.
- Unfortunately, as the consortia do not receive direct HRSA TA grants, consortia are not deemed to have standing in helping a health center.
- This limits the support a health center can receive and an important voice in the conversation.

⇒ Is there anything that can be done to resolve this challenge?

⇒ Last time we met you shared you would look into the matter. Is there anything to report?

NOTES- THEY ARE REVIEWING AND WELCOME SUGGESTIONS

California Primary Care Association

INFORMATIONAL

Date: September 24, 2017

To: 330 Committee

From: Beth Malinowski, Deputy Director of Government Affairs

Re: Proposition 56 Supplemental Payments

MEMORANDUM

Overview

The Budget Act of 2017 included an agreement on a spending plan for the **Proposition 56, California Healthcare, Research and Prevention Tobacco Tax Act of 2016.** This spending plan includes $1.3 billion projected to flow to Medi-Cal in 2017-18:

- **Commitment to Medi-Cal Providers**: Supplemental payments, totaling $546 million, will be divided among five groups of providers – Physicians (up to $325 million), Dentists (up to $140 million), Women's Health Providers (up to $50 million), Developmental Disability Providers (up to $27 million), and HIV/AIDS Providers (up to $4 million).

- **Medi-Cal Stabilization**: Funds that are allocated to Medi-Cal, and not utilized for rate increases (approx $711 million), will be allocated for spending growth that would typically be paid for by General Fund dollars.

- **Supporting State Oral Health Plan**: $30 million ongoing allocation to the state dental director's office.

FQHCs and Supplemental Payments

As part of the spending plan agreement, DHCS had until July 31, 2017 to determine the rules for allocating these supplemental payments. Honoring this deadline, DHCS has outlined payment methodologies and begun submitting state plan amendments for the use of California Healthcare, Research and Prevention Tobacco Tax Act funds for supplemental payments.

FQHCs will be eligible for the supplemental payments for FPACT services. Pending SPA approval (SPA 17-029), time-limited supplemental reimbursements under the Family Planning, Access, Care and Treatment (Family PACT) program will be available to all FPACT providers for the Evaluation and Management portion of office visits rendered for the purpose of comprehensive family planning services. These payments will be retroactive to July 1, 2017.

FQHCs will not be eligible for any other supplemental payments, including Medi-Cal and/or Denti-Cal fee-for-service or managed care supplemental payments that could have caused challenges during reconciliation.
It is important to note that these supplemental payments will be in jeopardy if CMS approvals are not received and/or federal support for the Medi-Cal program is reduced.

Resources

- **Proposition 56 Supplemental Payment Methodologies (DHCS)**
- **Notice of Proposed Change to the Medi-Cal Program (DHCS)**

INFORMATIONAL

Date: October 10, 2017

To: 330 Committee

From: Andie Patterson

Re: Legal Update: Retrospective Dental Claims Litigation

MEMORANDUM

The Notice of Appeal of Judge Krueger's ruling ordering the State to process and pay the claims of the plaintiffs was filed by the Attorney General's office on behalf of Department of Health Care Services and its director on January 27, 2016. The superior court clerk took until October to put together the transcript of the superior court proceedings, and on October 27, 2016, the court ordered the State to file its opening brief on December 6, 2016.

The State obtained a total of 104 days of extensions and delays and filed their opening brief on March 21, 2017. We filed our brief on May 16, 2017. The State's brief was originally due on June 5, 2017, but the AG received extensions of time until September 5, 2017 to file its brief. On August 31, 2017, the State requested a third extension of time, which we opposed. The Court granted the State's request for an extension of time on September 5, 2017, but with the statement, "No further time will be granted." Accordingly, the State's reply brief is due September 26, 2017.

Once the reply brief has been filed (or the time to file it has passed), the court will send the parties a notice with the date for oral argument, likely in early 2018. After the case is "submitted" (generally after oral argument is completed unless the court does not grant oral argument or asks for additional briefing on an issue), the court will have 90 days to decide the appeal.

California Primary Care Association

INFORMATIONAL

Date: September 20, 2017

To: 330 Committee

From: Emili LaBass, Senior Program Coordinator of Health Center Operations

Re: Emergency Preparedness Final Rule

MEMORANDUM

Emergency Preparedness Final Rule - Background:
On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* The regulation went into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017. The final CMS Emergency Preparedness Rule (Rule) was designed to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and man-made disasters.

CPCA Activities:
Over the past 18 months, in an effort to assist Health Centers become compliant with the Rule, CPCA has created a multitude of resources, training opportunities, and has provided daily technical assistance to health center staff. Resources, templates, instruction manuals, plans, examples, checklists, and tool kits have been primarily disseminated through the Clinic Emergency Preparedness Peer Network and through CPCA's Training and Events. Pertinent and timely information has also been shared through the CPCA Emergency Preparedness website and the CPCA Weekly Update Newsletter.

Recognizing the complexity of the Rule, the short year-long timeframe in which to become compliant, and the immense burden it puts on health centers, CPCA put together a CMS Emergency Preparedness Compliance Checklist (attached to this memo). The Checklist references the Rule language, breaks down what it means in laymen's terms, and provides easy to understand Tips for Compliance. Also included are links to existing resources and how they can be applied to meeting compliance with the Rule.

In addition to these check lists and guides, CPCA has worked closely with our national and local partners to quickly find and consolidate existing materials, identify gaps and missing elements, and work to create tools to fill the gaps. This has resulted in two CMS Emergency Preparedness Rule Webcasts, an updated CPCA Emergency Preparedness Flip-Chart, an updated Emergency Operations Plan with supplemental annexes, as well as many more example plans and templates.

CPCA continues to work closely with our members to assist them with their emergency preparedness technical assistance needs. If you have any questions or concerns, please don't hesitate to reach out to Emili LaBass, at elabass@cpca.org.

CMS EMERGENCY PREPAREDNESS RULE

COMPLIANCE CHECKLIST

CMS issued the Emergency Preparedness Requirements for Medicare and Medicaid providers to establish consistent Emergency Preparedness requirements for health care providers participating in Medicare and Medical, increase patient safety during emergencies, and establish a more coordinated response to natural and man-made disasters. **Providers must meet all requirements by November 15, 2017.**

CPCA is committed to ensuring the success of community health centers and clinics. As part of this commitment, CPCA, in partnership with Constant Associates, conducted a thorough review of the CMS Emergency Preparedness Rule to develop a concise, user-friendly guide. This guide addresses the four components of the CMS Emergency Preparedness Rule specific to FQHCs and RHCs. Most importantly, it offers useful tips and resources to assist FQHCs and RHCs in becoming compliant with these new requirements.

Updated on 06/01/07

RISK ASSESSMENT & EMERGENCY PLANNING

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(a)	▪ Develop and maintain an emergency preparedness plan ▪ Review and update emergency preparedness plans at least annually	Emergency plans designed in accordance with risk assessment results and that include processes that provide the most comprehensive response to a broad range of emergencies	Review and update emergency preparedness plans using the risk assessment results and guidance provided in the Final Rule. Plan must address the following: ☐ The most likely risks to the institution based on risk assessment ☐ Patient populations, including, but not limited to the type of services the FQHC has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans ☐ Include a process for cooperation and collaboration with local, tribal, regional, state, and Federal emergency preparedness officials' effort to maintain and integrate response during a disaster or emergency situation ☐ Be reviewed and updated at least annually	CPCA's Continuity of Operations Plan (COOP) Toolkit can aid clinics in developing a COOP customized to their facilities and business plan. Visit the CPCA store to purchase the toolkit. CPCA's Emergency Operations Plan Template is an excellent resource to help clinics get started in creating emergency preparedness policies and procedures.
Section 491.12(a)(1)	▪ Develop a documented, facility- and community-based risk assessment utilizing an all-hazards approach ▪ Identify the medical and non-medical emergency events likely to occur at the facility and in the surrounding area	Identifying key components of a healthcare facility's emergency plan that apply to a full range of disasters or emergencies An all-hazards approach is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies & disasters	☐ Update existing risk assessments using the guidance of the Final Rule and document the work ☐ If you do not have a risk assessment to start from, collaborate with your local emergency management, public health, and health care coalition planning partners to access the jurisdiction's Threat and Hazard Identification and Risk Assessment (THIRA) or other agencies' Hazard Vulnerability Analyses (HVA) to work from. ☐ Perform a risk assessment using an all-hazards approach to identify hazards that are most likely to occur at the facility and in the surrounding area	Kaiser Permanente Hazard Vulnerability Analysis (HVA) is a great tool to help clinics identify likely hazards. For those who do not prefer the HVA format, the Hazard Risk Assessment Instrument (HRAI) guide and worksheets can also be used to complete a risk assessment. ASPR TRACIE has a resource comparing the purpose, benefits, and limitations of various hazard vulnerability assessment tools.

POLICIES & PROCEDURES

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(b)	▪ Develop and implement emergency preparedness policies and procedures based on the emergency plans, risk assessments, and communication plans ▪ Review and update policies and procedures at least annually	Healthcare institutions must define and document policies and procedures for their emergency program and its associated emergency plans	☐ Revise and/or develop policies and procedures that support the execution of an emergency response plan ☐ Policies and procedures must respond to the risks identified in the risk assessment ☐ Policies and procedures must be identified in writing, and current regulations stipulate that a physician, in conjunction with a nurse practitioner or physician's assistant, develop the facility's written policies ☐ Policies and procedures must address the following: ☐ Safe evacuation (including staff responsibilities and patient needs) ☐ A means to shelter in place for patients, staff, and volunteers, who remain in the facility ☐ A system of medical documentation (paper-based, electronic, or ideally both) that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records ☐ The use of volunteers in emergency or other emergency staffing strategies, including the process for integration of State and Federal designated health center professionals to address surge needs during an emergency ☐ Integration and overlap between the facility's EOP and response partners emergency plans within the community ☐ Review policies and procedures at least annually	CPCA's Emergency Operations Plan Template is an excellent resource to help clinics get started in creating emergency preparedness policies and procedures. Additional resources include an Evacuation Plan Template and Shelter in Place Plan Template. This Emergency Preparedness Toolkit for Primary Care Providers is a useful resource to access for additional, hazard-specific fact sheets to include in your plan, as well as links to trainings, exercise resources, and some sample Tabletop Exercise scripts.

COMMUNICATIONS PLAN

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(c)	▪ Develop and maintain an emergency preparedness communication plan that complies with both federal and state law ▪ Review and update plans at least annually	A system to communicate with all relevant internal and external parties, all in compliance with federal and state laws	☐ Develop and document a formal communications plan for emergencies (if one does not already exist) that conforms to the CMS requirements ☐ Communications plan that provides the broadest and most timely notification of an emergency. ☐ Maintain list name and contact information for staff, entities providing services under mutual aid arrangements, physicians, other FQHCs, and volunteers ☐ Maintain contact information for Federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance ☐ A system to communicate with all relevant parties, all in compliance with federal, state, and local laws ☐ Identify alternate communications systems in the event that their standard communications systems become unavailable ☐ Cross-functional plan to coordinate patient care issues within the facility ☐ A means of providing information about the general condition and location patients under the facility's care as permitted under the HIPPA Privacy Rule ☐ A means of providing information about the FQHC needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee ☐ Review and update plans at least annual	CPCA's Communication Plan Template offers tools and guidance designed to help prepare clinics to communicate effectively in a crisis.

TRAINING & TESING

Reference	Requirements	What it Means	Tips for Compliance	Resources
491.12(d)	▪ Develop and maintain emergency preparedness training and testing programs ▪ Review and update training programs at least annually	Training and testing programs ensure all employees and emergency teams are prepared to execute their duties in an emergency, and receive regular refresher training and testing.	☐ Develop and/or update training and testing activities that ensure all employees and emergency teams are fully trained in their roles and duties ☐ Review and update programs at least annually	While not required, we recommend creating a Multi-Year Training and Exercise Plan (MYTEP) either for your facility or for your coalition and community that outlines your planned schedule of trainings and exercises for the next 3 – 5 years. A sample MYTEP template can be found here.
491.12(d)(1)	▪ Provide initial training in EP policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation	See section 491.12(d)	☐ Update policies and procedures to include initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement (such as vendors), and volunteers, consistent with their expected roles according to your Emergency Plan ☐ Ensure staff could demonstrate knowledge of emergency preparedness and document knowledge outcomes from trainings ☐ Maintain documentation of training conduct, such as sign-in sheets and Feedback Forms, as well as training curricula ☐ Provide emergency preparedness training at least annually	CPCA's Training Pre and Post-Test Template can be used and customized to create pre and post-tests for all staff trainings to help demonstrate knowledge outcomes.

TRAINING & TESING CONTINUED

Reference	Requirements	What it Means	Tips for Compliance	Resources
491.12(d)(2)	▪ Participate in a community-based exercise at least annually and an additional testing exercise (e.g., paper-based tabletop exercise) at least annually	See section 491.12(d)	☐ Participate in a community-based exercise annually (if a community-based exercise is not possible or feasible, a facility-based exercise may be substituted if proper justification is provided). If the FQHC has to activate its emergency plan, it can be exempt from the requirement of an exercise for one year following the onset of the event, with proper documentation of the incident and the response. FQHC is still required to conduct a tabletop exercise at least annually. ☐ Conduct an additional exercise that may include, but is not limited to, a second full-scale exercise that is community- or facility-based or a table top exercise including a group discussion led by a facilitator ☐ Analyze the FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the emergency plan as needed	Participation in your local healthcare coalition is highly encouraged. Refer to the healthcare coalition listing to find out who your healthcare coalition is and how to contact them. The California Statewide Medical and Health Exercise website can offer a wealth of exercise documentation templates to be tailored and used for your facility to both participate in and create a community-based exercise. Additional training for health care facilities on the Homeland Security Exercise and Evaluation Program (HSEEP), sample After Action Reports, Exercise Checklists, and more can be found at the Wisconsin Department of Health Services Website. At a **minimum**, we recommend the following documents for conduct of a full-scale or tabletop exercise within your facility: ☐ Exercise Objectives ☐ Exercise Scenario ☐ Exercise Plan (the previous two may be included in this document) ☐ Exercise Sign-In Sheets/Participant List ☐ Exercise Feedback Forms and Evaluator Notes (sometimes called Exercise Evaluation Guides) ☐ After Action Report and Improvement Plan