330 Committee

October 2, 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	• July 2018 Minutes	Louise McCarthy	A
IV. SPA Negotiations	• Memo: SPA(s) Status Update and Next Steps • DHCS 4-Walls SPA Updated Final Draft • Aggregated Member Feedback on 4 Walls SPA • CMS response to pending SPA 18-003 • CPCA comments on SPA 18-0032 • Planning for Billing for MFTs FAQ	Ginger Smith Andie Patterson	D
V. Pay-for-Performance	• Memo: Status Update	Andie Patterson	D
VI. A&I Challenges	• Memo: Status Update • Escalation Strategy with auditors	Andie Patterson Ginger Smith	I
VII. MIPS	• Memo: Process to respond to state	Meghan Nousaine	A
VIII. Payment Reform	• Memo: Status Update	Andie Patterson	D
IX. Legal Update: Retrospective Dental Claims Litigation	• Memo: Legal Update	Ginger Smith Andie Patterson	I
X. HRSA	• Notes: Meeting with HRSA August 25	Andie Patterson	I
XI. Adjourn		Louise McCarthy	A

California Primary Care Association

Executive Summary

Date: September 18, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

SPA

- On March 30, 2018 the state submitted SPA 18-003 for approval and CMS responded officially June 11 with comments. DHCS commenced discussion but the SPA and how it will ultimately looks is still unknown.
- CPCA has continued to engage on the SPA 18-003 regarding matters we continue to disagree with. CPCA, in partnership with CAPH, submitted a letter outlining our legal arguments as to why the state's amendments regarding change in scope were not consistent with state and federal law. We continue to push for a meeting with the DHCS attorneys.
- The 4 walls SPA discussion with DHCS is underway. CPCA have aggregated pages of feedback for the state and every three weeks we meet to review.
- CPCA with member input has crafted a 4 walls SPA that we believe is appropriate.
- DHCS submitted SPA 18-0032 to CMS on June 29, 2018 to authorize PPS reimbursement for services performed by qualifying Teaching Health Center Graduate Medical Education (THCGME) Primary Care Resident Physicians at participating FQHCs and RHCs.
- CPCA submitted formal comments on June 29, 2018. The SPA is still pending CMS approval.

P4P

- On April 27 the Superior Court of Sacramento denied a Writ of Administrative Mandate filed by the County of San Mateo FQHCs, which upheld the decision that DHCS auditors were correct in including the San Mateo incentive payments in the reconciliation.
- CPCA has advocated to DHCS to stop the recoupments and DHCS has confirmed that A&I auditors have been instructed to stop including quality payments/P4P payments in annual reconciliations, until DHCS policy has been finalized.
- CPCA is supporting Assemblymember Wood's efforts through AB180 to protect FQHCs' rights to P4P, and is primed to work with DHCS on appropriate guidelines.

A&I

- Per the challenges with A&I auditors, CPCA and a small group of CFOs have commenced a process to work through the challenges and find agreeable solutions. Two meetings have already been conducted and many more are in process.
- Working with A&I a roadmap for escalating issues within A&I has been circulated to members.

MIPS

- Between the end of 2016 and August 2018, California Department of Healthcare Services (DHCS) did not engage CPCA or our health centers in this work regarding the development of "educational materials". We remained concerned about the provision stipulated by CMS regarding "consistent with state policies" as one of our main issues was that there are no clear policies regarding clinical care nor provision of services.
- As of late September 2018, DHCS reached out to CPCA requesting comments on what we believe are the CMS required "educational materials" in the form of updates to their *PRIHD Provider Manual Dental Handbook*.
- CPCA staff responded to their outreach with a request to meet and discuss in person thru an iterative process similar to the process we've undertaken with the State Plan Amendments in 2017 and 2018.
- The proposed plan of action includes: Meetings with DHCS with small member workgroup; all member update webinars and comment periods; and legal review and guidance.

Payment Reform

- CPCA has determined that we will pause on the APM 2.0 concept until after we try working on the already approved APM with the new administration coming in the next few months.
- There is still a desire for reform but an interest in first leveraging the work already done.

Legal Update: Retrospective Dental Claims Litigation

- On June 19, the Court of Appeal for the Third Appellate District has affirmed the decision of the Sacramento County Superior Court granting the health centers' writ petition directing the Department to follow its procedures to process and pay the retrospective claims.
- We are working with the State on a process to bill for past claims.
- At this point the State is contending non-named plaintiffs cannot be paid for past claims.

HRSA Update

- CPCA staff and members met with HRSA leadership in August during the NACHC Community Health Institute.
- The meeting talking points and notes from the meeting are included. Issues covered ranged from 330 federal rule requirements to California 4 walls issues.

CALIFORNIA PRIMARY CARE ASSOCIATION

330 COMMITTEE
July 12, 2018
1:00pm-2:00pm

Members: Louise McCarthy – Chair, Robin Affrime, Doreen Bradshaw, Linda Costa, Maximiliano Cuevas, Deb Farmer, Rachel Farrell, Rosa Fernandez, Ben Flores, Tim Fraser, Cathy Frey, Naomi Fuchs, Alvaro Fuentes, Jane Garcia, Greg Garrett, Franklin Gonzalez, Chloe Guazzone-Rugebregt, Nik Gupta, Alicia Hardy, Sherry Hirota, Kerry Hydash, Constance Kirk, Becky Lee, Deborah Lerner, Marty Lynch, Kevin Mattson, Scott McFarland, Nichole Mosqueda, Anitha Mullangi, Danielle Myers, Christine Noguera, Rakesh Patel, Courtney Powers, Joanne Preece, Carole Press, Lucresha Renteria, Tim Rine, Gary Rotto, Corinne Sanchez, Graciela Soto-Perez, Deanna Stover, Terri Lee Stratton, Mary Szecsey, Sabine Talaugon, Vernita Todd, Henry Tuttle, Christina Velasco, David Vliet, Christy Ward, Tony Weber, Anthony White, Paula Zandi

Guests: Dolores Alvarado, Harold Carlson, Burt Margolin, Karen Lauterbach, Sabra Matovsky, Raphael Irving, Chad Vargas, Krista Kazhe, Melissa Eidman, Yamilet Valladolid, Laura Sheckler, John Price, Maria Paz, Meryl Schlingheyde

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Meaghan McCamman, Ginger Smith, Emily Shipman, Victor Christy, Jana Castillo, Liz Oseguera, Meghan Nousaine, Nataly Diaz, Christina Hicks, Beth Malinowski, Michael Helmick

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 with the exception of adding Corporate Practice Agenda from Kevin Mattson if time allows (however it didn't). **The motion carried. (D. Myers, N. Gupta)**

III. Approval of Minutes
A motion was made to approve the minutes of April 26, 2018. **The motion carried. (D. Myers, N. Gupta)**

IV. DHCS Challenges
There are a number of matters with DHCS that all combined are creating a very challenging environment for health centers. CPCA is dealing with each matter individually but is aware that all of the matters overlap and influence each other, and thus CPCA is reviewing them all comprehensively together to build an appropriate strategy.

V. SPA Negotiations
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 and CMS responded officially June 11 with comments. DHCS has 90 days to respond to the feedback. CPCA has continued to engage on the SPA 18-003 regarding matters we continue to disagree with. CPCA, in partnership with CAPH, submitted a letter outlining our legal arguments as to why the state's amendments regarding change in scope were not consistent with state and federal law.
CMS responded to the SPA 18-003 with a number of issues. CPCA met with the state on July 2nd to discuss the CMS letter, but DHCS had no analysis or reaction to the CMS response or our legal letter on CSOSR other than to say they are reviewing all of it and will be responding to CMS within 90 days-which would be around September 11. The first discussion on matters of 4 walls for a DHCS projected SPA in October 2018 is scheduled to take place in early July.

VI. Pay-for-Performance
CPCA has advocated to DHCS to stop the recoupments and DHCS has confirmed that A&I auditors have been

instructed to stop including quality payments/P4P payments in annual reconciliations, until DHCS policy has been finalized. CPCA is lobbying to be engaged with DHCS during the policy development process. CPCA's legal counsel has advised that providers must cooperate with requests for information during audits as part of the Conditions of Participation in the Medi-Cal program.

VII. DHCS Update

DHCS has confirmed that FQHCs/RHCs cannot bill for MFT services until they receive federal approval from CMS. SPA 18-003 was submitted to CMS on March 30, 2018 and included the reimbursement of MFT services. Per the challenges with A&I auditors, CPCA had a meeting with DHCS about the concerns and DHCS has committed to working with CPCA and a small group of CFOs to address the challenges. CPCA will be working with A&I to develop a roadmap for escalating issues within A&I and identify and agree on the rules of the top 10 challenging areas and then provide training. CMS provided DHCS A&I with direction that they can no longer require a FQHC/RHC to rebase the site's PPS rate due to a relocation.

VIII. Payment Reform

CPCA has officially put forward the framework for an APM 2.0 proposal. The Payment Reform WG is meeting 1 x a month to work through the idea, and three health plans are also engaging with the aim of helping to create a few viable models to further vet in the fall with a greater number of a health plans. Assuming a viable model, CPCA is positioned to work with CaliforniaHealth+ Advocates to introduce legislation on an APM 2.0 in 2019.

IX. HRSA Update

Legislative Mandates restricting use of 330 Federal grant funds have been announced via Bulletin Number 2018-04; sample policies complying with the mandates are available from NACHC. Unmet conditions at SAC award can result in project periods being shorted from 3 years to 1. Grantees should ensure conditions are resolved prior to SACs. HRSA is exploring the feasibility of a developing and implementing a Service Area Needs Assessment Methodology (SANAM) that would automatically calculate the "need" of a geographically defined service area. This automated SANAM would replace the current manual Need for Assistance (NFA) section of the health center application.

X. Legal Update

On June 19, the Court of Appeal for the Third Appellate District has affirmed the decision of the Sacramento County Superior Court granting the health centers' writ petition directing the Department to follow its procedures to process and pay the retrospective claims. We are awaiting determination if the State will appeal, or if we can commence working on a process to bill for past claims.

XI. Adjourn

The meeting was adjourned at 2:01pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care ASSOCIATION

DISCUSSION

Date: September 19, 2018
To: 330 Committee
From: Ginger Smith, Director of Health Center Operations, Andie Patterson, Director of Government Affairs
Re: SPA(s) Update

MEMORANDUM

I. SPA on Four Walls

DHCS has shared that submitting a SPA on Four Walls in October is their number one priority. Recently we learned however that the October deadline is artificial and they have created it to ensure urgency and engagement on the subject.

Their intent with the Four Walls section is to provide clarity and to try and assure greater access. From their vantage there are many inconsistencies with how health centers approach and bill for visits outside of the Four Walls and the SPA is their attempt to ensure the rules are clear. When asked how they were approaching the SPA knowing that CMS indicated detail was not appropriate (via their informal feedback on the pending SPA 18-003), DHCS indicated the work was still valuable and they would find an alternate means of putting the clarity out to the field if its not accepted in a SPA.

The first official meeting between CPCA, CAPH, and DHCS on the drafted Four Walls SPA language was July 2, and there have been 4 additional meetings for a total of 5. Another meeting is scheduled for October and one the first of November. In between each of these meetings with the state, CPCA has held member webinars and has gone line by line through the 9 page SPA in order to secure feedback. All of the feedback has been shared with DHCS. CPCA has consistently requested health center participation in the meetings but to date the state has been reluctant. The state indicated that at the October 11 meeting they would welcome health center representatives. CPCA is looking to include members from the Executive Committee at that meeting and subsequent meetings.

In the meetings from DHCS are policy/finance staff as well as A&I representatives. For the most part the state takes notes and occasionally will ask follow up questions about process for how health centers conduct their care delivery. CPCA primarily provides feedback the whole time. All this to say, as of the time of this writing it is not clear how much progress we are making in terms of agreement.

In late September the state indicated they were working on a revised SPA and would share it at the end of September. In parallel fashion, CPCA has solicited our legal team to draft the Four Walls SPA as we envision it to be. We aim to have members review the language in advance of the board meetings, and will be sharing it with the state upon agreement from the members. While we are not confident the state will see the four walls issue from our perspective, we believe it is a more appropriate starting place to begin from where health centers agree rather than the opaque starting point the state introduced. Drafting the SPA as we deem it appropriate is also helpful when we engage the legislature as it clearly will articulates our position and focus on serving vulnerable populations.

In July we discussed a legislative strategy which included educating legislators via key contacts in the summer to tee up the goal of asking them to help us push back on DHCS regarding timing of the SPA later in the fall. Many health centers have been incredibly helpful in this work, and legislators are primed. CPCA staff had a briefing with key capitol staff on September 24 to continue working this strategy. Outcomes of the briefing and next steps will be shared verbally at the board meeting.

Discussion Questions:

1. Is the current strategy on the 4 walls SPA still the direction we want to go in?
2. There is a general legal argument that CPCA/CAPH have presented to the state that there should be no restrictions on Four Walls so a SPA is not necessary. Should we prime a legal case against the state?
3. Do we want to prepare legislation on Four Walls for January?
4. What else can we be doing to achieve our goals?
5. Other concerns not yet discussed?

II. Pending SPA 18-003 Process

CPCA and our partners CAPH, including the attorneys at Foley Lardner and Kathryn Doi on behalf of CPCA, have continued to push for further discussion with DHCS regarding the elements of SPA 18-003 we disagree with. Most principally we disagree with the amendments the state has made to Change in Scope of Service Requests (CSOSR). We firmly contend that the state's amendments violate state and federal law.

On June 21 the state shared with us the CMS response to the SPA submitted in March. The letter outlines in part what the state had shared already from preliminary conversations- that per CMS there is too much detail which is inappropriate for a SPA but allowed through a state administrative process. Our interpretation of CMS' letter is that they disagree with the state's attempt to limit CSOSRs. Further they appear to be requiring the development of an alternative payment methodology (APM) for MFTs and dental hygienists, as CSOSR are voluntary not mandatory. The state remains in informal dialogue with CMS about SPA 18-003 to determine next steps. DHCS contends they want the SPA as written.

There is no set date for when the SPA 18-003 has to be approved. The timeline on the SPA at this point has been paused so that DHCS and CMS can engage in informal dialogue.

Discussion Questions:

1. Is the current strategy (meeting with the DHCS attorneys to understand their legal basis for changing the CSOSR, lobbying CMS not to accept the changes, potential litigation) still the direction we want to go in?
2. What else can we be doing to achieve our goals?
3. Other concerns not yet discussed?

III. SPA 18-003 Issue with "Optional Benefits"

We found post DHCS submission of SPA 18-003 incorrect language that limits the chiropractic and podiatry benefits to only a certain group of beneficiaries. This language contradicts the CARHC case which established that chiropractic and podiatry services are not 'optional benefits' when provided by a FQHC or RHC. We raised the issue with DHCS and asked that they make the necessary updates to reflect that these services are not limited to the two groups listed. On July 2 and in recent meetings in August/September, DHCS shared they continue to review our concern but have no additional feedback.

Reference:
Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries:

- *Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy.*
- *Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit.*

IV. SPA 18-0032: GME/PPS

DHCS submitted SPA 18-0032 to CMS on June 29, 2018 to authorize reimbursement, under the Prospective Payment System (PPS) methodology, for services performed by qualifying Teaching Health Center Graduate Medical Education (THCGME) Primary Care Resident Physicians at participating Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Currently, services performed by primary care resident physicians at FQHC and RHC sponsored THCGME programs are not eligible to be reimbursed on a per visit basis. SPA 18-0032 will authorize reimbursement of services performed by qualifying primary care resident physicians, under the supervision of a teaching physician at FQHC and RHC sponsored THCGME programs.

SPA 18-0032 is still pending approval and if approved will be effective April 1, 2018. CPCA submitted formal comments (attached) to DHCS on June 29, 2018 after obtaining member feedback. Our letter requested that they broaden the coverage to any FQHC or RHC with an accredited ACGME-accredited program or continuity training site with the goal of extending this benefit to more of our members. We have had several calls with DHCS to vocalize our recommendations and share residency expertise, but are still unclear whether DHCS is incorporating our comments. Regardless, we will continue to engage with them to advocate for this expansion.

V. Resources

- Federal Guidance Related to Medicaid FQHC Payment and "Four Walls" Limitations
- CMS response to DHCS SPA submitted on March 30, 2018
- CPCA analysis of CMS Response
- 330 Memo: SPA Process and Next Steps- April 2018 https://www.dropbox.com/s/irvnmpzfjyez676/Memo-SPA%20Process%20and%20Next%20Steps_20180410.pdf?dl=0
- 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
- CPCA submitted edits to SPA (April18, 2018) https://www.dropbox.com/s/nz1uqvfc2nebn35/CA_SPA_18-003_withCAPH-CPCAedits.pdf?dl=0
- 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

California Primary Care Association

DISCUSSION

Date: October 2, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs
Re: FQHC P4P Update

MEMORANDUM

Overview

Earlier this year, a health center in San Mateo ultimately lost a series of appeals relating to whether their P4P incentive payments were properly included in the Medi-Cal PPS reconciliation. A Superior Court Judge upheld an earlier administrative decision that DHCS auditors were correct in including the San Mateo incentive payments in the reconciliation. The final decision held that FQHCs may exclude financial incentive payments tied to reductions in utilization or reductions in cost; they may not exclude financial incentive payments for increased utilization of preventive services or outcomes that are not tied to cost.

Because decisions of California trial courts do not serve as binding legal authority, the results of the San Mateo case do not set binding precedent for the treatment of incentive payments FQHC reconciliation. Unfortunately, however, some auditors within the Department of Health Care Services were using the decision to justify changing their policy around the treatment of incentives during reconciliation. Ultimately, CPCA was successful in getting confirmation from DHCS in writing that the director's office has directed A&I auditors to "*pause on disallowing quality payments or P4P payments from the annual reconciliations,"* essentially creating a moratorium on the inclusion of incentive payments in reconciliation.

Unfortunately, we understand that there approximately four or more FQHCs in the state who had their reconciliation audits prior to the moratorium and have had A&I auditors include their incentive payments in reconciliation. CPCA has been unsuccessful in getting resolution for those outstanding audits through DHCS. The unfortunate few are currently in the appeals process. As far as we know, only one FQHC – the San Mateo FQHC – has actually lost their incentive funds at this time.

Advocacy Strategy

We have developed a two-pronged advocacy strategy to address the larger issue of creating P4P guidance in partnership with the Department, and to support the clinics currently in appeal around their P4P incentives being included in reconciliation:

- ***Legislative:*** A health center who had their P4P incentive payment included in reconciliation worked with Assemblymember Wood to gut-and-amend one of his moving bill vehicles. The resulting bill, AB 180, was passed by the legislature and is on

the Governor's desk. The bill requires DHCS to work with FQHCs and RHCs to create guidelines regarding the treatment of incentive payments, and states that reconciliations that take place for years prior to the issuance of guidance, should be treated under the auspice of the broad existing federal guidelines – which exempts bonuses, risk pools, and withholds. It's our hope that this language will protect those health centers currently fighting their audits.

- ***Regulatory:*** DHCS has acknowledged that the treatment of incentive payments in reconciliation is an outstanding issue that needs to be corrected immediately. CPCA has revised the board-approved white paper into a letter outlining a series of recommendations and has submitted the letter to DHCS. We aim to work with DHCS and the health plans to finalize guidance and ensure that once it is approved and enacted, health centers and plans have ample time to appropriately craft their P4P programs.

Discussion Question:

1. In addition to the above strategy, are there other strategies CPCA should be pursuing to help protect past P4P and position health centers to be successful in the future?

INFORMATION

Date: September 7, 2018

To: 330 Committee

From: Andie Patterson, Director of Government Affairs; Ginger Smith, Director of Health Center Operations

Re: Audits and Investigation Challenges: Status Update

MEMORANDUM

A&I Challenges

In response to health centers growing frustration with DHCS Audits & Investigations (A&I) and the unclear rules auditors are using around rate setting, change in scope, and reconciliation, CPCA has been working with a small subset of CFOs and consultants on working through a process with A&I to understand the problem and provide solutions.

On June 28, 2018, CPCA along with the workgroup of CFOs and consultants met with DHCS' health care policy and A&I leaders. At the meeting, CPCA shared the concerns expressed by members, examples of the inconsistencies, and our recommended solution of agreeing on the rules to be followed and then training auditors and health centers. DHCS committed to working collaboratively with CPCA on our proposed solution. DHCS and CPCA agreed -on developing a roadmap for escalating issues within A&I and identifying and agreeing on the rules of the top 10 challenging areas associated with rate setting/change in scope and then provide the necessary training either by hosting webinars or creating frequently asked questions documents.

Escalation Process

In August, CPCA and health center CFOs met with A&I to continue the process. During this meeting we jointly finalized the escalation strategy (attached) which has been shared with individual health centers. The process should help to immediately relieve grievances for individual health centers who are stuck with an auditor and cannot find a solution, and it should also bring to light for A&I and CPCA patterns of behavior and inconsistency in rule application.

Top Challenges

We also commenced going through the top areas of challenge. Top issues identified include:

1. Incident to costs
2. Medicare imputation of revenue
3. Reasonableness criteria for cost allowability (leases, providers' salaries, etc)
4. Comparable sites for rate setting
5. Clear outline of situations where clinics have to submit a mandatory scope of service rate change request (pharmacy contracting, deletion of intermittent clinic etc)
6. Relationship of what costs are allowable on a rate setting cost report/scope of service rate change request to what gets reported on the PPS reconciliation

7. Trying to tie Trial balance or audited financials (accrual) to reconciliations (cash basis)

The first two covered include Incident to costs and Medicare Impute.

On **"incident to"** we raised that in many rate setting cases the health center experience is for A&I to exclude 100% of these costs - which we believe is inappropriate and not following Medicare Reasonable Cost Principles. This then ultimately leads to an informal hearing, after which point A&I adds many of the costs back in. The question to A&I was how do we set some standards of understanding to avoid the extra, unnecessary process. Jim Burkhardt, A&I Assistant Deputy, noted the section in the CMS publication 100-02, Ch 13, section 120, that auditors are told to follow which is the same section FQHCs follow but in our meeting with A&I we determined that there are areas in that publication that are subjective. We discussed developing appropriate parameters but agreed first that A&I would survey the various sections to determine their experience with "incident to" and most frequent challenges as a starting point. It was also noted that FQHCs need to do a better job of documentation for incident to services and charting. We will need to discuss efficiency, appropriateness and timeliness of what needs to be in a chart as much clinical judgment determines many of the encounters.

The next area of discussion was **"Medicare Impute."** In the experience we relayed, the Department wants the health center to add the Medicare revenue even though the FQ didn't receive that revenue. The department imputes revenue a health center did not receive using the Upper Payment Limits (UPL). We believe most FQs just accept this because the issue is complicated and they don't know how to argue but for those FQs with high Medicare, it ends up as a significant reduction in the receivable. We explained that Medicare doesn't cover 100% -which A&I agreed with- but we challenged how A&I can determine a figure with only the Medicare cost report and not also reviewing the health center data. A&I argued that the time to deal with the discrepancy is during the 15 day letter process, and when health centers do respond the issue is easily resolved. We acknowledged that this specific issue may go away with the UPL; however, we are concerned that setting G codes is challenging and further conversation with A&I is necessary. Health centers set G codes based on charges not on the maximum they can get.

Next Steps

The next meeting with A&I is on October 12. During that meeting we will continue to work through the first issues, address the next two on the list of top 7, and review trainings we believe would help ease confusion in the field.

Updates on progress are provided regularly to the CFO Peer Network. Issues not listed in the top 7 that members want to raise can be brought forward to Ginger Smith or Andie Patterson for inclusion in the dialogue with A&I.

Resources

Below are links to the proposals we are bringing forward to A&I on each of the top challenges.

1. Incident to costs
2. Medicare imputation of revenue
3. Reasonableness criteria for cost allowability (leases, providers' salaries, etc)
4. Comparable sites for rate setting
5. Clear outline of situations where clinics have to submit a mandatory scope of service rate change request (pharmacy contracting, deletion of intermittent clinic etc)
6. Relationship of what costs are allowable on a rate setting cost report/scope of service rate change request to what gets reported on the PPS reconciliation
7. Trying to tie Trial balance or audited financials (accrual) to reconciliations (cash basis)

DHCS Audits & Investigations (A&I) Escalation Process

August 2018

In an effort to standardize a process of communicating challenges and to more quickly resolve issues with the Department of Health Care Services (DHCS) A&I, DHCS and CPCA worked collectively to identify the path health centers can utilize to escalate issues within A&I prior to an informal appeal.

1. Health centers should attempt to address and resolve their concerns with the district office assigned auditor
    - Auditor should review the health center's permanent file and consult with previous auditors

2. If no resolution, the health center should contact the assigned auditor's supervisor.
    - A health center is advised to copy clinics@dhcs.ca.gov to keep a record of the matter

3. If the district office staff and health center are at an impasse, the health center will escalate their concern to Allison Clinton, FQHC/RHC Section Chief, Allison.Clinton@dhcs.ca.gov
    - FQHC/RHC Section Chief will assist in resolving and tracking the issues for identifying trends and internal A&I and/or industry training needs
    - Health center should copy CPCA, Ginger Smith, gsmith@cpca.org, in the communication for CPCA tracking purposes only

4. If the health center is unable to get resolution with the FQHC/RHC Section Chief, they can escalate to the FAB (Financial Audit Branch) Assistant Deputy, Jim Burkhardt, Jim.Burkhardt@dhcs.ca.gov

5. If the health center is unable to get resolution with FAB Assistant Deputy, they can escalate to the FAB Chief, Steve Gary, Steven.Gary@dhcs.ca.gov

6. Lastly, if the health center is unsuccessful with resolving their concern at all levels, they can contact the A&I Deputy Director, Bruce Lim, Bruce.Lim@dhcs.ca.gov

ACTION

Date: September 21, 2018

To: 330 Committee

From: Meghan Nousaine, Assistant Director of Health Center Operations

Re: Update on the Medicaid Integrity Program Audits & Educational Materials Development

MEMORANDUM

I. Background

Throughout 2015 and 2016, 12 federally qualified health centers (FQHCs) in California had either gone through a completed Medicaid Integrity Program (MIP) audit, were undergoing an audit, or were notified that an audit would be conducted with respect to their dental sites. For the five health centers with a completed audit, the sum being requested (in advance of the CMS resolution) for recoupment was over $20 million dollars. The primary main reasons provided by the auditors for the recoupments were that the FQHCs allegedly had excessive visits (not performing enough procedures in the same visit) or the visits did not meet clinical standards of care or were not medically necessary. In short, auditors were concluding that FQHCs in California were not performing enough services for patients in a single visit. These MIP audits were conducted by CMS in partnership with each state Medicaid department. The goal of the audits was to identify any overpayments and decrease inappropriate Medicaid claims. The audit company for California was Health Management Systems (HMS) out of Nebraska.

CMS shared with CPCA that in their review of the audits they concluded that the main reason for the denials was lack of documentation justifying the need for a visit. They also determined that because the audit process methods were fair they could move forward with the 12 audits in process, however without using the extrapolation methodology leading to such high recoupment amounts. CMS also shared that in order to enhance the dental program integrity, the state would be instructed to develop and disseminate educational tools that are consistent with state policies to dental practices, ideally by March 2017. For future audits, CMS committed to not engage in any further audits, for up to 18 months 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.

Between the end of 2016 and August 2018, California Department of Healthcare Services (DHCS) did not engage CPCA or our health centers in this work regarding the development of "educational materials". We remained concerned about the provision stipulated by CMS regarding "consistent with state policies" as one of our main issues was that there are no clear policies regarding clinical care nor provision of services.

II. Update

As of late September 2018, DHCS and the Medi-Cal Dental Division reached out to CPCA requesting comments on what we believe are the CMS required "educational materials" in the form of updates to their *PRIHD Provider Manual Dental Handbook*. CPCA staff responded to their outreach with a request to meet and discuss in person thru an iterative process similar to the process we've undertaken with the State Plan Amendments in 2017 and 2018. That process is described below.

III. Proposed Plan of Action:

It's our understanding that the edits and comments DHCS is requesting to their *PRIHD Provider Manual Dental Handbook* are the "educational materials" CMS directed them to produce with input from stakeholders. We will confirm this assumption at our first meeting. The next steps described below are predicated on that assumption. In order to assure the educational materials and expectations upon their release are feasible for community health centers across California we suggest the following plan of action.

1. In-Person Meetings with DHCS and Small Member Work Group: CPCA staff, along with a select number of health center dental representatives and ideally one Board Member will be meeting with DHCS regularly to discuss the materials, health center's overarching comments, suggested modifications, and the impact they will have on all community health centers in California. Our goal is to continue to meet with DHCS for as long as it takes to come to a resolution and finalized set of educational materials. The first meeting with DHCS is currently scheduled for Monday, October 1 2018.
2. All Member Update Webinars and Comment Periods: Additionally, CPCA staff will continually solicit feedback and provide on-going updates to all health centers on the evolution of the educational materials through various methods. Methods of communication will include: (1) regularly scheduled virtual meetings (webinars), (2) open comment periods through email, and (3) regularly scheduled meetings including the Dental Directors Peer Network meeting/s, CFO Peer Network meetings and quarterly committee meetings. The first round of comments solicited via email were due on Monday, September 24. Additionally, the first all member webinar is scheduled for Wednesday, October 17 following the October 1 meeting with DHCS.
3. Legal Insight and Guidance: CPCA staff have reached out to Kathryn Doi, JD who has agreed to participate in the all member calls and meetings with DHCS in order to provide feedback as requested.

IV. Requested Action

- ***CPCA staff request the following action be taken by the Board of Directors***

  To approve the outlined proposed plan of action for the development of the educational materials (at this time known as updates to the PRIHD Provider Manual Dental Handbook) related to the Medicaid Integrity Program audits.

California Primary Care Association

DISCUSSION

Date: September 13, 2018
To: 330 Committee
From: Andie Patterson, Director Government Affairs
Re: Status of Payment Reform Work

MEMORANDUM

Overview

The work on an APM 2.0 over the past six months has fostered important conversations with health centers and health plans. The survey conducted with the Payment Reform WG highlighted that there remains a strong desire for flexibility in how care can be delivered and how health centers are paid. However, the work to develop an APM is no small feat. CPCA and health centers have already invested extensive time and resources in APM 1.0; time and resources that should continue to be leveraged. The APM we developed and got signed by the Governor in 2015 is not the wrong APM, but the leadership in DHCS is not willing to make the necessary changes to enact it through a State Plan Amendment.

With a new administration coming in a matter of months, we have an opportunity. We are hopeful that there will be a new vision and commitment to partnership from the Governor and the appointees to HHS, thereby enabling us to make the requisite change to the APM (i.e. removing the risk triggers) and then moving forward with the APM for those health centers that volunteer.

Should we not be able to secure traction with the new administration, we will re-evaluate the APM and the opportunities to secure the flexibility health centers in California desire. For these reasons the Payment Reform Workgroup is on hiatus until we are able to reengage in conversations with the new administration in 2019.

Discussion Question:

1. Does the Committee agree this is the appropriate strategy to take?

California Primary Care ASSOCIATION

INFORMATION

Date: September 20, 2018

To: 330 Committee

From: Ginger Smith, Director of Health Center Operations; Andie Patterson, Director of Government Affairs

Re: Legal Update: Retrospective Dental Claims Litigation

MEMORANDUM

I. Overview

The superior court's decision in June expressly did not order the Department to process and pay any particular claim, to open the 60-day claim submission window for these claims, or to address the beneficiary eligibility information issue. Rather, the superior court directed the Department to follow its procedures to determine how to address your claims.

Accordingly, now that the court of appeals has upheld the superior court's decision, on September 13, Kathryn Doi and CPCA staff, Ginger Smith and Andie Patterson, met with attorneys from the Attorney General's Office and the Department to discuss and agree to an orderly process to address the eligibility information issue, the opening of the 60-day window, and a timeline for submission of the claims. The 60-day window will be triggered by actions of the court of appeal. For reasons explained below, it is anticipated that the 60-day window will open on or around October 17.

The meeting was productive and the beginnings of a process were established, part of which included the state sharing that they are developing an instruction sheet for health centers that will be submitting past claims. The next steps were for both sides to share additional information and for the Department to share the instruction sheet for health center consideration. Kathryn and Ginger had a call with the participating health centers on September 18 and provided additional feedback to the Department for consideration in developing the instructions.

II. Other FQHCs

The State contends that only the named plaintiffs in the case may submit and be potentially reimbursed for past claims. Any other health center that attempts to submit claims will have the claims denied.

It is our attorney's position that the writ does not limit the ruling to only the named plaintiffs. The State agreed to look at the issue again, however we are not confident they will change their position.

If the State declines to open the process up to non-plaintiff FQHCs and RHCs, the primary option being considered would be to ask the superior court judge to issue an order to show cause why the State should not be held in contempt to failing to comply with the court's order to process and pay FQHC and RHC adult dental, chiropractic, and podiatric claims for the period in question.

III. History

On June 19, the Court of Appeal for the Third Appellate District affirmed the decision of the Sacramento County Superior Court granting the health centers' writ petition directing the Department to follow its procedures to process and pay the retrospective claims. A copy of the decision is linked in the resources section below.

The opening paragraphs of the 25-page decision succinctly summarize the appeal and the court's decision on the issues:

> *Characterizing the Clinics' writ petition as a suit for damages, [the Department] contends (1) sovereign immunity bars the Clinics' claims for retroactive payment; (2) the CARHC decision is not – and cannot be – retroactive because the Medicaid Act is spending clause legislation and its terms were not sufficiently clear as to the requirement to cover adult dental, chiropractic, and podiatric services provided by the FQHC's and RHC's; and (3) retroactive relief violates the separation of powers doctrine because it forces the Legislature to appropriate money.*
>
> *We disagree with the Department's characterization of the Clinics' lawsuit. Rather than a suit for damages, the lawsuit seeks an order to compel performance of a mandatory duty and did not result in a money judgment. Under well-settled California law, such a mandamus proceeding is not barred by sovereign immunity. The Department's contentions based on spending clause legislation and separation of powers are new arguments raised for the first time on appeal. We exercise our discretion to consider only the spending clause argument. We reject it because the Department has not shown its obligations under Medicaid law, and determined by CARHC, came as a surprise. The separation of powers argument raises factual issues about appropriations that should have been presented in the trial court and we decline to consider this new argument.*
>
> *Accordingly, we affirm the judgment.*

The State chose not to appeal the court of appeal decision, although it has asked the California Supreme Court to depublish the decision. We have objected to the depublication request. The granting or denial of the depublication request has no bearing on merits but only affects the precedential value of the court of appeal decision.

In the meantime, although the State did not appeal the court of appeal decision, the California Supreme Court always has the option to grant review of any court of appeal decision on its own motion. The deadline for the Court to grant review is October 17. Neither party anticipates that the Court will grant review of the court of appeal decision. If the October 17 date passes with no action taken by the Court, the court of appeal will issue a remittitur to send the case back to the superior court. The remittitur is supposed to be issued "immediately." The issuance of the remittitur will trigger the 60-day window for the health centers to submit claims.

III. Resources

- Court Decision Affirming Judgment of Write: https://www.dropbox.com/s/xradsqrhq5crht4/COURT%20-%20DECISION%20Affirming%20Judgement%20re%20Writ.pdf?dl=0
- Judgment: https://www.dropbox.com/s/mi5r8mr435le6yt/Judgment.pdf?dl=0

Talking Points

NACHC CHI
August 25, 2018

CPCA Meeting with Jim Macrae, et al, HRSA

NOTES: Text in Red

I. HRSA – Update on State of Affairs

⇒ Can you share how Azar's leadership is influencing the direction of HRSA?
⇒ Any federal issues being prioritized we should pay attention to?
⇒ Anything we can do to be further supporting you and your team?
⇒ Any more work on compliance we should be prioritizing?

NA- due to a shortened meeting we jumped into the CA questions

II. Federal/ State Law Conflicts

- We continue to be challenged regarding the restrictions on how 330 dollars can be used, and then how to align these federal rules with state rules.
- In California the law requires comprehensive health coverage and yet we appreciate that the federal rules restrict certain provisions of this.
  ⇒ Does HRSA have guidance on the best approach for how to reconcile federal/state law when these situations occur?

Bureau staff Jim and Tanya did not know how to answer and believed restriction on how federal funds can be used is still confusing. They committed to looking into it further and circling back.

III. Workforce

Area Health Education Center (AHEC)

- Ten of the thirteen regional California AHEC sites are hosted by regional CHC consortia that are members of CPCA.
- Given the overlap in partners and missions, we continue to work closely with the CA AHEC to proactively plan the design and implementation of this new requirement.
- CPCA and CA AHEC developed a Memorandum of Understanding to support our collective workforce efforts.

- Throughout this past year, a major part of our ongoing collaboration has focused on implementing the AHEC Scholars Program.
- Together with our CHCs and academic partners, this planning process has brought to our attention multiple and significant challenges that may affect the success of rural and urban regional AHECs in the implementation of their respective programs.
- We submitted a letter to Luis Padilla, Sheila Pradia-Williams, and Lorener Brayboy on July 30th respectfully urging the HRSA's Bureau of Health Workforce to consider three key strategies that would help lead to a stronger AHEC Scholars Program in California:
    - Expand student eligibility beyond current limitations to include medical residents, nurse practitioner and physician assistant post-graduate trainees
    - Utilize AHEC fiscal bumps in the future or other funding available now to offset the increased unfunded costs of implementing and administrating the AHEC Scholars Program
    - Organize additional grantee webinars to provide guidance and share best practices
        - ⇒ How does HRSA intend to offset the increased implementation and administration costs incurred by the AHEC Centers to deploy the AHEC Scholars Program?
        - ⇒ Will new additional funding be available in the future to support this program?

Appreciated the concern and issues, and felt Dr.Luis Padilla who runs Bureau on Health Professions was in the best position to respond.
In regards to Teaching Health Center $$- the debate internally at the Bureau is whether to give out one time awards or ongoing and the cliff is looming.
CPCA will make sure to connect with Dr.Padilla about CA's recent THC investments and AHEC concerns.

Auto HPSA

- CPCA continues to be actively involved in NACHC's informal Auto-HPSA work group, which provides PCA and health center feedback to HRSA's Auto-HPSA workgroup via Colleen.
- One of the recent decision points we carefully evaluated as a group was the provider FTE default.
- Through collaborative work with NACHC, we increased national awareness of the issue surrounding percent of non-validated provider data and were able to find a way to input Medicaid Claims Data into the system. This contributed to the review of more than 98% of provider files, which were reported opened by HRSA.
- NACHC has been a tremendous partner in this effort to-date and we appreciate your collaboration with them.
- We also thank you for sending the initial impact analysis in late August to the state PCOs in advance of health centers receiving them.

⇒ While this will help the state PCOs evaluate any large issues, we would like to recommend that HRSA also send the statewide and national results of the impact analyses to the PCAs at the same time. In doing so, we can work closely with the state PCO to address any issues and update information as necessary for accurate results.

NA

CA Progress

- Since March 2017, CPCA has brought together cross-sector partners to identify and advocate for needed health workforce policy changes at the state level.
- This work is aligned with larger statewide efforts through the California Future Health Workforce Commission to develop a masterplan that will address the state's primary care, behavioral health, and geriatric workforce challenges.
- CPCA recently submitted a letter to advocate for strategies that support the development of the health center workforce and should be included in the masterplan.
- Our recommended strategies focused on ways we can increase the supply, diversity, and distribution of providers; align education and training with changing roles; strengthen recruitment and retention; and accelerate technology, process, and payment innovations.
- Two of our health center CEOs, Jane Garcia (La Clinica de la Raza) and Dean Germano (Shasta Community Health Center), sit on this Commission and will be able to advocate for their inclusion.
- CPCA also works closely with the Commission's staff, so we are excited to move these strategies forward and ensure that health centers have an active voice at the table.

IV. STATE ISSUES

STATE PLAN AMENDMENT - Pending SPA 18-003

- We continue to work through SPA issues with the state.
- As you may recall we have been in discussions with them about this since Dec 2016.
- The SPA work has morphed into 2 SPAs- one dealing with productivity standards, MFTs as billable providers, and change in scope, and a second SPA now related to four walls.
- We were successful in getting administrative caps or executive compensation caps removed from the first SPA, among other proposals we disagreed with.
- The first SPA was submitted at the end of the March to be effective January 2018.
- While we disagree on productivity standards the compromise we reached effectively helps to ensure all health centers will meet them and those with special populations will have an exception process to work through.
- An area we continue to disagree with the state on is Change in Scope. We believe their edits effectively are changing the law.
- CMS has responded to the state arguing too much detail and the state has until around September 11 to respond
- At this point the state is holding to the SPA they submitted and are pushing for it as is.

- Depending on what happens we may need to pursue a legal strategy regarding the Change in Scope changes.
    - ⇒ Could HRSA help us challenge the changes the state is aiming to make in regards to Change in Scope?

Endorsed our strategy and urged us to continue. They will be helpful in whatever ways they can.

STATE PLAN AMENDMENT – Discussion regarding SPA on Four Walls

- Due to our advocacy we were successful in having the state pull out the portion regarding four walls.
- We are now discussing that and it's the state's priority to submit a SPA specifically on four walls in October.
- They have messaged that the reason for this is twofold- 1) there is confusion in the field, 2) the clarity will help to provide more access
- There is a potential opportunity for health centers to have state approved services out of the four walls, but there remain a lot of challenges set up by the state in the original language.
    - ⇒ Does HRSA have a position on what is and is not allowed to be billed PPS outside of the four walls?

BPHC is working on the definition with the lawyers largely because of the need to make telehealth a bigger option.
As a part of this work they are re-examining the scope of project policy.
Both are a high priority and BPHC will keep in close coordination with CPCA.

V. Administrative Streamlining

- CPCA appreciated the opportunity to comment on the HRSA Administrative Streamlining and Burden Reduction RFI due in July.
- Our full comments were submitted on July 2nd, but today we'd just like to highlight the two most impactful suggested changes we were able to identify:
    - ⇒ Easing Budget Carryover – *What requirements are burdensome in the post-award process?*
        - The biggest area of opportunity for burden reduction is the unnecessary carryover requests required by 330 supplemental awards that are awarded across two budget periods. A supplemental award is issued, usually with a specific one year period that almost inevitably crosses over two 330 budget years. Work on the supplemental award is supposed to occur over the one year award period, however health centers are required to submit a carryover budget and justification, despite the fact that the grant was expressly awarded for a period that is longer than the 330 budget year and funds are being expended in accordance with the project timeline. This process unnecessarily creates

additional work for grantees, Project Officers and Grants Management Specialists alike.
CPCA recommends an automatic authorization for this type of planned carryover - we highly recommend that HRSA adopt the approach of SAMHSA, which is to allow automatic carryover.

Agree that they should allow automatic carryovers. The issue they have to contend with is that they don't want health centers sitting on lots of money because then its hard to argue that the money is necessary.

⇒ Expanded UDS Timeframe – *Should HRSA give health centers the option to begin populating their UDS data earlier than January 1?*

- It would be very helpful to have more time to populate UDS. However, because some UDS elements are not quantifiable until the close of the calendar year, providing an extended time to report post-January 1, would be more helpful than the Bureau's current proposal to allow health centers to populate earlier in the year.
  CPCA recommends an extended UDS reporting time frame, but the extension should be an extension of the deadline, opening January 1, and closing March 15 or later.

They are working on this. They believe they will be able to create more time and will make sure the extra time goes to health centers.

VI. **Immigration**

PUBLIC CHARGE

- We are anxiously awaiting the public charge proposed rule.
- We met with the OMB in July about our concerns and shared the attached fact sheet outlining the projected impact to CA health centers.
  - We estimate that we will see about 132,000 to 397,000 patients disenroll from Medicaid and become uninsured.
  - The growth in uninsured and loss of Medicaid revenue will create a financial loss of $74 million to $221 million per year in California's CHCs
  - This analysis solely considers the financial loss in Medicaid reimbursements and does not take into account the loss of other reimbursement from county health insurance programs.
  - The fiscal impact for health centers is likely to be much greater than the Medicaid losses estimated.
    - Research Methodology
      - Utilizing OSHPD data on reimbursement by payer, we determined that FQHCs, RHCs, and look-alikes receive an average of $189 per patient visit from Medicaid and average three visits per year, equaling $567 per patient per year. Community and free clinics average a reimbursement rate of $183 per Medicaid patient visits and average two visits per year, equaling $366 per patient per year.

- Aggregating those figures, we determined that the average annual revenue for Medicaid patients at a California's CHCs is $558 per year.
- According to the DHCS, approximately 17.4 percent of Medicaid enrollees are non-citizens
- we estimate that approximately 662,385 of our 6.5 million patients are non-citizens.
- For the purpose of this analysis we've used Migration Policy Institute's evidence-based numbers to assume that 20 - 60 percent of CHC non-citizen patients would disenroll from Medicaid (based on what happened in 1996 with PRWORA)

- We intend to aggressively push back against changes to public charge and have a communications and advocacy plan ready to go.

BPHC lawyers looked into this and have concluded that receiving care at a health center, using sliding fee or not, is not considered a "means tested public benefit."
The logic is that the grant goes to the health center, not a specific individual.

MENTAL HEALTH/ IMMIGRANT PATIENTS

- CPCA partnered with other organizations to release a policy brief titled, 'Emerging Health Needs of Immigrant Families in California,' which details the impacts of anti-immigration policies and rhetoric on the health of immigrant families.
- *Summary of Findings*
  - Overall, findings indicate that immigrant families are at risk for poor health outcomes.
  - Health Care providers reported that among children in immigrant families, they've seen a:
    - 90% Increase in anxiety and fear due to detention and deportation
    - 70% Increase in depression systems
    - 50% increase in anxiety and depression diagnosis
    - 25% increase in seeking mental health care
    - 62% increase in concerns about enrolling in public benefit programs, like WIC and Medicaid

- Questions for the Bureau
  - ⇒ What is the Bureau doing to protect our ability to serve everyone?
  - ⇒ Is there any guidance forthcoming that would put restrictions on us?
  - ⇒ What can the Bureau do to protect against the public charge threats?

VII. **Behavioral Health**

SUBSTANCE ABUSE FEDERAL FUNDING

- Substance use disorder (SUD) is a crippling issue in CA – as it is in many other states.
- Of the top 5% of counties nationally that are most vulnerable for opioid related overdose, Plumas and Lake, are the two CA counties. In 2017, 1,882 Californians died from all opioid related overdoes.
- We understand there are 2 current federal funding streams and 1 coming down the pike for SUD:

- HRSA to health centers - $350 million nationally via *Expanding Access to Quality Substance Use Disorder and Mental Health Services.*
- SAMHSA to CA - $90 million over 2 years for *State Targeted Opioid Response*
- CA is applying to SAMHSA for an additional $136M *State Opioid Response* grant

- We really appreciate the flexibility of HRSA funding being available for all SUD and mental health services. These are interrelated issues and cannot easily carve out SUD from other mental health problems.
- We encourage SAMHSA to move in the direction of offering funding for BH/SUD rather than just opioids. Meth and other SUDs are still a major issue in Ca.
    - ⇒ Question: What additional federal funds are coming for SUDs and what can we do to ensure those funds can be used for non-opioid – but still terrible and disabling – substance use disorders?

BPHC committed to giving more money on SUD
$200M more going into SUD
$350 m this year, $200 m one time, $150m on going
Trying to make $200m on going

VIII. 340B

- The Governor's proposed budget from January included language that would've eliminated the 340B Drug Discount Program (340B) from Medi-Cal in both Fee-for-Service and Managed Care Programs.
- However, we are excited to share that our advocacy efforts have paid off, since the enacted budget reflects no changes to the 340B program.
- CaliforniaHealth+ Advocates (Advocates) fought the Governor's proposal on behalf of health centers and continues to work with Department of Health Care Services (DHCS), plans, and covered entity stakeholders to find a solution to the duplicate discount concerns.
- We were hopeful to be working on legislation to codify the rules in state law but unfortunately the Department of Health Care Services has signaled wanting to resolve this through administrative procedures.
- We are concerned they could still undermine our ability in 340B but continue to fight for the solution we secured with the legislature.
- We are also aiming to be proative against another state effort and efforts federally.
- In July the CPCA board voted to move forward on a project where CA health centers agree on how where we put 340B savings and how we spend the resources so that we can be aligned in future advocacy to protect the program.
- 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 Azar?

BPHC really likes the direction CPCA is taking with this and urged us to continue embracing transparency because that's the direction they see the federal government going. Also important to show the impact.
They noted there is not much legally to stop PBMs and states from working to take the money. Its going to take the advocacy we are engaged in to convince the feds to allow the 340B program to continue.