330 Committee

April 26, 2018
1:00 p.m. – 2:00 p.m.
Louise McCarthy, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Louise McCarthy	A
II. Approval of Agenda	• Executive Summary	Louise McCarthy	A
III. Approval of Minutes	• January 2018 Minutes	Louise McCarthy	A
IV. SPA	• Memo: Process Review and Next Steps • Final CPCA Comments submitted (March 23, 2018) • Letter to DHCS regarding additional changes/ clarity needed	Ginger Smith Andie Patterson	A
V. DHCS Update	• Memo: DHCS update –MIPs, A&I Challenges	Ginger Smith	D
VI. Pay-for-Performance	• Memo: Status Update	Meaghan McCamman	A
VII. Payment Reform	• Memo: Status Update	Andie Patterson	D
VIII. HRSA Update	• Notes: HRSA-CPCA Meeting at P&I • Bipartisan Budget Act of 2018: Section 330 Statutory Changes • One pager on key pages to 330 Changes in BBA	Andie Patterson Emily Shipman	I I I
IX. OIG Forthcoming Review	• Memo: Review of Grantees Receiving Multiple Grants from HHS	Emily Shipman	I
X. Legal Update: Retrospective Dental Claims Litigation	• Memo: Legal Update	Andie Patterson	I
XI. Adjourn		Louise McCarthy	A

California Primary Care Association

Executive Summary

Date: April 12, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

SPA

- CPCA and members engaged extensively on the SPA 18-003 which included providing comments and edits
- On March 30, 2018 the state submitted SPA 18-003 for approval.
- Many of CPCA's edits and changes were included, however not all.
- CPCA continues to work with DHCS on editing the SPA 18-003.
- Per negotiations in March, DHCS agreed to take out Four Walls so long as CPCA and CAPH continue to negotiate this section with a goal of submitting another SPA in October 2018.
- CPCA proposes a process for how to engage in SPA 2.0 on Four Walls.

DHCS Update

- Per the MIP audits and required action by the state, CPCA heard from DHCS that they have submitted to CMS a project for moving forward
- DHCS will be reaching out to CPCA about the project and process ideally within the next 90 days.
- Per the challenges with A&I auditors, CPCA has had conversations with DHCS about the concerns and DHCS has committed to working with CPCA and a small group of CFOs to address the challenges.
- The goal will be to agree on the rules and develop training for both A&I auditors and health centers to ensure the same message is conveyed.
- The timing of these conversations was delayed by the SPA 18-003 but CPCA has pushed that the discussions commence immediately.

P4P

- CPCA has led a concerted effort to educate health centers and health plans on the "FQHC Incentive Best Practices" developed by the P4P workgroup
- We have recently learned that A&I Auditors are beginning to cite the San Mateo decision in current reconciliation audits, indicating they believe that incentives must be directly tied to reductions in utilization or cost in order to be held outside of reconciliation.
- CPCA recommends we move forward with engaging DHCS on P4P in light of these new developments.

Payment Reform

- Despite the setback with not moving forward with SB147 CPCA remains committed to ensuring a PPS equivalent APM moves forward, and we continue the work of developing an alternative proposal where the SPA is the vehicle for the APM, with the goal of a new proposal in 2019.

HRSA Update

- CPCA and members met with HRSA, Jim Macrae and his team in March at the P&I. A summary of the meeting is included in the notes.
- The Bipartisan Budget Act of 2018 Contains Numerous "Tweaks" to Section 330 Statute.
- Grantees with active conditions at the time of their SAC will be limited to a one year project period and must correct conditions before end of period or risk losing funding.
- Health centers must now directly employ their CEO/Project Director
- P&Ps now required to address prohibiting use of Federal funds for non-allowable activities

OIG Forthcoming Review

- March 2018 OIG announced audits of HHS grantees receiving funding from multiple sources
- The audits will review whether the selected grantees are allocating and claiming costs in accordance with Federal requirements
- The OIG did not report how many grantees will be audited
- Health center program grantees should refer to the Compliance Manual and their grant agreements for compliance requirements

Legal Update: Retrospective Dental Claims Litigation

- A date for oral argument before the court of appeals has been set for May 22, 2018, at 9:30 a.m., here in Sacramento.
- The court will have 90 days post to make a decision (approximately August 20).

CALIFORNIA PRIMARY CARE ASSOCIATION

330 COMMITTEE
January 18, 2018
1:00pm-2:00pm

Members: Louise McCarthy – Chair, Robin Affrime, Alex Armstrong, Linda Costa, Doreen Bradshaw, Eddie Chan, Rachel Farrell, Ben Flores, Timothy Fraser, Cathy Frey, Alvaro Fuentes, Jane Garcia, Greg Garrett, Dean Germano, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Steve Heath, Cathryn Hyde, Daniel Kazakos, Constance Kirk, Deena Lahn, Becky Lee, Marty Lynch, Kevin Mattson, Scott McFarland, Leslie McGowan, Nichole Mosqueda, Danielle Myers, Christine Noguera, Rakesh Patel, Joanne Preece, Tim Pusateri, Lucresha Renteria, Jacqueline Ritacco, Melinda Rivera, Corinne Sanchez, Michael Schaub, Mary Szecsey, Vernita Todd, Christina Velasco, David Vliet, Anthony White

Guests: Anitha Mullangi, Raphael Irving, John Price, Ellen Piernott, Larry Garcia, Karen Laterbach, Henry Tuttle, Julie Sinai, Jason Vega, Laura Sheckler, Meryl Schlingheyde, Diana Kawasaki-Yee, Angie Melton, Sergio Bautista, Paula Zandi

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Meaghan McCamman, Allie Budenz, Emili LaBass, Bao Xiong, Mike Witte, Ginger Smith

I. Call to Order
Louise McCarthy, Committee Chair, called the meeting to order at 1:02pm.

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

III. Approval of Minutes
A motion was made to approve the minutes of October 10, 2017. **The motion carried. (C. Frey, N. Gupta)**

IV. Year in Review
Andie provided an overview of what the committee projected from 2016 and what happened in 2017.

V. Payment Reform
In November CPCA received a legal analysis from Feldesman Tucker Leifer Fidell (FTLF) and per the analysis staff do not recommend moving forward with the APM in an 1115 Waiver at this time. CPCA remains committed to the APM and payment reform, and intend to continue developing an alternative proposal where the SPA is the vehicle for the APM. A meeting with a subset of health plans is already scheduled for February 2018 to begin discussions about a model where both risk and a SPA are utilized.

VI. DHCS Update
CPCA has concluded conversations and negotiations with DHCS on their proposed SPA changes with productivity standards, a 90-day requirement for the initial rate setting application, and the Change in Scope of Service Request. CPCA and DHCS will begin discussing the "Four Walls" issue next. DHCS' new goal is to submit their proposed SPA language to CMS for all issue areas by March 31, 2018.

VII. Acupuncture

DHCS has confirmed that acupuncture services provided by a licensed acupuncturist have been added to the FQHC visit definition in the State Medicaid Plan. No public notice has been issued on this change, nor has the provider manual been updated.

VIII. Pay-for-Performance

CPCA has begun to work with health plans and health centers to share the 'FQHC incentive best practices' developed by the P4P workgroup. CPCA has developed an array of easy-to-digest materials that we, RAC, and health centers can use to evaluate P4P programs and provide technical assistance to plans.

IX. A&I Challenges – Progress Update

CPCA staff have met with DHCS about the issues raised and how to resolve the challenges. DHCS has suggested we develop a training curriculum. A draft training curriculum has been shared with DHCS and efforts to build the curricula will soon be underway, with a training for CFOs and auditors hopefully mid 2018.

X. Legal Update: Retrospective Dental Claims Litigation

We are waiting for the court to send us a notice setting a date for oral argument, which will likely be in early 2018.

XI. Adjourn

The meeting was adjourned at 1:45pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care ASSOCIATION

ACTION

Date: April 12, 2018
To: 330 Committee
From: Ginger Smith, Director of Health Center Operations
Andie Patterson, Director of Government Affairs
Re: SPA Process and Next Steps

MEMORANDUM

This memo provides an overview of the SPA history and process, main issues discussed and resolution, as well as next steps.

I. SPA History, Process and Issues

The SPA notice was first issued by DHCS in December 2016 and the state's intention at that time was to submit in March 2017. CPCA aggressively fought back against that timeline and we were successful in securing an additional year for negotiation. The SPA 18-003 was submitted to CMS on March 30, 2018 with an intended effective date of January 1, 2018. A SPA 2.0 process has yet to commence, but will soon and will focus at this point solely on the issues of "Four Walls."

Member Engagement

CPCA staff have been in conversations with the state since December 2016 regarding the SPA. In January 2017 the 330 Committee voted to form a subcommittee to work with CPCA and DHCS to develop a policy and exceptions for the use of productivity standards as a tool for determining reasonableness. Another workgroup was approved to focus on the matters of the SPA proposal. For each topic of discussion with the state, CPCA staff brought back related information to the membership for input. The conversations have primarily been in the form of webinars. One meeting was scheduled for health centers to directly provide input to DHCS, and the feedback was a culmination of the discussions that had taken place to date. All of the feedback was brought back to the state and is documented in emails and memos to the Board and membership summarizing CPCA's position. In addition, these issues were discussed at our quarterly Board and committee meetings.

Players

CPCA has worked closely with the California Association of Public Hospitals (CAPH) on the SPA. This is an important relationship as they, too, have FQHCs in their membership. CAPH brings strong regulatory and legal strength to this issue and related negotiations. We have worked with the law firm, Foley Lardner, which has expertise in matters pertaining to FQHCs. Kathryn Doi has also been providing legal input. CPCA negotiations have been led by two of CPCA's

Directors, Ginger Smith, Director of Health Center Operations; and Andie Patterson, Director of Government Affairs

Issues in the SPA

The majority of the time spent in 2017 was on **productivity standards** - an issue CPCA has been trying to resolve with the Department for years. CPCA and CAPH have contended and still contend the state doesn't have the right to implement productivity standards. We agreed to discuss the application of productivity standards only after CMS told DHCS, CPCA and CAPH that the standards could be used but that the Department had to work with the stakeholders to develop language for the SPA. Despite our continued resolve that the standards are inappropriate, we believe that CPCA, with significant member input, was able to find a good compromise on the standards, as well as a reasonable exception process. Moving the standards from 4200/2100 to 3200/2600 means that the vast majority of health centers will easily pass the standards - a great improvement over today.

The next issue CPCA spent significant time on was the **90-day effective date** of a rate for new sites. The central issue on this matter was the need for additional clarity around the effective date of the 90 days and the concluding language in the SPA affords sufficient clarity.

Both the productivity standards revisions and exception process, and the 90 day effective date, were approved by the 330 Committee and the CPCA Board in July 2017.

The **change of scope** section initially read as a major change in policy; however, the state has argued that many of the issues in this section are actually the result of poor drafting on their part and are not intentional policy changes. The major revision in the change in scope section of the SPA is the requirement for 12 months of cost data. In exchange for this, health centers receive their rate the year the change was triggered, not the year after when it's submitted. Securing payment at the start of the fiscal year for when the change occurs both aligns and reinforces the FQHC right of full payment.

Additionally, CPCA pushed hard that the effective date of the SPA be July 2018. The state did not acquiesce to this request, but did make the change in scope section of the SPA effective December 31, 2018. This is an improvement over what we had originally asked for and ensures health centers operating under the old rules can continue to do so.

Summary of the issues in pending SPA

- Officially moves intermittent sites from no more than 20, to no more than 30 hours
- Effective date for a new rate is based on 90 days from the date of written notification of federal approval
- MFTs billable as of January 2018
- Revised productivity standards (3200/2600), with exceptions
- Scope changes to require full fiscal year and to be paid at the new rate retroactive to the date the change occurred
- Triggering events on or before December 30, 2018 use old CIS rules, triggering events on or after December 31, 2018 use new CIS rules.

Issues out of the SPA

Due to CPCA and member advocacy, the state dropped some damaging proposals from the change in scope section and four walls. For Change in Scope they dropped the proposal to require a CIS to take three (3) years for full review and audit, and the proposal to adjust every health center's PPS rate based on the most recent audited home office allocations, regardless if every health center was under audit. The state also responded to our concerns and dropped the Four Walls section from the SPA entirely. We will now have the opportunity to negotiate with the Department on a separate track, after this SPA 18-003 is submitted.

Legal Analysis

As we have two legal firms at the table, we have discussed and evaluated a legal strategy and have determined that our best strategy is to ensure the submitted SPA is as protective and supportive of health centers as possible. This is due in large part to the fact the courts tend to show deference to the state, especially if approved by CMS. However, by engaging in this process, we have not lost any ability to engage legally if we so choose, and we have already favorably resolved several policy issues.

II. Next Steps: SPA 18-003

Before the SPA 18-003 was submitted by DHCS on March 30, CPCA submitted a letter articulating all of our edits and feedback, as well as a version of the SPA with track changes. CPCA also provided a template comment letter for health centers to submit and we are aware that dozens of health centers also submitted comments.

All of the feedback was discussed with the state to ensure they understood the rationale and concerns behind the edits. Ultimately the SPA submitted did not include all of the feedback and edits CPCA, CAPH and members advocated for. DHCS has shared that edits can continue post the March 30 submission. CPCA has review the pending SPA with members, gathered feedback, also reviewed the pending SPA with CAPH and legal counsel, and have submitted a subsequent set of edits and a narrative letter outlining the rational.

III. Next Steps: Medicaid State Plan Amendment 2.0 (ACTION)

In March, CPCA successfully negotiated with DHCS to remove the "Four Walls" section from SPA 18-003. As part of the agreement, DHCS requested that CPCA and health centers continue to negotiate this section with the state's intention of submitting another SPA in October 2018.

CPCA has not commenced negotiations or discussions on the "four walls" yet. The goal is to first fully resolve SPA 18-003 first, and then proceed with "four walls."

ACTION: *CPCA proposes to utilize the same methods to engage members in providing feedback as was used for SPA 18-003. This process included CPCA staff directly meeting with DHCS approximately every 2-4 weeks and then holding a webinar or call with the SPA subcommittee in between the DHCS meetings. Feedback gathered from members during those meetings is then shared with DHCS. One additional component CPCA proposes to include is to facilitate a health center and DHCS meeting per each major item of the Four Walls, i.e. homeless, telehealth, etc.*

IV. **Resources**

- The December 2016 SPA notice can be found here: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001_PN.pdf
- Proposed SPA language is available here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Proposed2018.aspx
- CPCA submitted edits to the proposed SPA: https://d3n8a8pro7vhmx.cloudfront.net/capca/pages/2108/attachments/original/1523556948/CPCA-CAPHedits.FQHC_SPA_Attachment_4.19-B_page_6_full_mark-up..032318.pdf?1523556948
- SPA submitted to CMS on March 30, 2018 and posted in the "Pending" category here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending_2018.aspx

March 23, 2018

Jennifer Kent
Director, Department of Health Care Services
1500 Capitol Ave
Sacramento, CA 95814

Re: Proposed State Plan Amendment 18-003

Dear DHCS Director Kent:

The California Primary Care Association (CPCA), representing 1300 clinic and health centers across the state that serve 6.5 million Californians, appreciates the opportunity to comment on SPA 18-003.

We would like to thank the Department of Health Care Services (Department) for the thoughtful and collaborative process to negotiate SPA 18-003. We recognize the state had originally sought a much shorter time frame and the inclusion of more issues than the SPA currently contains. The additional year of negotiation and conversation we believe has improved relations between our association and the state, has enabled a better understanding of the perspectives of each party, and has helped us find a compromise that furthers both the Medi-Cal Program and the ability for health centers to delivery high quality care responsive to patient need.

CPCA has incorporated health center feedback throughout the process and informed health centers of the discussions and proposals by the state. We have worked with the state to provide as much time for thoughtful feedback as was possible.

Overarching Comments
Initially, we offer two overarching comments on the current draft of the SPA.

1. Implementation

We acknowledge that standard process is to submit a SPA at the end of a quarter, with an effective date retroactive to the first day of the quarter the SPA was submitted. We also understand that this protocol is not required by law, and **request that the state submit the SPA**

for a future implementation date of July 1, 2018. In the case of this SPA, significant changes are being proposed, and attempting to operate today under rules that would be retroactively be replaced by significantly different rules makes it very challenging for the health centers and their patients to both operate day-to-day and plan for the future. The July 1, 2018 date aligns with AB 1863 (Wood), signed by the Governor in 2016, which authorizes MFTs to be billable providers in FQHC and RHCs. A future implementation date for the SPA will afford health centers the necessary time to amend processes and plan accordingly.

If such a request cannot be accommodated we request the state consider policies that would enable health centers with triggering events that occurred in 2017 and who are submitting for a scope change within 150 days of their fiscal year end date (which could mean submission in 2018) to not be held to the new SPA which requires 12 months of data before submission. This allowance still conforms to the SPA that is law today and was law in 2017, and health centers conforming to the 2017 law should be held in accordance with the rules of 2017. There need to be methods to honor the current law while conforming policy change into the future. We have submitted edits to the SPA to allow for such a policy.

2. Section Q: FQHC and RHC Services Provided Offsite (Outside of the four walls of the facility)

We understand that the state's motivation in drafting the SPA was multi-fold. The state had to amend the SPA to include MFTs as billable providers, now to be effective no later than July 1, 2018 (per AB1863 Wood signed in 2016), and additionally, as directed by CMS, to include how productivity standards would be implemented in PPS rate setting. Further we understand from the state that there have been outstanding areas of confusion among health centers and auditors on rules related to rate setting and billing PPS and the state hoped to use this SPA to clarify those elements.

CPCA understands the impetus of the SPA, as our organization sponsored the MFT legislation, and while we have consistently disagreed with the state's use of and legal authority[1] to apply productivity standards, we did engage with the state on how they would be implemented and what the exception process would look like. These two matters needed to be included in the SPA for legal and legislative reasons. The other issues under discussion are not required to be clarified or drafted but we have sought to be partners at the table discussing reasonable clarifications and amendments to existing processes.

[1] There is nothing in federal or state law or the State Plan that allows for the use of productivity standards. Federal law 42 U.S.C. Section 1396a(bb)(2) provides: "the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services….which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 13951(a)(3) of this title…". Furthermore in Connecticut Primary Care Association v Wilson-Coker, 2006 WL 2583083 (D.Conn. 2006), the court found CMS' approval of Connecticut's SPA that imposed productivity standards was not entitled to deference where neither the federal government nor the state made an assessment of "reasonable and related" costs of FQHCs in adopting the screen.

We regret not having more time to work through complicated aspects of the SPA, in particular the Four Walls section. Health centers were created to serve communities' most vulnerable people and to ensure that everyone, regardless of income, would have access to primary health care. While we appreciate the state's prudence in attempting to create a Medi-Cal program with clear rules, we believe there has been an overreach to prevent fraudulent billing that is creating a real threat to the health and wellbeing of our state's most vulnerable populations.

Health centers, like other health care providers, understand that the health system must move to value over volume, and to meeting patients where they are, not where the doctor prefers to be. Flexible, real time care, by the most appropriate team member is how we should continue fashioning the health care system; unfortunately, we do not see the Four Walls section of this SPA as aligning with that vision. Rather this section would revert the system to the prior, more restrictive FFS system that we all acknowledge does not serve the needs of health center patients. Furthermore, while CMS has offered guidance on Medicaid services outside of the Four Walls, it expressly does not apply these same restrictions to FQHCs. FQHCs are required to ensure that services within their scope are available and accessible to all of their patients, which can necessitate arrangements for services provided outside of the Four Walls of a health center, particularly given the medically underserved/ hard to reach nature of their patient population.

For the aforementioned reasons, we request that the state remove the section on Four Walls and continue the negotiations with CPCA and our partners at the California Association of Public Hospitals (CAPH). We are committed to value and helping to make sure the state's limited resources are expended in the most prudent fashion, but the currently drafted Four Walls section of the SPA does not achieve either goal.

Specific Comments

Below we provide more detailed feedback on elements of the SPA as drafted and request the state consider these in editing and finalizing the submitted SPA.

While many of the comments are provided to amend or improve the proposed language, as you know, we have done so without agreeing with many of the underlying policies held or otherwise being proposed by the Department. Accordingly, we and our individual members reserve the right to continue to challenge those underlying policies and their implementation.

1. Clarifying Language

- References to "intermittent sites" should be aligned with the Health and Safety Code Section 1206 which stipulate "no more than 30 hours per week." The current SPA draft language reads "less than 30 hours per week."

- In the productivity standards section c.1. (iv) C. it reads "If the specific reason(s) for an exemption is related to lengthy visit times…" The term "lengthy" is vague and subjective and would offer an alternative phrase of "longer than average." Our recommended language has a clear data point that can be used as a comparison.

- Per the section on the 90 day rule, or section 5.(a) it reads "…it must submit a complete Initial Rate Setting Application Package to the Department within 90 days from the date of federal agency's written notification of approval as an FQHC or RHC." The effective date we propose should be amended to read "…from the date first qualified by the applicable federal agency," which effectively is as we also amended in "date of receipt of the federal agency's written notification of approval." This amendment will help to create greater clarity on when exactly the 90 day officially commences.

- In section on the 90 day rule, or section 5. it stipulates "….is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC…". The term "licensed" should be removed from this section because licensure is not required of all FQHCs and RHCs, and further those that are licensed, the licensure process can often take more time than when the site's new rate can start.

- In the MFT section it requires a rate change within 90 days but all other scope changes are required within 150 days following the beginning of the FY. We recommend aligning the language for consistency. In addition, the SPA does not acknowledge and needs to in order to conform with AB1863 how a PPS rate will be adjusted if MFT costs are already included in a FQHC's or RHC's PPS rate. A section that mirrors that regarding Dental Hygienists needs to be added to the new SPA.

- In Section K. 2 (a) the edits we have submitted to the SPA more clearly format what a scope-of-service means, breaking apart the paragraph into more clearly delineated bullets. We do include additional language to better define what a "new health professional" is to articulate a new service with new or existing staff.

- Additionally, in Section K.2(e) we have included language for consistency regarding the definition of what constitutes a scope change to include in addition to intensity, also "type, amount or duration."

- In Section K.8.(c) we have added amendments to update the dollar figures and dates used as the example for how to understand how rate changes work, as well as deleted a portion of the portion discussing MEI rates as the dates are outdated and are more confusing than helpful.

2. <u>Section F.1.(c): Productivity Standards</u>

During the negotiations on productivity standards we agreed that an even **broader list of providers would be exempt** from productivity standards than just those listed in (c) 1. In addition Doctors of Osteopathy, Doctors of Psychiatry, Dental Hygienists, licensed acupuncturists and other health care professionals exempted by the state should be included.

Additionally, the proposed SPA lacks the language that sets forth **how the productivity standards are calculated and applied** and the negotiations on productivity standards were far more extensive than are captured in the SPA language. The Social Security Act 1902(a)(30) requires the state plan to "provide such methods and procedures relation to the utilization of, and the payment for, care and services available under the plan….", and 42 CFR 447.201 requires that "a state plan must describe the policy and the methods to be used in setting payment rates for each type of service included in setting payment rates for each type of service included in the State's Medicaid program." As such, we are submitting additional language to be considered for inclusion. The additional changes are consistent with the negotiations with the state.

The productivity standards section includes a requirement to maintain adequate records of productive and nonproductive time. We do **not recommend the inclusion or tracking of unproductive time.** It is our contention that the standard is on productive time and that is the data point that must be verified. It is not as simple to say that productive time is total time minus nonproductive time. The standard should be based on auditing the providers' productive time seeing patients or scheduled to see patients.

The language regarding exemptions lacks a standard by which a **request for an extension** would be evaluated. We recommend that the following language be added regarding the appropriate standard of review: "A request for an exemption shall be granted if the FQHC or RHC has demonstrated that there is a reasonable basis for the granting of the exemption."

3. Section 5. Effective Date of a New Rate

The proposed language in Section 5 regarding how new rates are established for intermittent sites and mobile units is contrary to current practice and is inconsistent with state law. Welfare and Institutions Code ("WIC") Section 14132.100(j) provides:

> "Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate."

Further, WIC § 14043.15(e) provides:

> "… an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary

care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units."

Securing a different rate than the parent site should be an <u>option</u> for a health center but not a requirement. We recommend amending the section to be permissive to allow for a scope change, but not to mandate one.

4. <u>Section K: Scope-of-Service Rate Adjustments</u>

It is our understanding based on conversations with the Department regarding Scope-of-Service Rate Adjustments ("scope changes") that the Department's intention is not to wholly change current policy but rather to standardize current practice. Such clarification is helpful because as it currently reads it appears that the scope change policy would be dramatically different than both current practice and what the law currently requires/allows.

For example, K.1.(a) reads as if a specific line item must increase rather than the overall costs of the health center. We understand from DHCS that the intention is to keep with current practice and the plain meaning of WIC § 14132.100(e)(3)(D), where the **total costs of the health center must increase by at least 1.75%, not the line item triggering the scope change**. We are submitting language edits to conform to this understanding.

Another example is **K.1.(c)(i)A.** which reads as if a scope change for an increase or addition of providers cannot be included unless no other provider is qualified to perform that function. This limitation is not found in WIC § 14132.100(e). We would argue that MDs for example can perform many medical functions but may not necessarily do so as primary role at the health center. **We would recommend eliminating the entire section** actually as the additional examples provided for further explanation of what is allowed are too limited to provide additional value and only actually, we believe unintentionally, add more confusion rather than less.

Similarly, **Section K.1.(c)(ii)** stipulates certain circumstances that would not constitute a scope change. It is our position that such a section is unnecessary as the law governing scope changes is detailed and specific enough to eliminate many circumstances without having to call out any one specifically. **We recommend eliminating this section entirely.**

We appreciate the state's willingness to make the effective date of the new rate due to a scope change to be the first day of the FY when the change occurred. This is a strong advancement over current practice. We support this change in the policy as it meets the intent of the law to ensure FQHCs receive their full costs. However we do recommend **amending the section to allow a change to occur within the first quarter of a fiscal year for determining a new rate** and that rate will be effective the first day of the FY that the change occurred. There needs to be some time afforded to a health center to implement a change. Should the change occur past the first quarter a health center would be able to commence billing on the day of the change

however would have to wait the remainder of the year and another full FY before being able to submit for a scope change.

We additionally have submitted amendments we believe are necessary to avoid potential conflicts with state law that currently provides that the effective date of a rate change is retroactive to the first day of the fiscal year in which the request for a change was submitted (WIC § 14132.100(e)(4)) rather than when the change occurred. Without the requested amendment, FQHCs and RHCs would be required to hold their requests for up to two years after a change was implemented – and while the SPA says that the rate would be retroactive to the beginning of the fiscal year when the change occurred, state law could limit the retroactivity to the fiscal year of the request. This would be a significant penalty for the FQHC/RHC. To minimize the potential for such conflicts, **we request the ability for the FQHC/RHC to submit the request during the window at the beginning of the fiscal year either in which the change occurs or in any subsequent year** to hold their arguments regarding the date of submission, even though the full fiscal year of data to evaluate the request may not yet be available.

Additionally, the state relayed to CPCA that the **comparison of 2 years of costs** is the practice today by the Department, and that the intention behind the requirement is to confirm that a change occurred. If the intention is simply to prove that there were costs associated with the scope-changing event, we recommend that the state use an accounting methodology that is less onerous than a cost report, as it does not serve the system, the State or the health centers to require the expenditure of the time and resources necessary to complete a cost report. **We recommend instead using documentation such as financial records, payroll reports, contracts, etc.** We have made additional conforming amendments in subsection (e) of Section K where the term "compare" was used in regards to determination of the new rate. A comparison of costs to determine whether there was a triggering event is different from how a rate is set which is by comparing the current PPS rate to the future PPS rate.

Section K.2.(d) adds an **unnecessary amendment regarding electronic health records**. The amendment reads that an EMR only constitutes a triggering event once; however we contend that should all the requirements of a change in scope be met, such a prohibition is unnecessary and contrary to current law. We recommend eliminating this amendment.

Section K.4. describes that a scope change must be submitted if there was a decrease in the scope of services. Similar to the comments and conforming amendments made regarding how PPS rate changes should be processed (remaining consistent with law and current practice) we have made amendments to this section to **clarify that the comparison made should be between the old and new PPS rates and not costs year over year.**

A new clarification we are adding to Section K.4.(a) is in regards to when a **conversion of space** at a health center triggers a scope change. We propose that for decreases in space that the threshold be at 5% of square footage as a clear marker for health centers to use.

Section: FQHC and RHC Services Provided Offsite (Outside of the four walls of the facility)
CPCA appreciates the state's intention to provide clarity on such an important issue as Four Walls and that they are engaged in negotiations on how such visits could occur. This is particularly salient as health centers continue evolving their practices, reaching towards value and away from volume. We believe however that the depth of this section and the nuances for each section warrant further discussion. We recommend removing the entire Four Walls section from the SPA and continuing negotiations with us in a more paced environment and the submission of clarifications via a future SPA after we have come to an agreed upon resolution for these visits.

While we believe the section should be removed, it would be imprudent to not offer feedback on each section.

Services outside of the Four Walls
One overarching comment is that this section gets into far more detail on which providers, which patients and how to document the visit than anywhere else in the SPA. The providers that can bill a visit in the four walls should be the same providers that can bill a visit outside of the four walls. As drafted, the list of providers excludes providers such as a dentist, dental hygienist, optometrist, podiatrist, etc. Furthermore, documentation of the visit should have no additional requirements or barriers than is required within the four walls. Extensive language is included about visit documentation and it appears to add new requirements that are not required for a visit within the four walls. For example, neither

- "the length of time the patient is expected to be unable to come to the clinic" nor
- "the patient's primary care physician must document his/her approval of any behavioral health services offered"

are required elements of documentation within the four walls. These elements are not relevant to the health of the patient or how to provide better quality of care and thus should be stricken.

The Four Walls section creates additional requirements for defining what an established patient is. The definition in the Medi-Cal manual defines an established patient as "one who has received professional services from a provider within the past three years." The draft SPA adds the additional stipulation that only patients that are established with a medical condition preventing them from travel may receive visits out of the four walls. Many patients, such as those with mental and physical impairments, who live in residential homes are capable of travel, but coming to the health center is out of routine, extremely arduous, and is ultimately too disruptive. And while they may have come to a health center in the prior three years (one of the new conditions of established patients) they may no longer be capable of doing so.

The definition proposed also requires that the patient be treated for a continuing issue, not a new ailment or condition. Such a rigid rule restricts much necessary care that is not planned or anticipated by the patient or the health center and is an unfair restriction on the patient who is challenged in coming to the health center.

Inpatient Settings

This section has a few problematic elements. The inability of FQHC providers doing rounds to care for a patient with a new condition, for example they come in to deliver a baby and are unable to provide care to the mother if she gets an infection while in the hospital, seems short sighted. A provider should be able to care for the patient and not be limited to a pre-existing condition.

Also with OB and maternity, while a woman can be assigned to an FQHC, that same woman in Medi-Cal managed care can self-refer to an OB at the hospital, but may want her baby to be assigned or treated by the FQHC. There should be the flexibility for an FQHC provider to care for the baby and not the mother if that is the mother's desire.

This section also stipulates that the FQHC provider billing inpatient services must spend the majority of their time at the FQHC providing services within the four walls and only occasionally go to the hospital. Many providers providing care in inpatient settings are contractors with the FQHC and are not full time with the FQHC providing the majority of their services within the four walls. We disagree that this arrangement should be prohibited.

Dental Services Rendered to FQHC Patients by a Private Dental Provider

We recommend modifying the requirement in section (a) that each FQHC site must have a separate contract with a private dentist. An easier, more streamlined approach that still meets the intent would be that a health center have one contract with the private dentist on behalf of all locations needing this arrangement.

Additionally, we would strike section (j) as it is overly restrictive based on the directive in SSA 1902(a)(72) that "the State will not prevent an FQHC from entering into contractual relationships with private practice dental providers in the provision of FQHC services." Additionally an established patient in this section should be one with a medical OR "dental" record with the FQHC.

For consistency we recommend adding the word "within" to section (h) "…The medical record must have been created WITHIN three years prior to the date…" and "work" and "as defined by HRSA" to section (i) "An established patient must also reside or work in the center's service area AS DEFINED BY HRSA and…."

Telehealth Services

This section deserves much greater conversation. CPCA has been operating under the guidance of an FAQ created with the Department for many years and we understood that this section was meant to codify what was in that FAQ. As written, the language in the SPA is confusing and not as clearly aligned with the FAQ as was understood. We are submitting language changes to this section to align with how the FAQ is drafted.

The agreement adopted in the FAQ was that when telehealth visits occurred between two separate FQHCs and "FQHC A" was the originating site presenting the patient, and FQHC A's billable provider elected to present the patient because there was a medical reason to do so, and FQHC B (the distant site) had the specialist, both FQHCs could bill its PPS rate. The language as proposed appears to not allow for this arrangement. It is important to allow providers to learn from each other as it lessens specialist visits in the future.

Moreover, none of the language affords the opportunity for one of the most necessary telehealth visits- when a patient is at home and the provider is at the health center. In order to continue advancing care and offering the easiest and best quality care, there should be an opportunity for a provider to deliver a telehealth visit to a patient who is at home. At the very least this option should be available to homebound patients.

Section (a) provides that if an FQHC with two sites is engaged in telehealth that only the originating site can bill; we suggest if only one site bills, it should be the "distant" site (where the provider is located) that bills. This is the practice today.

Section (b)(i) and (c)(i) provide that in order for the distant site to be reimbursed at the PPS rate, the services cannot be furnished at the originating site. FQHCs and RHCs should not be limited from expanding existing specialty services through telehealth services when their face-to-face specialty services are not sufficient to cover their demands. We recommend eliminating this requirement.

<u>Store and Forward Telehealth Services</u>
We are submitting language edits for this section.

<u>Mobile Units and Intermittent Sites</u>
Services provided within mobile units and intermittent sites should be considered to be provided within the FQHCs four walls and should be removed from this section entirely.

The language in this section 6.(b). provides that an intermittent clinic's address must be listed on the establishing FQHC's licenses, but such a requirement will hold up the operation of the intermittent clinic as licensing delays abound. CDPH currently requires FQHCs to notify of them during a site's annual renewal process and there is no indication that this practice is deficient in any way. This provision should instead read that the establishing FQHC will notify CDPH through the annual licensing renewal process of the site and add the address at that time.

Section (d). should better define with respect to actual measurement what "closest" means. We recommend the language be amended to read "must be the FQHC that is closest to providing similar services to the intermittent service site or is the closest site capable of providing the necessary administrative support."

Section (e)(iv) provides that the location where a mobile unit parks when not in service must be considered when determining which FQHC or RHC is considered to have established the mobile

unit. The location where a mobile unit is parked when not in service does not have any bearing on the operations of a mobile unit. We recommend eliminating this provision.

Section (f) indicates a licensed mobile until does not have to meet the hours of services requirements of an intermittent clinic. It is unclear as to what section (f) is implying. We recommend more clarity to be added.

Homeless Services

This section in the Four Walls is the most problematic because of the inherent challenges in providing care, much less consistent care, to homeless individuals.

The established patient issue is challenging with respect to homeless patients as it requires a patient have an established patient record for care provided within the health center's four walls. There are many homeless patients of a health center that receive care arising out of the health center doing street outreach. These individuals for the most part will never come within the four walls of the health center. Health centers need to be able to do outreach to our state's most vulnerable people and establish care outside of the four walls.

Section (g) excludes all provider types that can bill a visit in the four walls of a FQHC or RHC. As drafted the list of providers excludes providers such as a dentist, dental hygienist, optometrist, podiatrist, etc. We do not understand or agree that the services should be so restricted.

Section (h) contains extensive language about visit documentation and it appears to add new requirements that are not required for a visit within the four walls. Documentation of visits providing homeless services should have no additional requirements or barriers than is required within the four walls.

Additional Services Provided Outside the Four Walls

In connection with the proposed future discussion of Four Walls issues, we recommend a subsection on Head Start Programs and Schools. Services may include dental screening, dental exams, cleanings and fluoride treatment, CHDP screenings, etc. The off-site services are often listed in the health center's HRSA scope of service on Form 5C.

We also recommend adding in a section on CPSP Services. Currently, the Medi-Cal Provider Manual under Pregnancy: Comprehensive Perinatal Services Program reads:

> Hospital-based outpatient departments/clinics and non-hospital based clinics that are certified CPSP providers may bill for CPSP and obstetrical services that are provided off-site or out-of-clinic. These outpatient departments and clinics may bill for CPSP and obstetrical services that are provided in off-site locations such as a physician's office, a school auditorium or mobile van operated by a clinic.

We appreciate the opportunity to comment. Should DHCS have any further questions, please contact Andie Patterson, Director of Government Affairs, at apatterson@cpca.org.

Regards,

Andie Patterson, MPP
Director of Government Affairs
California Primary Care Association

April 18, 2018

Lindy Harrington
Deputy Director, Department of Health Care Services
1500 Capitol Ave
Sacramento, CA 95814

Re: Proposed FQHC State Plan Amendment 18-003

Dear Deputy Director Harrington:

Both the California Primary Care Association (CPCA), representing 1300 clinic and health centers across the state that serve 6.5 million Californians, and the California Association of Public Hospitals and Health Systems (CAPH), representing California's 21 public health care systems (including numerous federally qualified health centers) that are owned or operated by counties, special county hospital authorities, and the University of California medical centers appreciate the opportunity to comment on proposed SPA 18-003. It is our understanding that while the proposed SPA has been submitted to CMS there still remains an opportunity for comment and continued negotiation as it proceeds towards finalization.

From our conversations with the staff at DHCS we believe that many of the changes to the SPA were not intended to change existing policy but rather offer additional clarifications. We appreciate the state's desire to elucidate what has been confusing in the SPA. However, our below comments outline where language edits are necessary for clarification on the part of health centers and to ensure the law is not being inappropriately changed by the proposed SPA.

Clarifying Comments/ Edits

A. Productivity Standards

On page 6L, paragraph J.3.(c)2.(v) we request that the review of a provider's time for the purposes of an exemption also include other unbilled encounters on the same day as it may increase the length of time a provider is spending on their patient panel.

On page 6L2, paragraph J.3.(c)2.(v)E we recommend adding in clarifying language that documentation of the continuing reason for the exemption is required only through the time in which the applicable rate setting audit rate occurs.

B. 90-Day Requirement

On page 6L3, paragraph J.5.(b) we request that DHCS remove that an Initial Rate Setting Application must be submitted to DHCS within 90 days for an intermittent site. An Initial Rate Setting Application is not required for intermittent sites since these type of sites are affiliated with a FQHC and do not obtain their own individual PPS rate.

On page 6L4, paragraph J.5(c)(iii) we request that DHCS remove that an Initial Rate Setting Application must be submitted to DHCS with 90 days for mobile units. An Initial Rate Setting Application is not required for mobile units since they are affiliated with a FQHC and do not obtain their own individual PPS rate.

C. Change in Scope

We appreciate what we understand is the state's willingness to make the effective date of the new rate due to a scope change be the first day of the FY *when the change occurred*. We support this clarification as it meets the intent of the law to ensure FQHCs receive their full costs. We also understand the state's desire to have a full year of data for which the change was in place the entire 12 months to evaluate the scope change request. However we highly recommend amending language in the SPA to allow for the proposed change (specifically page 6R1, paragraph K.1.(d), Page 6R3, paragraph K.3, and page 6R4, paragraph K.6.(c)). As it is drafted now we believe there to be a conflict with state law. Without the requested revisions, FQHCs and RHCs would be required to hold their requests for up to two years after a change was implemented – and while the SPA says that the rate would be "retroactive to the beginning of the FQHC's or RHC's first full fiscal year in which the change occurred," state law could limit the retroactivity to the fiscal year of the request, which would be more than one year later. This would be a significant penalty for the FQHC/RHC. One way to address this state-law issue is to authorize an FQHC/RHC to submit the request during a window at the beginning of the fiscal year in which the change occurs to hold the date of submission, even though the full fiscal year of data to evaluate the request will not yet be available. We have provided suggested edits to accomplish this result, which are consistent with our earlier proposed approach, in that we limit this ability to circumstances in which the change is implemented within the first 90 days of the FQHC's fiscal year.

We have provided additional edits to the sections of the change in scope related to the now five part test. The edits we are forwarding are to ensure that the proposed changes do not result in any change in policy and are consistent with state and federal law. We believe our proposed language edits meet the state's intentions as well.

a) Clarification that the provider must demonstrate an increase or decrease in cost that is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.
b) The *cost is allowable* under Medicare reasonable cost principles set forth in 42 CFR Part 413.
c) The change in scope of services is a *change in the type, intensity, duration, or amount of services,* or any combination thereof.
d) The FQHC or RHC must *implement the change in scope of service continuously for a full fiscal year* (12 months) before the state can evaluate a change in scope of service request.
e) The net change in the FQHC's or RHC's per-visit rate equals or *exceeds 1.75 percent* for the affected FQHC or RHC PPS rate that was applicable in the preceding full fiscal year without the change.

On page 6R, paragraph K.1.(a), we suggest a simpler construction to communicate what we understand to be the purpose of the requirement: to demonstrate that the FQHC or RHC has a change in costs that is attributable to the change in scope of services. We are concerned that the more complicated language makes it appear that the demonstration is part of the aggregate cost comparison that is subject to the 1.75% threshold. If given that interpretation, the language could inadvertently harm a health center with a legitimate change in scope by prematurely cutting off the analysis of costs before the threshold comparison..

The edits to section K.1.(c) address one of the most troublesome of all the proposed SPA changes. It potentially dramatically changes what constitutes a CIS and limits it to just the addition of a new service that requires adding new professional staff and the deletion of an entire service. Thus, circumstances that impact intensity or duration of existing services would not be recognized, contrary to current policy and state and federal law. As DHCS has assured us that is not its intention with this section, we recommend that the state adopt our clarifying language that directly frames the examples as exactly that, examples, and not a limitation to the section. We've also added clarifying language to the examples of what does not constitute a change in scope to explain how certain events could be elements of a CIS so long as they are in conjunction with other circumstances that meet the CIS test. Our proposed clarifying language is derived from the Maine SPA, which we understand was also the source of the Department's added language to this section.

Also, we continue to believe that additional clarification is necessary on Section K.1.(e) regarding the 1.75% threshold. The clarifying language we have submitted aims to make clear that the 1.75% threshold is applied when comparing the old PPS rate and the projected new PPS rate.

We appreciate the continued dialogue the Department has provided on a matter that is of great importance to our respective memberships. As you know, because we still differ on several of the underlying principles and policies for the proposed SPA, we and our individual members reserve the right to continue to challenge such policies and their implementation.

Should DHCS have any further questions, please contact Andie Patterson, CPCA's Director of Government Affairs, at apatterson@cpca.org or CAPH's VP/General counsel Richard Rubinstein at rrubinstein@caph.org.

Regards,

Andie Patterson, MPP
Director of Government Affairs
California Primary Care Association

Richard Rubinstein
Vice President, General Counsel
California Association of Public Hospitals and Health Systems

DISCUSSION

Date: April 11, 2018

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 with DHCS. These meetings are also an opportunity to strengthen our relationship with DHCS and clarify commonly asked questions.

II. Issues

Dental Educational Material (MIP Audits)

In 2016, twelve federally qualified health centers (FQHCs) in California were part of a CMS Medicaid Integrity Program (MIP) audit. MIP audits are conducted by CMS in partnership with each state Medicaid department with the goals of identifying any overpayments and decreasing inappropriate Medicaid claims. CPCA and the impacted FQHCs had significant concerns regarding the process and outcomes of the audits which led to a successful advocacy push to pause the audits. CMS concluded that while the audit findings were fair, they decided to not use an extrapolation methodology, and that before continuing with any further audits in California DHCS would need to develop and disseminate educational materials consistent with state policy on the dental benefit. DHCS committed to engaging CPCA and our members in the development of the material.

Over the last year, CPCA has been following up with DHCS regarding the status of the FQHC dental education project and expressing our continued commitment to be part of the process. Recently, CPCA heard from Bruce Lim, DHCS Deputy Director of Audits & Investigations (A&I), who indicated that DHCS has developed a proposed action plan for the project and is waiting on CMS' feedback and approval before reaching out to CPCA and other appropriate stakeholders to work through their proposed plan. Although there is not a definitive date to start the conversation, DHCS is hoping it is within the next 90 days. As more information is known CPCA will share it with members and engage members in the process as the educational material is developed.

As a reminder, the resolution in 2016 from our negotiations with DHCS and CMS regarding the MIP audits included CMS directing the state to work with stakeholders on a plan, then educate providers across the state regarding the contents of the plan, and not engage in any further audits, for up to 18 months, until after education is provided. After that time however CMS may initiate audits, even of FQHCs that have already been audited, and extrapolation could be applied moving forward. The audits in the future would only look at visits post the education being delivered.

A&I Challenges

CPCA is aware that some health centers are experiencing individual challenges with A&I auditors and understands that it is often unclear what rules around rate setting, change in scope, and reconciliation are followed by A&I. A survey of the membership last year did not identify a pattern of issues, but rather clearly highlighted the high level of frustration members are experiencing. CPCA has had some initial conversations with DHCS about the concerns and they committed to working with CPCA and a small group of CFOs in addressing the challenges. The goal will be to agree on the rules and develop training for both A&I auditors and health centers to ensure the same message is conveyed.

The timing of these conversations was delayed by the SPA 18-003 but CPCA has pushed that the discussions commence immediately.

California Primary Care Association

ACTION

Date: April 26, 2018
To: 330 Committee
From: Meaghan McCamman, Assistant Director of Policy
Re: FQHC P4P Update

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. 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 and approved at the July 13, 2017 330 Committee meeting.

At the October 330 Committee Meeting, a motion was made and seconded for CPCA staff to share the 'FQHC incentive best practices' developed by the P4P workgroup, approved by the Board, and disseminated in the white paper. The Board of Directors directed CPCA staff to work with health centers, health plans, and IHA to move the industry toward meeting the standards outlined in the White Paper, and, once those best practices are implemented, the Committee would meet again to consider working with the state to promulgate guidance around FQHC P4P.

Update

Per the direction of the CPCA Board of Directors, CPCA has spent the seven months working with health plans and health centers to share the 'FQHC incentive best practices. We have been well-received, and it's our understanding that the health plans we have worked with – including Partnership, Anthem, Health Net, and Molina, have made or are making changes to their P4P programs to align with best practices. All health centers should be aware of their own P4P structures and should be working with contracted plans and IPAs to meet the best practice recommendations.

Meanwhile, the health center in San Mateo has filed a Writ of Mandate in the Sacramento County Superior Court, which will be heard on April 27, 2018. The Writ seeks to correct what San Mateo believes was an erroneous decision by the Administrative Law Judge in deciding that DHCS had the right to recoup San Mateo's P4P incentive payments, but will not offer any legally binding precedent on this matter unless and until the case is taken up to the court of appeals by one or both of the parties.

Finally, we have received word that A&I auditors currently reconciling 2014 cost reports have begun to cite the San Mateo decision in their findings, recommending that P4P payments be reconciled if they were not paid based on a direct link to cost savings or utilization reduction. While none of these findings have yet been finalized, CPCA has conferred with our attorney and the public hospitals' attorney regarding A&I's use of San Mateo in current audits and have recommended the following action:

Action

CPCA believes it necessary to commence discussion with DHCS regarding FQHC P4P. We no longer believe it is in the best interest of FQHCs to wait to have these discussions, as the San Mateo ruling is not the standard to which health centers should be held accountable and A&I is beginning to use it as a standard around the state.

CPCA proposes to work with the P4P workgroup, chaired by Ralph Silber, and advised by attorney Larry Garcia, to set an agenda and set of questions for the state in order to discern the most appropriate next steps for protecting health centers and their P4P arrangements. The goal of the work would be to set standards for moving forward, and to protect historic arrangements.

Resources

- CPCA's P4P White Paper
- Incentives FAQs
- San Mateo Memorandum of Points and Authorities in support of a Writ of Mandate

California Primary Care ASSOCIATION

DISCUSSION

Date: April 12, 2018

To: 330 Committee

From: Andie Patterson, Director Government Affairs

Re: Status of Payment Reform Work

MEMORANDUM

Overview

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. With the goal of introducing a new APM 2.0 in 2019, CPCA has been exploring the various concerns and issues related to payment reform with plans, the state, members, and NACHC.

Health Plan Engagement

We have discussed the situation with a subset of the health plans and have asked that they engage with us in planning for how to advance payment reform with FQHCs in a way that could be done through a state plan amendment. The small group being engaged up front includes Partnership, HealthNet and LA Care. This group met in March and will meet again in May.

The initial meeting and subsequent conversations have been positive. In summary, the health plans we have engaged want to continue working with us because they are interested in value with flexibility for patients and health plan spending, paying smarter, and a rational way to maximize FQHC capacity.

Health landscape issues identified include DHCS' focus on encounter data and their desire for specificity, as well as the complicating factors of data integrity challenges as the layers within the health care system increase. A number of issues to work on moving forward included:

1. Build on IHA's development of **common measure set**
2. Continue the work to **improve and strengthen Data**
3. The need to **address SDOH (social determinants of health)**- and how to work with actuarial soundness principles
4. **Clarify current P4P** ambiguity for FQHCs in light of A&I issues
5. **Improve Care for High cost utilizers**
    a. CaliforniaHealth+ Advocates SB 456 particular important to this effort
    b. LA Care and Centene/Health Net to discuss co-funding a pilot; Partnership and some other plans already working with FQHCs in this area

The goal of working with a subset of plans is to secure a deeper buy-in to partnership, develop a few ideas in collaboration, and then invite a larger group of health plans to engage in the effort. In May the goal will

be to get closer to defining the subareas of collaboration and determine next steps for broader engagement.

New Concept and Payment Reform WG

The Wrap Cap WG has not yet commenced meeting in earnest as there is not yet a version of the APM 2.0 for conversation. The goal is to have a new concept ready in May to commence workgroup conversations with health centers.

NOTES

NACHC P&I 2018

CPCA Meeting with Jim Macrae, et al, HRSA

I. HRSA – Update on State of Affairs

- It was a long 2017 for us and we are sure for your team as well.
- We have a few questions to better understand how we can learn from the past year and how to best position the health center program for the future

⇒ Is there anything now in retrospect that we could have done differently or that you know now that would have helped the larger effort?

⇒ Has the cliff battle changed anything in how the program operates or expectations on the Bureau? On health centers?

⇒ How are you planning on allocating the resources that have been appropriated?

⇒ Can you share new developments since Azar has been confirmed and how it has or has not changed the direction and goals for HRSA?

⇒ Could you share with us your priorities? How can we best help the Bureau?

- Compliance issues:
    1. We have heard you speak about the importance of health centers being compliant. Can you say more about this? What specifically should we be focused on? Where is this pressure coming from?
    2. The OSV site visits are so rigorous and at present we don't really have a way of proving the value of these assessments.
        a. Has there been any thought to providing a Certification to health centers that pass? Much like NCQA certification.

NOTES:

Reflections on Secretary Azar and Federal Discussions

- He understands that 340B and Medicaid are important to health centers
- He really supported CHCs during his speech

340B

- To protect 340B at the federal level we have to argue:
    - That its allowing us to give access to health care to the underserved and uninsured
    - That it helps make us even better partners in combatting the opioid epidemic
- Azar wants to see those who have benefited rightly from the program continue, and the abuse to stop
- Main questions being asked about 340B
    - How does 340B translate to lower cost drugs for patients?
    - What are you doing with the money and can you prove it?
- Anticipate greater regulation on the program

- May come with state autonomy because right now the law is ambiguous

Health Center Funding

- To protect and secure health center funding we have to argue:
  - CHCs are a good investment
  - Quality is always important
  - Cost savings, cost savings, cost savings
- Yes we argued during the cliff about patients and jobs, but we need to talk more about what the system saves by leveraging us and what is lost if they don't invest in us
  - There is discussion about the CBO starting to score the health center program

Balancing law and needs

- Azar will be balancing Medicaid rules and 340B against state flexibility
- For Azar, following the law is really important

Compliance

- Federal Funding
  - Statute in the Balanced Budget Act will give them more ability to invest in CHCs to improve quality, like an innovation fund ($200M year 1, $400M year 2)
  - There will be $ for capital, but no details yet
  - Still working out details for what and when and how much per award
  - In the first year it will be an accelerator, but it isn't meant to be long term
  - Things they are thinking about: integrated BH, telehealth, care coordination
  - In order to get the budget deal they secured they had to agree to tighter level of enforcement and expectation of compliance. That is what the manual is all about.
- New rule
  - If you are found to have just 1 condition on your SAC award or OSV, you will only receive a 1 year project grant. If the next year you are found to just have 1 condition, you will again receive a 1 year project grant. If in the third year you have just 1 condition, you will not receive a grant at all.
- Conditions
  - Most of the conditions they find are in the OSV (80%), and 20% are in the SAC award. They are working to reduce those in the SAC which they believe can be done by streamlining guidance.
  - OSV is an open book test, but you have to study
  - HRSA working hard at standardizing everything they can and training the reviewers
  - Everyone is encouraged to do the satisfaction survey because the reviewer him/herself doesn't see, just HRSA staff.
  - HRSA wants to fix compliance so the conversation and effort can be focused on improving quality

II. Immigration

- The **anti-immigrant rhetoric** at the federal level has increased fear for our immigrant patients causing many to cancel appointments. According to a provider survey conducted by CPCA in collaboration with the Children's Partnership and funded by The California Program on Access to Care we found that:
  - Two-thirds of respondents observed an increase in families concerns about enrolling in Medi-Cal, WIC, CalFresh or other public programs, while nearly 40% stated that immigrant families have increasingly expressed interest in dis-enrolling in Medi-Cal, WIC, CalFresh or other public programs.

- 42% reported children in immigrant families were increasingly skipping scheduled health care appointments
- 38% stated that immigrant families were increasingly abstaining from scheduling routine prevention or primary care appointments for their children

- The Trump Administration has shown interest in broadening the definition of **public charge** to include public benefit programs, such as Medicaid, Children's Health Insurance Program (CHIP), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
  - This change would be devastating to immigrants and immigrant communities, increasing fear and anxiety that could ultimately deter many from accessing public programs for which themselves and their children are legally eligible for, regardless of whether they are directly affected by the policy change or not.
  - Would increase the uninsured population in Ca.
  - Changes to the public charge would require clinics to update their screening process / enrollment of immigrant patients into public benefit programs
  - CPCA and its members oppose any changes to the public charge rule
- CPCA and its members are very concerned that Congress has not taken action to protect the **DACA** program.
  - Providers have noticed an increase in anxiety and depression within our DACA patients who live under constant stress of not knowing if they will lose their ability to work and live in the United States.
- The Trump administration has increased immigration enforcement in Ca., causing a drastic increase of **immigration raids** in February. This combined with immigration debate has increased mental health issues in our immigrant patients. According to the survey we mentioned earlier, our findings revealed that:
  - 90% of providers stated that children in immigrant families experienced increased anxiety and fear due to detention and deportation
  - over 70% reported an increase in children experiencing symptoms of depression (such as feelings of sadness, sleeping problems, loss or gain of appetite, loss of interest in activities they used to enjoy)
  - Nearly 50% of respondents stated that immigrant children are increasingly being diagnosed with mental health conditions such as anxiety and depression, and almost a quarter said that parents are increasingly seeking mental health care for their children

- **CPCA has responded** to concerns from patients by:
  - Creating an Immigration Peer Network focused on providing CPCA guidance on how to respond to immigration policy on behalf of clinic staff and patients.
  - Developing FAQs and six sample policies and procedures, in collaboration with Feldesman Tucker Leifer Fidell LLP and the National Immigration Law Center (NILC), to help clinics prepare a protocol for how to work with law and immigration enforcement.
  - Developing an online immigration resource page, which is a compilation of the resources available for clinics and their staff regarding immigration, Know Your Rights, executive orders, legislation and much more.
  - Creating resources to help health centers inform patients of their rights, while also providing patients information about current policy changes impacting immigration
  - Developing webinar trainings

⇒ With the rhetoric around the United States not being a “country of immigrants” are there threats to the health center program and our mission to serve all that we need to know about?

⇒ What is the Bureau doing to protect our ability to serve everyone?
⇒ Is there any guidance forthcoming that you know of that would put restrictions on us?
⇒ What can the Bureau do to protect against the public charge threats?
⇒ Will patient information, including that of our immigrant patients, continue to be protected and not shared with Homeland Security?

NOTES:

- Impressed by the DACA figures reported in the room
  - Health Center A: 20% employees are DACA
  - Health Center B: 15% employees are DACA
- They had their lawyers review the guidance they issued back in '98/'99 related to FQHCs being a public benefit against the leaked public charge order and their lawyers maintain their position from two decades back that the health center program is not a public benefit.

III. 340B

State Budget

- As we shared in August we won our budget battle last year regarding 340B.
- You can imagine our dismay to see the proposal resurrected in the January 2018 Budget and that now its even worse than last years.
- The 2018 proposed budget seeks to eliminate the 340B program from Medi-Cal FFS and Managed Care.
- The state's rational is that they are complying with federal law, that duplicate discounts are too hard to prevent, and that they can secure a greater amount of rebate if there is no 340B program in Medicaid.
- Our attempts in the summer and fall to work with the state to create a system to better track went nowhere because the state appears to be immovable in their resolve to attain all the money they can from drug rebates.
- We have not provided any dollar figures to the state, as they have not scored the proposal in the budget, but we believe it could be $50-$100M hit to health centers alone if they were successful.
  - This hit would cause many health centers to:
  - Reduce clinic staff, eliminate services and end relationships with contract pharmacies.
  - Reduce case management and wrap around services, including paying for certain exams that patients are unable to afford. This could cause many patients to stop seeking care (lack of wrap around services could reduce health care visits).
  - Halt expansion of new sites in rural areas.
  - See an increase of waiting list for services and programs, since funding would be lost and in some areas there is no other provider of these services.
  - Postpone housing, medical, and dental clinic expansion and abort key quality improvement initiatives such as patient satisfaction efforts
  - End case management and care coordination
- We are working in collaboration with hospitals and consumer groups to fight the proposal
- This is our number one proposal to defeat this year. The impact to access is just too great to lose.

Federal

- The federal backdrop on 340B casts a shadow on our efforts however.
- We are aware of the dialogue and efforts 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?
⇒ Any signals from Sigounas or Azar?
⇒ How can we continue to participate safely?
⇒ Any advice as we continue our negotiations with the state?
⇒ If we lose the battle with the state, are there plans for how the Bureau or the federal government can help us mitigate the major loss of revenue?

Notes above

IV. Title X

- We have been hearing about Title X issues and that it could be affecting all Title X grantees in a negative way.
  - We understand that HHS missed putting out the Title X applications back in November and are just now releasing them.
  - Because the applications are going out now, the awards won't be given until September
  - Current Title X funding expires at the end of March which would leave a gap in funds between April - Sept when the new award kicks in.
  - We understand that the award won't reimburse the gap either.

⇒ Can you shed any light on this issue?

Didn't discuss

V. Behavioral Health

Opioids

- California is struggling to combat the opioid epidemic. The trifurcated system in which California has segregated the SUD and MH services and does not lend to deepened integration of physical and behavioral health.
  - CA received $90 million in the CURES act to develop a statewide response that focuses largely on building MAT infrastructure, like x-waivered providers and reimbursement. DHCS elected to invest in the Vermont Hub and Spoke model, which has mixed reviews; and admittedly hasn't been tested in a state as large as CA. Unfortunately, CHC's are not the focus of this model or the direct recipient of the funding. But, it does provide an opportunity to get to know partners in the care continuum that we otherwise would not have worked with (e.g. narcotic treatment programs).
- FQHCs are working hard to expand SUD services in general, but doubling down on MAT.
  - The HRSA SUD Expansion and AIMS grants were incredibly helpful as catalysts for MAT integration. They provided the start-up funds for training, and funding for otherwise unreimbursed services.
  - We appreciate the Bureau including questions in UDS about the rate of x-waivered prescribers. It helps the association to monitor progress.

- We have heard that the SAMHSA warm line and SAMHSA/HRSA Center for Integrated Health Solutions is helpful for T/TA resources.
- DATA 2000 x-waivers have increased throughout CA but CHCs are still challenged by arduous training requirements for MAT prescribers, especially for advanced practice clinicians.
- In the last year, CHCs have worked through initial concerns over how their MAT programs may/may not be subject to privacy regulations under 42 CFR Part 2.
- A few exemplary health centers are working with their managed care plans to identify the cost savings of a high functioning outpatient MAT program versus unnecessary utilization of other health services (e.g. ED admits) and are show a significant cost savings.

- We were successful in passing **SB 323**- our specialty mental health and drug Medi-Cal bill which will help strengthen health center ability to offer a range of behavioral health services, which will expand the ability of FQHCs to work in SUD
- This year we are sponsoring legislation that would allow **same day billing** for primary and behavioral health care services. The inability for same-day visits is the biggest barrier to a sustainable CHC MAT program.
- Another big barrier is being able to protect funding associated with care coordination **services provided outside of PPS** that support care coordination or care management. MAT programs rely on robust care management strategies that are often provided outside of PPS. CPCA is sponsoring legislation this year to clarify that providers may keep these funds (SB456).
- CPCA also sent comments to the President's Commission on Combating Drug Addiction and Opioids Crisis Interim Report.
  - Specifically, our comments sought to address the recommendation that would have forced all physicians, PAs and NPs to obtain an X-waiver to prescribe buprenorphine for opioid treatment.
  - Mandating this training would likely not have the intended effect and would:
    - Extend the providers time away from patient care;
    - Provide a barrier to effective recruitment efforts, especially for the rural communities who have been hit hard by the opioid epidemic.
  - Additionally, providers are currently allowed to provide buprenorphine for pain management without an X-waiver and this discrepancy would create.
  - Are recommendation for the Commission was to remove the X-waiver for providing buprenorphine for MAT, or to greatly reduce the amount of training requirements.

Questions:

⇒ Is there any movement federally around the X waiver being eliminated or the requirements being drastically reduced? Especially for mid-level licensed providers who are subject to 3 times the required training burden?

⇒ The president has indicated a willingness to invest in the opioid epidemic. Is HRSA expecting to expand programs again under this new potential funding stream?
  - Any advice for how we can best position ourselves to secure the resources?
  - Has the administration highlighted any programs which they plan on championing?

⇒ There are numerous legislative proposals at the Federal level, including at least one which would increase funding for MAT services. Has HRSA been involved in these conversations and is it possible to highlight the benefit that health center participation in these programs brings for the safety net population?

NOTES:

- Heard the concern about the X waiver being too onerous, but shared it was really hard to get the NPs and PAs as authorized and they think the extra training requirement is what helped get the policy decision across the line.
- Encouraged us to keep data to show that the extra training is not necessary and its hampering treatment (as we are arguing).
- They are working on getting some of the $3B for Opioids to go to health centers. No additional details.

V. Workforce

DACA

- Health centers are proud employers of DACA recipients, who help ensure health center patients, some of which are DACA recipients themselves, can be provided culturally and linguistically appropriate care.
- California is already experiencing a severe shortage of health care providers and any changes to current visa and work permit rules could further hamper health centers' ability to serve their patients.
- The loss of young DACA recipients will have a detrimental impact on California's health care workforce, and exacerbate the dearth of skilled, multi-lingual personnel.
- Revoking the ability of current DACA recipients to renew their deferrals would force health centers into the difficult and extremely costly position of having to fire productive employees only because of an arbitrary change in federal policy.
- This issue is a major concern for us and we are mobilizing and activating our advocates to fight for a path to citizenship. We want to see Congress create a path to citizenship for our Dreamers.

Teaching Health Centers

- We were very pleased that Congress recently reauthorized the Teaching Health Centers Graduate Medical Education Program (THCGME) through the end of Fiscal Year 2019 at double the prior annual appropriations level.
- We would like to stress the importance of allocating the newly appropriated funds expeditiously this month and in an amount that will sustain and expand training at Teaching Health Centers (THCs).
- The legislation provided sufficient appropriations for a sustainable level, like $157,000 per resident, which a HRSA-commissioned study showed to be a national average training cost for a resident.
- We also understand that HRSA requested and received results of a survey of THCs earlier this month that reflected a national average cost of roughly $161,000 with 84% of the THCs reporting.
- This year, so far, THCs have received funding at a wholly inadequate level annualizing to less than $80,000 while operating under Continuing Resolutions.
- Our THCs need a sustainable per resident amount (PRA) that recognizes these financial commitments and newly available resources.
- For this reason, we would like to have a discussion here today on:
  - ⇒ How will HRSA determine the per-resident allocation?
  - ⇒ What steps is HRSA taking to implement the new program requirements, particularly the expansion of new programs within centers and the creation of entirely new Teaching Health Centers, while emphasizing sustainable funding?
- We are aware that HRSA will put together a small committee of THCs who will be involved in a THC cost analysis early next year. We hope that California can be a key player in this Committee and contribute to this critical work.

NOTES:

- Questions about what the per resident amount will be.
    - CPCA arguing for $158K.
- HRSA still hasn't decided but will be soon.
- They want to see more data by state, and over time about the amount really is.

Geriatrics

- Our patient population is getting older.
- We know this will happen at an increasing rate in the near future but our system is not prepared for it.
- In California, a foundation led California Future Health Workforce Commission is now meeting to help provide direction to California's state leadership on workforce solutions in the areas of primary care and prevention; behavioral health; and geriatrics.

⇒ What has the Bureau been thinking about this coming change?

⇒ A few proposals to consider are funding specifically to build or expand geriatric programs with competencies needed for new models of care.

⇒ Also loan repayment for geriatricians would be very helpful.

NOTES:

- Agreed there needs to be a bigger focus on elderly
    - Just funded their first NCA for the elderly- Harbor.

Telemedicine/ UDS

- The UDS 2017 reporting instructions say only to count visits and that telemedicine, except BH telemedicine, is not a visit
- Many health centers are actively using telemedicine for all types of visits.
- We all know that the health system is moving to be more electronic, so why would we not be encouraged to expand our capacity to do so?

⇒ Can we eliminate this provision and report telemed visits?

NOTES: HRSA is working on this.

CALIFORNIA'S PROGRESS

- CPCA continues to dedicate increased resources to address the critical workforce needs of our membership.
- 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,
    - Participants representing academia, educational institutions, provider associations, health centers, health plans, health system, and the public sector continue to engage in robust conversations on developing long-term policy solutions to address industry-wide primary care workforce needs.
    - We share a strong commitment to diversify and grow all levels of the care team as a way to ensure that the primary care workforce better reflects diverse and underserved communities.
    - 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. And another meeting in November.
- Coming out of these meetings, CPCA staff are now working to identify how this group can work together to advance workforce legislation and strategy that relates to educational equity; residency; and primary care incentives.

VI. STATE ISSUES

STATE PLAN AMENDMENT

- We continue to work through PPS and SPA issues with the state.
- As you may recall we have been in discussions with them about this since Dec 2016.
- The SPA we are working through together includes an array of issues including: productivity standards, MFTs as billable providers, change in scope, and four walls.
- It thankfully no longer includes administrative caps or executive compensation.
- The process we used was to go one issue at a time, and we made it comprehensively through a few but unfortunately only a few weeks to discuss change in scope and 4 walls.
- In terms of process the SPA will be submitted to CMS at the end of March to be effective January 2018.
- Overall we really appreciate the state's willingness to engage in such a prolonged conversation on many of these issues, rather than just issuing the draft and getting our comments within 30 days as is required.
- That said there is a very real and palpable tension at play.
- Health centers experience A&I to be very antagonistic and feel that they are making up rules left and right, and the SPA language reinforces the scrutiny and limitations the state seeks to impose.
- Particularly challenging for health centers are the limitations suggested for how visits outside of the four walls can be done.
- Health centers feel terribly constrained by the language proposed in the SPA and are concerned by the restrictive direction DHCS appears to be heading.
- We will be submitting comments in greater detail outlining the array of concerns.

SPONSORED LEGISLATION

- We have four bills this year:
    - Assembly Bill 2428 (Gonzalez-Fletcher) Consolidated Licensing
    - This bill will allow a health center that moves to full time and wants to be licensed under a campus license to use the PPS rate of the original site.
    - Particularly important because rate setting and PPS has becoming so challenging with the state.
    - Assembly Bill 2576 (Aguiar-Curry) Declared Emergencies
    - In partnership with Redwood Community Health Coalition (RCHC), Advocates is co-sponsoring comprehensive legislation that builds on the lessons learned from the 2017 fire season. In particular, this bill aims so address payment for telephonic visits, payment for care provided at alternative locations, and permitting issues.
    - Senate Bill 1125 (Atkins) Same Day Billing

- In partnership with the Steinberg Institute, Advocates has moved forward with reintroducing Same Day Billing legislation.
- We are doing this bill again because we see an opportunity to partner outside of the health center system, there is a raging opioid epidemic, and a greater appreciation for the intersection of primary care and mental health services.
- Senate Bill 456 (Pan) Care Coordination
- We continue to work on this bill that will help ensure health centers can deliver services not captured in PPS but that help patients be better served by the system, and protects the additional payment from reconciliation.

PAYMENT REFORM

- CMS unfortunately concluded a Waiver was necessary to implement the APM in CA
- And CPCA has elected that we should not pursue using a waiver at this time
- The APM pilot as constructed through SB147 is thus not moving forward at this time because the state is not willing to make changes that would allow it to move forward using a SPA (essentially the risk triggers would have to be dropped)
- CPCA remains committed to this endeavor
- We are actively working with the health plans on solutions, as well as our partners at the Public Hospitals and intend to bring forward new proposals to the 2019 Administration in California

VII. Administrative Issues

Compliance Manual

- Going really well! Your hard work has paid off.
- The grantees have shared that the Manual has helped to eliminate the gray area in terms of what the requirement is and what meets the definition of complying.
- In conjunction with the Site Visit Protocol, grantees are able to self-assess compliance and use the checklist to ensure all of the required elements in place.
- Big huge thank you for standardizing the documents that are required to be reviewed as part of the OSV (this has always been a moving target and is no longer).

⇒ We would like to request that a simpler method be created to change an address however. What can be done?

Didn't discuss

Immunization Measure Change

- The new immunization measure has been challenging to meet.
- We understand it was changed to align with CMS but the way its being applied feels unfairly penalizing.
- We get harmed by having a patient under two without immunizations but we cannot control where they were before being at the health center.

⇒ Can we amend the measure to allow for "catch up" schedule and/or (2) allow us to reset our targets to be more realistic with the updated guidelines?

NOTES: Challenge is they are conforming to CMS. Appreciated the feedback.

HCCN ROI Justification

- HCCNs were asked to submit a 3:1 ROI justification.

- We understood it was to be the first of a 3 step process each getting more detailed and involved.

⇒ What has come from that?
⇒ Leasons learned?
⇒ Was that helpful?
⇒ Are the subsequent 2 steps still forthcoming?
⇒ Did that satisfy the administration?
⇒ Is more expected?

Didn't discuss.

California Primary Care ASSOCIATION

INFORMATION

Date: April 26, 2018
To: 330 Committee
From: Emily Shipman, Senior Program Coordinator
Re: Bipartisan Budget Act of 2018: Section 330 Statutory Changes

MEMORANDUM

Background: Bipartisan Budget Act of 2018 Contains Numerous "Tweaks" to Section 330 Statute. While many of the changes simply "clean up" the statute (e.g., eliminate outdated authority, make the statute mirror actual BPHC practice), there are some policy changes, including:

Limited Project Periods for Grantees with Outstanding Award Conditions
When HRSA determines that a health center is not demonstrating compliance with one or more of the Health Center Program requirements, a condition(s) is placed on its Notice of Award/Look-alike Designation. Moving forward, grantees with an active condition on their award at the time of their Service Area Competition (SAC) application will no longer be granted full 3 year project periods, but instead will be renewed for 1 year only. If outstanding award conditions remain at the end of the 1 year period, the grantee will lose eligibility to continue receiving health center program funding. BPHC has shared that they intend to provide grantees ample time before their next SAC in order to address existing conditions. Grantees should refer to the Health Center Program Compliance Manual for the detailed progressive action process and how to resolve conditions prior to the SAC in order to avoid this penalty.

Requirement for Direct Employment of Health Center CEO/Project Director
The law now requires a health center to directly employ its Chief Executive Officer (CEO)/Project Director (Section 330 (k)(3)(H)(ii)). HRSA anticipates releasing an updated Compliance Manual and compliance-related tools (i.e., Site Visit Protocol, Conditions Library) to align with statutory changes by July 2018. HRSA will begin assessing compliance with this new requirement through fiscal year (FY) 2019 Service Area Competition applications and operational site visits occurring after release of the updated Compliance Manual. HRSA encourages all health centers that do not directly employ their CEO/Project Director to begin any necessary changes in employment arrangements in accordance with this statutory requirement.

Requirement for Written Policies & Procedures Related to Use of Federal Funds
The law now requires a health center to have written policies and procedures in place to ensure that all Federal funds are being used in a manner that complies with all Federal

rules (Section 330 (k)(3)(N)). The SF-424 Two-Tier Application Guide for the Section 330 grant, pages 31 through 37, describes the legislative mandates (12 in total) that must be developed into policies and procedures: salary limitation; gun control; anti-lobbying; acknowledgement of federal funding; restriction on abortions; exceptions to restriction on abortions; ban on funding human embryo research; limit on use of funds for promotion of legalization of controlled substances; restriction on distribution of sterile needles; restriction of pornography on computer networks; restriction on funding ACORN; and confidentiality agreements. Please contact CPCA for sample policies.

Changes to Section 330 Statute Included in Bipartisan Budget Agreement of 2018
Monday 2/12/18

Preserves key programs while eliminating outdated language:

- Makes no change to the Loan Guarantee Program for buildings (which is based in Title XVI.)
- Eliminates loan guarantees for networks and managed care plans, which have not been used since the 1990s. *See former subsection (d).*
- Retains the authority for HCCN grants at (e)(5)(B), and expands the list of activities which are explicitly named as allowable uses of HCCN funding (*see subsection (e)(1)(C)).*
- Eliminates HRSA's authority to support managed care networks and plans, which has not been used. *See former subsection (c)(1)(B).*

New Access Point (NAP) and Expanded Service (ES) Awards: *Subsection (e)(6)*

- Gives HRSA explicit authority to make NAP and ES awards.
- Requires applicants to demonstrate that they "consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site." *Subsection (k)(2)(D)*
- For NAPs, permits (but does not require) HRSA to:
    - consider Service Area Overlap, and/or
    - give priority to applicants who propose to serve sparsely populated areas and areas with relatively high unmet need.
- Gives NAP awardees 120 days from the date of award to submit a implementation plan that complies with all 330 requirements.
- For ES, permits (but does not require) HRSA to give priority to applications that address emerging public health and behavioral health issues, including substance use disorders.

Requires all health centers to:

- Employ their CEO directly. *Subsection (k)(3)(H)(ii)*
- Have written policies and procedures in place to ensure that all Federal funds are being used in a manner that complies with all Federal rules. *Subsection (k)(3)(N)*

Requires HRSA to:

- Reduces from two years to one year the maximum project period for new awardees who do not meet certain Section 330 requirements *Subsection (e)(1)(B)*.
- Limit spending on T/TA activities (both HRSA activities and those provided via cooperative agreement) to 3% of total Section 330 funding. *Subsection (l)*
- Limit waivers to audit requirements to a maximum of one year. *Subsection (q)(4)*
- Report additional data to Congress each year, such as the urban/rural breakdown of funding, and the amount of unexpended funding in the Loan Guarantee Program. *Subsection (r)(3)*

Explicitly permits (but does not require) HRSA to:

- Consider a health center's sustainability plans when making supplemental quality awards. *(d)(2)*
- Give grants for "innovative programs" targeting homeless veterans. *Subsection(h)(1)*

Provides additional $25 million for FY2018 for health centers to participate in NIH's Precision Medicine Initiative. *Subsection (r)(5)*

California Primary Care ASSOCIATION

INFORMATION

Date: April 10, 2018
To: 330 Committee
From: Emily Shipman, Senior Program Coordinator for Health Center Operations
Re: OIG Announces Review of Grantees Receiving Multiple Grants from HHS

MEMORANDUM

In March 2018 the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) announced that it will review select grantees receiving HHS grant funding from multiple sources. The review will determine whether the selected grantees are allocating and claiming costs in accordance with Federal requirements. The review was added to the OIG's Work Plan.

Grantees must maintain financial management systems that contain written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with applicable Federal cost principles and the terms and conditions of the award (45 CFR § 75.302(b)(7)). Grantees also must maintain accounting records supported by source documentation (45 CFR § 75.302(b)(3)) and financial management systems that provide for accurate and complete disclosure of the financial results of each project or program sponsored by HHS (45 CFR § 75.302(b)(2)).

Along with the review of grantees, the OIG will also review the procedures in place for HHS oversight and coordination between various grant programs.

The OIG has not announced how many grantees will be subject to this review. The OIG expects to issue various reports in FY2019. View the OIG's Active Work Plan Items.

Health Center Program Requirements

Health Center Program grantees should refer to the following Health Center Program Compliance Manual chapters (https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf) for requirements pertaining to the use of Federal grant funds as well as health center program income, and required financial management and accounting systems:

- Chapter 12: Contracts and Subawards
- Chapter 13: Conflict of Interest
- Chapter 15: Financial Management & Accounting Systems

INFORMATIONAL

Date: April 12, 2018

To: 330 Committee

From: Andie Patterson

Re: Legal Update: Retrospective Dental Claims Litigation

MEMORANDUM

A date for oral argument before the court of appeals in the retrospective claims litigation has been set for May 22, 2018, at 9:30 a.m. in Sacramento. The hearing is open to the public. Each side will have 15 minutes to present its case and answer questions from the three justices on the panel. A copy of the notice from the court is attached.

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 issue a decision (approximately August 20).

Resources

- Judgement: https://d3n8a8pro7vhmx.cloudfront.net/capca/pages/2108/attachments/original/1523564627/Judgment.pdf?1523564627