



# Table of Contents

Board/Committee Meetings  
October 10-11, 2017

All meetings at Hilton Anaheim Laguna A/B  
(except CPG – meeting in San Clemente room)

## Tuesday, October 10, 2017

- 9:00 – 9:30a**                      **Finance / Ventures Finance**
- Review Insurance Coverage & Investment Policy
  - Cash Reserve
  - Other Business
  
  - Ventures Loan Report

- 9:30 – 10:00a**                      **Governance Committee**
- Application for Membership
  - Review Board Attendance
  - Implementation and Bylaws Changes
  - Membership Satisfaction Survey

- 10:00 – 10:30a**                      **AG Worker Health Committee**
- Immigration Update
  - Access 2020 Campaign
  - NACHC CHI Ag Committee meeting update
  - NWRPCA 2017 Western Forum
  - Open Forum
  - Migrant Health Coordinator

- 10:30 – 11:00a**                      **Rural Committee**
- CMSP Update
  - HPSA Score Redetermination
  - Restructuring the Rural Committee
  - Combating the Opioid Epidemic
  - Rural and Behavioral Health
  - Rural Health Events

- 11:00 – 12:30p**                      **Government Programs**
- 340B
  - Licensing
  - OSHPD 3
  - Managed Care
  - Behavioral Health
  - Pharmacy & Adult Immunizations

- Lifeline Grant Program
- Immigration Update
- 2703 PCHH
- Oral Health

**12:30 – 1:00p                    LUNCH**

**1:00 – 2:00p                    Workforce Committee**

- California Future Health Workforce Commission
- Goal 7: Serving as a Catalyst and Coordinator
- Goal 6: Growing and Diversifying Health Center Professions

**2:00 – 3:30p                    330 Committee**

- Payment Reform
- Pay-for-Performance
- Proposed State Plan Amendment
- A&I Challenges – Progress Update
- DHCS Update
- HRSA Notes
- Prop 56
- Legal Update
- Emergency Preparedness Final Rule

**3:30 – 3:40p                    BREAK**

**3:40 – 4:40p                    Consortia Policy Group (meeting in San Clemente room)**

- Policy Prioritization – Process Review & Next Steps
- Federal Advocacy
- NACHCs Policy & Issues Forum 2018
- State Politics, Legislation & Advocacy

**3:40 – 4:40p                    Executive Committee**

- CEO Report
- Update on Epic Partnership
- CaliforniaHealth+ Advocates Board Seats

**Wednesday, October 11, 2017**

**8:30 – 10:00a                    Clinicians Committee**

- CMO Report
- CP3 & Data Report
- Integrated Care/Behavioral Health
- Legislative Update

- Workforce Update
- Tele-dentistry

**10:00 – 10:15a            BREAK**

**10:15a – 11:45a            Legislative Committee**

- Federal Politics & Advocacy
- State Politics, Legislation & Advocacy
- FY17-18 State Budget
- Policy Prioritization
- Advocacy and Communication

**11:45 – 12:15p            LUNCH**

**12:15p – 2:30p            Board of Directors**

- Financial Audit presentation
- Board Financial presentation
- CEO Report
- Speaker: James Luisi, NACHC Board Chair
- Epic Partnership
- Committee Reports
- CaliforniaHealth+ Advocates Board Seats
- NACHC Update
- RAC Update
- Seating of FY 2017-18 Board

**Board Ventures**

- Approval of Financial Audit
- CEO Report
- Seating of FY 2017-18 Board

**2:30 – 3:30p            CaliforniaHealth+ Advocates Board of Directors**

- Financial Report
- Board Seats
- Staff Report
- Public Affairs Peer Network Update



**Finance Committee**  
 Tuesday, October 10, 2017  
 9:00am – 9:20am  
**Kevin Mattson, Chair**

**CPCA Finance Agenda**

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Kevin Mattson	I
II. Approval of Agenda		Kevin Mattson	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 13, 2017</li> </ul>	Kevin Mattson	A
IV. Approval of Financials	<ul style="list-style-type: none"> <li>Financials ending August 31, 2017</li> </ul>	Sandy Birkman	D/A
V. Review Insurance Coverage & Investment Policy	<ul style="list-style-type: none"> <li>Insurance Coverage Policies</li> <li>Investment Policy</li> </ul>	Sandy Birkman	I
VI. Cash Reserve	<ul style="list-style-type: none"> <li>Cash Reserve Policy Memo</li> </ul>	Sandy Birkman	D/A
VII. Other Business -Financial Reporting -Audit	<ul style="list-style-type: none"> <li>Board Presentation</li> </ul>	Sandy Birkman	I
VIII. Adjournment		Kevin Mattson	A

**CALIFORNIA PRIMARY CARE ASSOCIATION**

**FINANCE COMMITTEE**

**July 13, 2017**

**Committee Members Present:** Kevin Mattson, Chair, Cathy Frey, Nik Gupta, Kerry Hydash, Louise McCarthy, Tiffany Robertson, Graciela Soto-Perez, Mary Szecsey

Guest: Ben Flores

**Staff:** Carmela Castellano-Garcia, Sandy Birkman, Janelle Mollgaard, Mike Witte, Tina Canupp, Lucy Moreno, Nataly Diaz, Kearsten Shepherd

**I. Call to Order**

Kevin Mattson, Chair, called the meeting to order at 8:01 am.

**II. Approval of Agenda**

A motion was made and seconded to approve the agenda as presented. **The motion carried.**  
(Szecsey, Myers)

**III. Approval of Minutes**

A motion was made and seconded to approve the minutes of May 5, 2017 as presented. **The motion carried.** (Gupta/Soto-Perez)

**IV. Approval of Financials**

A motion was made and seconded to approve the financials ending May 31, 2017. **The motion carried.**  
(Gupta, Frey)

**V. Financial Policies**

Birkman provided an update on policy. A motion was made and seconded to approve the allowable and unallowable cost policy. **The motion carried.** (Gupta/Frey)

**VI. Other Business**

No other business to discuss

**VII. Adjournment**

The meeting was adjourned by Kevin Mattson, Chair at 8:10am

Respectfully submitted,

Janelle Mollgaard  
Recording Secretary

**CALIFORNIA PRIMARY CARE ASSN**  
**Profit & Loss Budget vs. Actual**  
April through August 2017

	<u>Apr - Aug 17</u>	<u>Budget</u>	<u>\$ Over Budget</u>	<u>% of Budget</u>	
<b>Income</b>					
4500.00 · Dues	817,708.31	817,708.31	0.00	100.0%	
4600.00 · Grants	1,274,865.37	1,160,772.07	114,093.30	109.83%	
4621.00 · Contributions	495,000.00	1,062,626.42	-567,626.42	46.58%	Recvd BS, TCE CP3 & other CP3
4749.00 · Licensing Fees- Health+	0.00	0.00	0.00	0.0%	project renewals later in year
4750.00 · Sponsorship	5,000.00	90,666.62	-85,666.62	5.52%	
4900.01 · Interest	4,892.30	3,750.00	1,142.30	130.46%	
4950.01 · Clinic Operations Support	180,297.75	353,169.50	-172,871.75	51.05%	
4955.00 · Miscellaneous Income	23,657.72	24,666.62	-1,008.90	95.91%	
4956.00 · Legal Fund Donations	18,500.00	0.00	18,500.00	100.0%	
4960.00 · Conference Income	461,417.50	607,142.90	-145,725.40	76.0%	
4999.99 · Training Income	601,050.00	475,416.69	125,633.31	126.43%	
<b>Total Income</b>	<u>3,882,388.95</u>	<u>4,595,919.13</u>	<u>-713,530.18</u>	<u>84.48%</u>	
<b>Gross Profit</b>	<u>3,882,388.95</u>	<u>4,595,919.13</u>	<u>-713,530.18</u>	<u>84.48%</u>	
<b>Expense</b>					
6100.00 · Salaries	1,621,631.58	1,878,428.53	-256,796.95	86.33%	
6300.00 · Employee Benefits	366,118.96	489,121.72	-123,002.76	74.85%	
6500.00 · Occupancy	152,975.15	148,770.31	4,204.84	102.83%	
6505.10 · Building Repair	3,277.36	4,173.69	-896.33	78.52%	
6510.10 · Communications	21,120.34	21,590.40	-470.06	97.82%	
6520.10 · Postage & Delivery	5,889.42	3,749.94	2,139.48	157.05%	timing filling postage machine
6530.10 · Supplies	30,903.04	36,931.62	-6,028.58	83.68%	
6540.00 · Printing	13,101.91	20,291.58	-7,189.67	64.57%	
6552.10 · Equipment Lease/Maintenance	9,001.98	12,035.69	-3,033.71	74.79%	
6554.10 · Small Equipment	20,472.13	11,458.24	9,013.89	178.67%	\$8800 pd for by EP
6560.10 · Insurance	9,305.31	7,812.40	1,492.91	119.11%	
6565.10 · Dues & Licenses	4,608.20	6,424.49	-1,816.29	71.73%	
6570.10 · Subscriptions/Pubs	74,583.33	18,551.89	56,031.44	402.03%	iMIS,
6580.10 · Marketing and Outreach	39,086.92	41,666.55	-2,579.63	93.81%	
7010.10 · Audit/Accounting	22,192.13	15,173.51	7,018.62	146.26%	timing
7020.10 · Legal Services	12,043.25	3,125.00	8,918.25	385.38%	personnel matter
7040.10 · Temporary Staffing	36,827.65	34,000.00	2,827.65	108.32%	
7110.10 · Board of Directors	31,956.63	29,166.62	2,790.01	109.57%	
7200.10 · Travel & Registration Fees	149,539.29	98,490.98	51,048.31	151.83%	
7275.00 · Staff Development	20,582.05	18,749.97	1,832.08	109.77%	
7350.00 · Training Expense/Meetings	420,410.84	428,571.45	-8,160.61	98.1%	
7450.00 · Annual Conference	244,933.73	428,571.45	-183,637.72	57.15%	
7500.00 · Consultants	653,389.43	737,024.02	-83,634.59	88.65%	
7800.00 · Sub-Grants	300,000.00	404,166.62	-104,166.62	74.23%	
7900.10 · Bad Debt	525.00	2,083.62	-1,558.62	25.2%	
<b>Total Expense</b>	<u>4,264,475.63</u>	<u>4,900,130.29</u>	<u>-635,654.66</u>	<u>87.03%</u>	
<b>Net Income prior to release from restricted</b>	<u><b>-382,086.68</b></u>	<u><b>-304,211.16</b></u>	<u><b>-77,875.52</b></u>	<u><b>125.6%</b></u>	
Released from temporarily restricted	574,112.38	600,000.00	-25,887.62	95.69%	
<b>Net Income after release</b>	<u>192,025.70</u>	<u>295,788.84</u>	<u>-103,763.14</u>	<u>64.92%</u>	

## Balance Sheet

As of August 31, 2017

	Aug 31, 17
<b>ASSETS</b>	
Current Assets	
Checking/Savings	
1000.00 · Cash	3,512,505.34
Total Checking/Savings	3,512,505.34
Accounts Receivable	
1300.00 · Grants Receivable	213,400.77
1305.00 · Contributions Receivable	146,285.00
1320.00 · Due from CPCA Ventures	196,520.04
1323.00 · Due from CA Health+ Advocates	69.41
1350.00 · Other Receivables	158,606.42
1400.00 · IMIS Receivable	257,151.22
Total Accounts Receivable	972,032.86
Other Current Assets	
1490.00 · Prepaid Expenses	6,000.00
1499.00 · Undeposited Funds	1,665.66
Total Other Current Assets	7,665.66
Total Current Assets	4,492,203.86
Fixed Assets	
1600.00 · 1231 I Street Suite 400	6,407,085.91
1650.00 · Furniture	331,111.39
1660.00 · Equipment	406,259.55
1670.00 · Capitalized Interest	69,592.00
1700.00 · Accumulated Depreciation	-660,366.00
1710.00 · Building Depreciation	-1,627,309.00
1740.00 · Interest Amortization	-52,773.00
1750.00 · Loss on Disposal of Assets	-1,954.00
Total Fixed Assets	4,871,646.85
<b>TOTAL ASSETS</b>	<b><u>9,363,850.71</u></b>
<b>LIABILITIES &amp; EQUITY</b>	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 · Accounts Payable	3,922.09
Total Accounts Payable	3,922.09
Other Current Liabilities	
2025 · Accrued Vacation	281,728.81
2040.00 · Prepaid Dues	538,319.89
2050.01 · Payroll Clearing	-3,867.58
2055.01 · Payroll FSA	-3,077.71
2200.00 · Sales Tax Payable	10,397.62
Total Other Current Liabilities	823,501.03
Total Current Liabilities	827,423.12
Long Term Liabilities	
2510.00 · Loan Payable IronStone Bank	3,715,326.26
Total Long Term Liabilities	3,715,326.26
Total Liabilities	4,542,749.38
Equity	
3000.00 · Opening Bal Equity	1,095,702.47
4000.00 · Net Assets	4,107,485.54
Net Income	-382,086.68
Total Equity	4,821,101.33
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b><u>9,363,850.71</u></b>

## CPCA and Subsidiaries Insurance Policies

Commercial Package – Hanover Company Policy #OBFD195174 4/17/17 – 4/17/18

General Liability including non-owned and hired autos

Building Personal Property \$3,360,800 (reminder our space is in a business condo)

With \$500 deductible

Liability & Medical \$1,000,000 per occurrence \$2,000,000 aggregate

Deductible \$5,000 each person, \$300,000 each peril

General Liability each occurrence \$4,000,000 aggregate \$4,000,000 rider

Workers Compensation – State Fund Insurance Company Policy #9147526 12/1/16 – 12/1/17

Employers Liability \$1,000,000 each accident

Bodily Injury by Disease \$1,000,000 aggregate, \$1,000,000 each employee

Directors and Officers Liability & EPLI – HIXCOX Insurance Policy #UDA 1223467 8/8/16 – 11/8/17

Total Limit of Liability \$1,000,000 between D&O and EPLI

D&O has \$10,000 retention

EPLI has \$25,000 retention

Surety Bond – Old Republic Surety Company Policy #W150196803 6/14/17 –continuous until cancelled

ERISA Coverage for \$450,000

Miscellaneous Professional Liability – Continental Casualty – Applied for

Would include Medical Billing & Coding/Computer Services/Consulting Services, Association Services for an aggregate of \$2,000,000

## ATTACHMENT A INVESTMENT SECURITIES POLICY

**Purpose:** The purpose of the Investment Securities Policy is to establish and document a set of prudent criteria that are consistent with the organization's strategic objectives and which support appropriate management of CPCA investment assets. Specifically, this policy will:

1. State California Primary Care Association's primary objectives regarding the management of its investment funds;
2. Define responsibility for investment oversight to the Board of Directors and assign authorities to management;
3. Define the universe of permitted investments;
4. Define accounting standards for investments;

**Responsibility:** It will be the responsibility of the Chief Executive Officer and the President and Treasurer of the Board to monitor and report management's compliance with the Investment Securities Policy.

1. Primary objectives of the CPCA Investment Securities Policy are as follows:
  - A. Ensure adequate liquidity to meet loan funding and programmatic investment requirements
  - B. Management will seek to obtain returns that are consistent with the preservation of investment principal
  - C. Achieve long term rate of return that exceeds the annual rate of inflation after investment management expenses

These objectives are listed in the order of importance as it relates to the overall management of investment funds of the California Primary Care Association

2. Use of Funds – investment securities shall be defined as the following:
  - A. Demand deposits in Selected Banks as defined below;
  - B. Marketable obligations of the United States;
  - C. Marketable obligations guaranteed by or insured by the United States or those for which the full faith and credit of the United States is pledged for the repayment of principal and interest thereon;
  - D. Marketable obligations issued, guaranteed or fully insured by any association, instrumentality or corporation of the United States established or to be established by the Congress, for which the credit of such an association, instrumentality or corporation is pledged for the repayment of the principal and interest thereon;
  - E. Marketable general obligations of a state, a territory or a possession of the United States, or any political subdivision of any of the foregoing or the District of Columbia, unconditionally secured by the full faith and credit of such state, territory, possession, political subdivision or district provided that such state, territory, possession, political subdivision or district has general taxing authority and the power to levy such taxes as may be required for the payment of principal and interest thereon;

- F. Domestic and Eurodollar, negotiable time and variable rate certificates of deposit issued by selected commercial banks and trust companies;
- G. Marketable Bankers' Acceptances accepted by Selected banks;
- H. Commercial paper with a minimum rating of P-1 from Moody's Investors Service, A-1 from Standard & Poor's or D-1 from Duff and Phelps;
- I. Repurchase and reverse repurchase agreements and security lending agreements collateralized by any of the eligible investment securities,
- J. Money Market mutual funds which invest primarily in eligible securities specified above

Selected Banks are defined as financial institutions which have a minimum investment rating of a single A by either Standard & Poor's or Moody's Investors Service.

## 2. Constraints

- A. All investments will have a maturity that is no greater than five years at the time of purchase.
- B. Investments in obligations which are not issued, guaranteed by, or fully insured, by the United States, an association thereof or corporation established by Congress, will be limited to thirty-three percent (33%) of investment portfolio assets
- C. All investments will be further restricted by any specific criteria that is established within the agreement reached with any organization from which CPCA has received a grant.

## 3. Social Investment Goals

- A. California Primary Care Association will make efforts to invest in institutions and other companies which have good records in community investment, labor relations and low income lending. CPCA shall also make efforts to avoid investing in companies that have shown a record of violating environmental regulations or standards, environmental pollution, unfair labor practices, or discrimination against women or minorities. Furthermore, CPCA shall avoid investing in companies involved in the manufacturing and/or distribution of tobacco, alcohol or weapons/handguns.

## 4. Accounting Standards

- A. California Primary Care Association will apply Generally Accepted Accounting Principles in accounting for its investment activity.

## 5. Reporting

Summary performance statistics and a policy compliance analysis shall be provided to the Board of Directors on a quarterly basis. It shall be the responsibility of the President/Chief Executive Officer to report to the Board of Directors any exceptions to this policy. The Investment Securities Policy shall be reviewed and approved at least annually by the Board of Directors



**ACTION**

Date: October 10, 2018  
To: CPCA Finance Committee  
From: Sandra Birkman, Director of Finance & Operations  
Re: Cash Reserve Policy

**MEMORANDUM**

**I. Background**

CPCA’s Board adopted a cash reserve policy at their meeting in October 2003. It has never been updated as the organization has grown.

**II. Discussion/Issues**

CPCA’s cash reserve should be increased to more accurately reflect the current financial budget.

**III. Recommendations**

Modify the reserve policy to say “up to 6 months operating expenses” to be held in reserve for the long-term organizational and operating stability.

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Current Cash Reserve Policy  
Adopted 10/10/03

The California Primary Care Association shall hold in reserve up to **\$1.5 million dollars (the equivalent of approximately three months operating expenses)** for long-term organizational and operating stability to accommodate the following situations:

- Cash flow shortages which arise when expenses fall due before the income to pay for them is received.
- Cash flow shortages which are caused by the unexpected emergencies, such as the withdrawal of a key funder or the loss of a key asset.
- Cash needed to start a new program or take advantage of an unexpected opportunity which will significantly contribute to our mission.
- Cash needed to replace/improve capital assets like equipment.

Board Financial Presentation

	March 31, 2017				August 31, 2017			
	CPCA	Ventures	Advocates	Combined	CPCA	Ventures	Advocates	Combined
<b>Statement of Financial Position</b>								
<b>ASSETS:</b>								
<b>Current Assets</b>								
Cash & Equivalents	\$ 3,090,327	\$ 4,168,171	\$ 1,063	\$ 7,259,561	\$ 2,638,654	\$ 3,743,848	\$ 312,634	\$ 6,695,136
Grants Receivable	\$ 510,692			\$ 510,692	\$ 359,686		\$ -	\$ 359,686
Dues and Accounts Receivable	\$ 324,242			\$ 324,242	\$ 415,758		\$ -	\$ 415,758
Current Portion of Loan Receivable		\$ 2,278,200		\$ 2,278,200		\$ 2,278,220		\$ 2,278,220
Prepaid Expenses/Undeposited Funds	\$ 186,649		\$ 846	\$ 187,495	\$ 7,666		\$ -	\$ 7,666
Due from (to) affiliate	\$ 99,241	\$ (128,849)	\$ 29,608	\$ -	\$ 196,589	\$ (196,520)	\$ (69)	\$ -
<b>Noncurrent Assets</b>								\$ -
Certificates of Deposit	\$ 806,713			\$ 806,713	\$ 872,449		\$ -	\$ 872,449
Loan Receivable, Net		\$ 4,099,373		\$ 4,099,373		\$ 4,580,822	\$ -	\$ 4,580,822
Property and Equipment, Net	\$ 4,871,647			\$ 4,871,647	\$ 4,871,647		\$ -	\$ 4,871,647
<b>TOTAL ASSETS</b>	<b>\$ 9,889,511</b>	<b>\$ 10,416,895</b>	<b>\$ 31,517</b>	<b>\$ 20,337,923</b>	<b>\$ 9,362,449</b>	<b>\$ 10,406,370</b>	<b>\$ 312,565</b>	<b>\$ 20,081,384</b>
<b>LIABILITIES &amp; NET ASSETS</b>								
<b>Current Liabilities</b>								
Accounts Payable	\$ 215,905			\$ 215,905	\$ 2,520	\$ -	\$ 1,750	\$ 4,270
Accrued Expenses	\$ 275,029			\$ 275,029	\$ 285,181	\$ -	\$ -	\$ 285,181
Deferred Revenue	\$ 427,794			\$ 427,794	\$ 539,820	\$ -	\$ -	\$ 539,820
Current Portion of Loan Payable	\$ 131,925	\$ 44,954		\$ 176,879				
Loan Payable (net)	\$ 3,635,667			\$ 3,635,667	\$ 3,715,326	\$ -	\$ -	\$ 3,715,326
<b>TOTAL LIABILITIES</b>	<b>\$ 4,686,320</b>	<b>\$ 44,954</b>		<b>\$ 4,731,274</b>	<b>\$ 4,542,847</b>	<b>\$ -</b>	<b>\$ 1,750</b>	<b>\$ 4,544,597</b>
<b>TOTAL NET ASSETS</b>	<b>\$ 5,203,191</b>	<b>\$ 10,371,941</b>	<b>\$ 31,517</b>	<b>\$ 15,606,649</b>	<b>\$ 4,819,602</b>	<b>\$ 10,406,370</b>	<b>\$ 310,815</b>	<b>\$ 15,536,787</b>
Unrestricted	\$ 3,062,255	\$ 10,371,941	\$ 31,517	\$ 13,465,713	\$ 2,904,173	\$ 10,406,370	\$ 310,815	\$ 13,621,358
Temporarily Restricted	\$ 2,140,936			\$ 2,140,936	\$ 1,915,429			\$ 1,915,429
<i>Cash on Hand - how many days organization could operate with no further cash</i>				257 days	257	8453	349	321 days
<i>Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations</i>				9.64				11.77
<b>Profit and Loss</b>								
<b>Total Income</b>	\$ 9,693,951	\$ 200,582	\$ 703,017	\$ 10,597,550	\$ 4,185,753	\$ 73,293	\$ 716,201	\$ 4,975,247
<b>Total Expenses</b>	\$10,128,130	\$ 151,986	\$ 703,017	\$ 10,983,133	\$ 4,569,340	\$ 35,984	\$ 436,903	\$ 5,042,227
<b>Net Income</b>	<b>\$ (434,179)</b>	<b>\$ 48,596</b>	<b>\$ -</b>	<b>\$ (385,583)</b>	<b>\$ (383,587)</b>	<b>\$ 34,409</b>	<b>\$ 279,298</b>	<b>\$ (69,880)</b>



**Ventures Finance Committee**  
 Tuesday, October 10, 2017  
 9:20am – 9:30am  
**Kevin Mattson, Chair**

**Agenda**

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION <small>A = Approval  D = Discussion  I = Information</small>
I. Call to Order		Kevin Mattson	A
II. Approval of Agenda		Kevin Mattson	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>• July 13, 2017</li> </ul>	Kevin Mattson	A
IV. Approval of Financials	<ul style="list-style-type: none"> <li>• Financials ending August 31, 2017</li> </ul>	Sandy Birkman	A
V. Ventures Loan Report	<ul style="list-style-type: none"> <li>• Loan Report – NCB Capital Impact</li> <li>• Loan Report – internal</li> </ul>	Sandy Birkman	I
VI. Other Business		Sandy Birkman	I
VII. Adjournment		Kevin Mattson	A

**CALIFORNIA PRIMARY CARE ASSOCIATION**

**VENTURES FINANCE COMMITTEE**

**July 13, 2017**

**Committee Members Present:** Kevin Mattson, Chair, Ben Flores, Cathy Frey, Nik Gupta, Kerry Hydash, Danielle Myers, Graciela Soto-Perez, Mary Szecsey

**Guests:** Anitha Mullangi, Lousie McCarthy, Tiffany Robertson

**Staff:** Carmela Castellano-Garcia, Sandy Birkman, Janelle Mollgaard, Mike Witte, Tina Canupp, Lucy Moreno, Nataly Diaz, Kearsten Shepherd

**I. Call to Order**

Kevin Mattson, Board Chair, called the meeting to order at 8:10am.

**II. Approval of Agenda**

A motion was made and seconded to approve the agenda as presented. **The motion carried.**  
(McCarthy/Soto-Perez)

**III. Approval of Minutes**

A motion was made and seconded to approve the minutes of May 5, 2017 as presented. **The motion carried.** (Gupta, Szecsey)

**IV. Approval of Financials**

A motion was made and seconded to approve the financials ending May 31, 2017. **The motion carried.**  
(Szecsey/ Myers)

**V. Ventures Loan Report**

A loan report was given by Sandy on both NCB Capital Impact and internal.

**VI. Other Business**

No other business at this time

**VII. Adjourn**

Business being concluded, a motion was made to adjourn at 8:14am

Respectfully submitted,

Janelle Mollgaard  
Recording Secretary

**CPCA Ventures**  
**Profit & Loss Budget vs. Actual**  
 April 1 through September 25, 2017

	<u>Apr 1 - Sep 25, 17</u>	<u>Budget</u>	<u>\$ Over Budget</u>	<u>% of Budget</u>
<b>Income</b>				
<b>4900.00 · Other Income</b>	70,393.21	97,222.20	-26,828.99	72.4%
<b>Total Income</b>	70,393.21	97,222.20	-26,828.99	72.4%
<b>Expense</b>				
<b>6100.00 · Salaries</b>	48,027.17	57,963.36	-9,936.19	82.86%
<b>6300.00 · Employee Benefits</b>	10,753.60	15,070.42	-4,316.82	71.36%
<b>6500.00 · Occupancy</b>	4,537.31	7,150.65	-2,613.34	63.45%
<b>6505.10 · Building Repairs</b>	0.00	2,993.45	-2,993.45	0.0%
<b>6510.10 · Communications</b>	582.29	364.58	217.71	159.72%
<b>6530.10 · Supplies</b>	467.09	1,093.75	-626.66	42.71%
<b>6540.00 · Printing</b>	0.00	486.08	-486.08	0.0%
<b>6552.10 · Equipment Lease/Maintenance</b>	267.88	568.24	-300.36	47.14%
<b>6554.10 · Small Equipment/Furniture</b>	284.54	0.00	284.54	100.0%
<b>6560.10 · Insurance</b>	266.31	486.15	-219.84	54.78%
<b>6565.10 · Dues &amp; Licenses</b>	0.00	282.92	-282.92	0.0%
<b>6570.10 · Subscriptions/Publications</b>	121.44	595.45	-474.01	20.4%
<b>7010.10 · Audit/Accounting</b>	0.00	1,093.75	-1,093.75	0.0%
<b>7110.10 · Board of Directors</b>	0.00	2,430.54	-2,430.54	0.0%
<b>7200.10 · Travel &amp; Registration Fees</b>	0.00	2,430.58	-2,430.58	0.0%
<b>7300.00 · Meetings &amp; Trainings</b>	383.78	0.00	383.78	100.0%
<b>7500.00 · Consultants</b>	1,979.33	4,212.11	-2,232.78	46.99%
<b>7950.00 · Interest</b>	92.72	0.00	92.72	100.0%
<b>8000.00 · Loan Funds/Reserves</b>	-31,779.00	0.00	-31,779.00	100.0%
<b>Total Expense</b>	35,984.46	97,222.03	-61,237.57	37.01%
<b>Net Income</b>	<u><u>34,408.75</u></u>	<u><u>0.17</u></u>	<u><u>34,408.58</u></u>	

**CPCA Ventures**  
**Balance Sheet**  
As of August 31, 2017

	Aug 31, 17
<b>ASSETS</b>	
<b>Current Assets</b>	
<b>Checking/Savings</b>	
1000.00 · Cash	3,743,848.37
<b>Total Checking/Savings</b>	3,743,848.37
<b>Accounts Receivable</b>	
1450.00 · Current Portion Loans Receivabl	2,278,219.73
1461.00 · Acct. Rec. Loan - Long Term	5,039,161.90
<b>Total Accounts Receivable</b>	7,317,381.63
<b>Other Current Assets</b>	
1465.00 · Loan Loss Reserve	-458,340.00
<b>Total Other Current Assets</b>	-458,340.00
<b>Total Current Assets</b>	10,602,890.00
<b>TOTAL ASSETS</b>	<b><u>10,602,890.00</u></b>
<b>LIABILITIES &amp; EQUITY</b>	
<b>Liabilities</b>	
<b>Current Liabilities</b>	
<b>Accounts Payable</b>	
2020.00 · Due to CPCA	196,520.06
<b>Total Accounts Payable</b>	196,520.06
<b>Total Current Liabilities</b>	196,520.06
<b>Total Liabilities</b>	196,520.06
<b>Equity</b>	
3000.00 · Opening Bal Equity	-0.13
3900 · Retained Earnings	10,371,961.32
Net Income	34,408.75
<b>Total Equity</b>	10,406,369.94
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b><u>10,602,890.00</u></b>

**CAPITAL IMPACT QUARTERLY REPORT TO CPCA**  
**Quarter Ending 6/30/2017**

**1. Loans Outstanding**

	Amount Outstanding	Loan Category	Interest Rate	Date Closed	Date Funded	Risk Rating	Original Loan Amount
	\$ 58,156.75	CL	3.175%	03/04/2015	03/04/2015	3	\$ 200,000.00
	\$ 58,707.39	CL	3.175%	10/16/2012	10/16/2012	4	\$ 300,000.00
	\$ 691,947.32	ISLP	3.175%	03/23/2015	03/23/2015	1	\$ 750,000.00
	\$ 8,017.12	CL	3.175%	06/28/2012	06/28/2012	2	\$ 445,000.00
	\$ 260,092.36	CL	3.175%	11/04/2014	11/04/2014	3	\$ 420,000.00
	\$ 35,830.26	CL	3.175%	04/19/2012	04/19/2012	2	\$ 400,000.00
	\$ 598,780.03	CL	3.175%	05/26/2015	05/26/2015	2	\$ 835,000.00
	\$ 585,639.81	CL	3.175%	09/17/2015	09/17/2015	2	\$ 750,000.00
	\$ 200,000.00	CL	3.175%	02/08/2017	02/08/2017	4	\$ 200,000.00
	\$ 251,703.82	CL	3.175%	05/19/2014	05/19/2014	4	\$ 500,000.00
	\$ 35,840.25	CL	3.175%	05/08/2012	05/08/2012	2	\$ 400,000.00
	\$ 23,122.25	CL	3.175%	12/16/2014	12/16/2014	3	\$ 100,000.00
	\$ 234,781.19	CL	3.175%	03/18/2015	03/18/2015	4	\$ 400,000.00
	\$ 251,703.82	CL	3.175%	04/24/2014	04/24/2014	2	\$ 500,000.00
	\$ 650,000.00	CL	3.175%	05/25/2017	05/25/2017	1	\$ 650,000.00
	\$ 21,618.24	CL	3.175%	01/12/2012	01/12/2012	1	\$ 600,000.00
	\$ 39,290.04	CL	3.175%	05/01/2014	05/01/2014	3	\$ 93,000.00
	\$ 77,396.75	CL	3.175%	08/13/2012	08/13/2012	2	\$ 482,000.00
	\$ 64,438.55	CL	3.175%	08/10/2011	08/10/2011	1	\$ 600,000.00
	\$ 780,852.99	ISLP	3.175%	09/15/2015	09/15/2015	1	\$ 1,000,000.00
	\$ 585,639.81	CL	3.175%	09/18/2015	09/18/2015	3	\$ 750,000.00
	\$ 377,555.85	CL	3.175%	05/21/2014	05/21/2014	2	\$ 750,000.00
	\$ 11,349.46	CL	3.175%	01/05/2012	01/05/2012	2	\$ 315,000.00
	\$ 750,000.00	CL	3.175%	06/24/2016	06/24/2016	4	\$ 750,000.00
	\$ 32,078.81	CL	3.175%	09/24/2014	09/24/2014	3	\$ 275,000.00
<b>Total</b>	<b>\$ 6,684,542.87</b>						<b>12,465,000</b>

**2. Loan Volume by Risk & Weighted Average Risk of Portfolio**

Risk Rating	# of Borrowers	Amount Approved	Amount Outstanding	% of Total Outstanding	% Reserve	Recommended Reserve
1	5	\$ 3,600,000	\$ 2,208,857	33%	0%	\$ -
2	9	\$ 4,877,000	\$ 1,982,113	30%	3%	\$ 59,463
3	6	\$ 1,838,000	\$ 998,380	15%	10%	\$ 99,838
4	5	\$ 2,150,000	\$ 1,495,192	22%	20%	\$ 299,038
5	0	\$ -	\$ -	0%	50%	\$ -
<b>Total</b>	<b>25</b>	<b>\$ 12,465,000</b>	<b>\$ 6,684,543</b>			<b>\$ 458,340</b>
<b>Portfolio</b>	<b>Compliance</b>	<b>Maximum</b>	<b>Actual</b>			
Loans rated "3" "4" or "5":	Y	65%	37%			
Loans rated "4" or "5":	N	20%	22%			

**3. New Loans Approved in the Quarter**

Health Center Name	Amount Approved	Loan Category	Approval Date	Closing Status
	\$ 750,000	CL	6/7/2017	Closed in 6/16/2017.
	\$ 650,000	CL	4/4/2017	Closed in 6/22/2017.
<b>Total</b>	<b>\$ 1,400,000</b>			

**4. Applications Under Review**

Health Center Name	Amount Requested	Loan Category	Date Received	Underwriting Status
	\$ 1,000,000	CL	6/1/2017	In underwriting, projected closing date is 7/14/2017.
	\$ 1,000,000	CL	11/15/2016	In underwriting, projected closing date is 8/18/2017.
<b>Total Loans in Process</b>	<b>\$ 2,000,000</b>			

**5. Applications Denied in the Quarter**

Health Center Name	Amount Requested	Date Received	Date Denied	Reason for the loan decline
N/A				

**6. Loan Modifications or Waivers in the Quarter**

Health Center Name	Risk Rating	Loan Category	Effective Date	Description of loan modification or waiver
N/A				

**7. Changes to Risk Ratings in the Quarter**

Health Center Name	Original Rating	New Rating	Effective Date	Reason for the risk rating change
N/A				

**8. Non-Performing Loans in Portfolio**

Health Center Name	Outstanding Amount	Days Past Due	Non-accrual Y/N	Updates on repayment plan
N/A				

**CPCA Ventures Loan Program  
8/31/2017**

		<b>TOTAL</b>								
<b>INCOME</b>										
Grant	\$					10,500,000				
Investment Interest	\$					1,019,560				
Miscellaneous Income	\$					854,666				
Principle Repayments	\$					47,765,231				
Interest on Loans	\$					3,322,780				
<b>TOTAL INCOME</b>	<b>\$</b>					<b>63,462,237</b>				
<b>DIRECT OUTLAYS</b>										
CPCA Operating	\$					5,073,217				
IS Loans	\$					9,614,502				
Capital Loans	\$					44,376,732				
Healthy California	\$					865,054				
Emergency	\$					506,382				
<b>TOTAL OUTLAY</b>	<b>\$</b>					<b>60,435,887</b>				
<b>LOAN LOSS RESERVE</b>	<b>\$</b>					<b>458,340</b>				
<b>BALANCE</b>	<b>\$</b>					<b>2,568,010</b>				
<hr/>										
		<b>Info Systems</b>		<b>Capital</b>		<b>Healthy CA</b>		<b>Emergency</b>		<b>TOTAL</b>
<b>PRIOR YR's TOTAL</b>	<b>\$</b>	<b>9,614,502</b>	<b>\$</b>	<b>40,520,184</b>	<b>\$</b>	<b>865,054</b>	<b>\$</b>	<b>506,382</b>	<b>\$</b>	<b>51,506,122</b>
<b>2016/2017</b>										
6/9/2016			\$	750,000					\$	750,000
6/28/2016			\$	700,000					\$	700,000
12/20/2016			\$	300,000					\$	300,000
2/8/2017			\$	200,000					\$	200,000
<b>TOTAL</b>	<b>\$</b>	<b>9,614,502</b>	<b>\$</b>	<b>42,470,184</b>	<b>\$</b>	<b>865,054</b>	<b>\$</b>	<b>506,382</b>	<b>\$</b>	<b>53,456,122</b>
<b>2017/2018</b>										
6/16/2017			\$	256,548					\$	256,548
6/21/2017			\$	650,000					\$	650,000
8/1/2017				1,000,000					\$	1,000,000
<b>TOTAL</b>	<b>\$</b>	<b>9,614,502</b>	<b>\$</b>	<b>44,376,732</b>	<b>\$</b>	<b>865,054</b>	<b>\$</b>	<b>506,382</b>	<b>\$</b>	<b>55,362,670</b>



## Governance Committee

Tuesday, October 10, 2017

9:30am – 10:00am

Mary Szecsey, Chair

### Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Mary Szecsey	I
II. Approval of Agenda		Mary Szecsey	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 13, 2017</li> </ul>	Mary Szecsey	A
IV. Applications for Membership	<ul style="list-style-type: none"> <li>Health to Hope Clinics</li> </ul>	Sandy Birkman	D/A
V. Review Board Attendance	<ul style="list-style-type: none"> <li>Board Attendance Policy</li> <li>Board Attendance Grid</li> </ul>	Mary Szecsey	I
VI. Implementation of Bylaws Changes	<ul style="list-style-type: none"> <li>Implementation Timeline</li> </ul>	Sandy Birkman	I
VII. Membership Satisfaction Survey	<ul style="list-style-type: none"> <li>2016 Membership Satisfaction Survey</li> </ul>	Sandy Birkman	I/D
VIII. Other	<ul style="list-style-type: none"> <li>Election Review</li> </ul>	Sandy Birkman	
IX. Adjournment		Mary Szecsey	A



***Executive  
Summary***

Date: September 27, 2017  
To: Governance Committee  
From: Sandy Birkman, Director of Finance and Operations

**MEMORANDUM**

Following is the Executive Summary for the Governance Committee meeting materials.

- IV. Health to Hope Clinics in Riverside has applied for CPCA membership.
- V. The Committee is charged with reviewing Board member attendance. A grid with attendance is included for review along with the Board attendance policy.
- VI. The Bylaws have been amended by the membership vote and now staff needs to implement the process for deletion of the affiliate membership process and the new associate structure.
- VII. The membership satisfaction survey questions from last year are included in order to have the committee make suggestions to update questions for this year.
- VIII. A summary of the election and bylaws voting process is included along with recommendations for future voting.

**CALIFORNIA PRIMARY CARE ASSOCIATION  
GOVERNANCE COMMITTEE  
July 13, 2017**

**Committee Members Present:** Mary Szecsey, Chair, Nik Gupta, Kerry Hydash, Kevin Mattson, Louise McCarthy, Danielle Myers, Ben Flores, Cathy Frey, Corinne Sanchez, Scott McFarland

**Guests:** Tiffany Robertson, Irma Cota, Alvaro Fuentes, Anitha Mullangi, Christina Velasco, Graciela Soto-Perez, Michael Schuab, Jennifer Hunter, Rachel Farrel, David Vilet, Henry Tuttle

**Staff:** Sandy Birkman, Janelle Mollgaard, Carmela Castellano-Garcia, Ginger Smith, Meghan Nousaine, Victor Christy, Robert Beaudry, Val Sheehan, Emily Shipman, Tina Canupp, Lucy Moreno, Miriam Orozco, Kristian Diaz, Nataly Diaz, Mike Witte, Jodi Samules, Meaghan McCamman, Allie Budenz, Cindy Keltner

**I. Call to Order**

Mary Szecsey, Chair, called the meeting to order at 8:30am.

**II. Approval of Agenda**

A motion was made and seconded to approve the agenda. **The motion carried.** (McCarthy/Myers)

**III. Approval of Minutes**

A motion was made and seconded to approve the minutes of May 4, 2017 as presented. **The motion carried.** (Gupta/Myers)

**IV. Applications for Membership:**

None at this time.

**V. New Associate Category**

Birkman reviewed suggested changes from workgroup. A motion was made and seconded to accept staff's recommendation for the non-member Associate fee structure and benefits. **The motion carried.** (Frey/Myers)

**VI. Bylaws**

Birkman reviewed the suggested changes to the bylaws. A motion was made and seconded to approve the suggested Bylaws changes to go to membership vote. **The motion carried.** (Frey/McCarthy)

**VII. Board Self-Assessment Survey**

Twenty four of thirty Board members completed the survey. Overall satisfaction with areas of improvement in furthering understanding of distinction of Advocates and CPCA funding and evaluation of Board attendance.

**VIII. Other Business**

Birkman reviewed the election timeline and nominations to date. Electronic voting to begin September 11<sup>th</sup> and to include bylaws vote.

**Adjourn**

Business being concluded, meeting was adjourned at 8:58am.

Respectfully submitted,  
Janelle Mollgaard, Recording Secretary

**CALIFORNIA PRIMARY CARE ASSOCIATION**  
**GOVERNANCE COMMITTEE**  
**NEW MEMBERS ELIGIBILITY DETERMINATION CHECKLIST**

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Applicant Name: Health to Hope Clinics

Date Application Submitted: 9/21/17

Membership Category: Community Health Clinic

Supporting Documents Submitted:

- ✓ Completed application
- ✓ Resolution by organization's governing body authorizing membership
- ✓ Copy of clinic license from principal site
  - Exempt under Section 1206 of the Health & Safety Code
- ✓ Copy of organization's bylaws
- ✓ Copy of organization's most recent "Annual Utilization Report of Clinics" required by the Office of Statewide Health Planning and Development
- ✓ Copy of Articles of Incorporation
- ✓ Copy of IRS 501 (c)(3) letter
- ✓ Annotated Board Roster
- ✓ Letter of Support
- ✓ Summary of staff interview - below

Application is:      Complete                    Incomplete

Comments: This FQHC provides primary medical and mental healthcare to homeless individuals and low income families located in and around Riverside County. Nancy Young, President/CEO of SAC Health Systems has provided the letter of support.

Prepared by: Sandy Birkman

Date: 10/2/17

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Action by Committee:      Application Conforms. Recommend Presentation to the Board.

Application Does Not Conform – No Presentation to the Board at this Time.

Rationale: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Administrative Office  
250 S. G Street San Bernardino, CA 92410

September 20, 2017

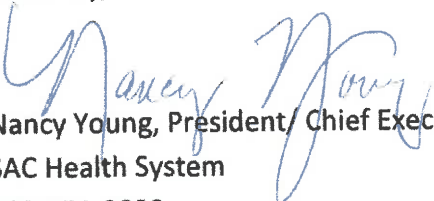
To: California Primary Care Association (CPCA)  
Bylaws Committee and Board of Directors  
1231 I Street, Suite 400  
Sacramento, CA 95814

Dear CPCA,

As the Chief Executive Officer or Director of SAC Health System, a good standing CPCA member, I attest that I have reviewed the CPCA membership criteria and have reviewed sufficient background information to confirm that each criterion is met by Health to Hope Clinics for membership as a Community Clinics and Health Center member. If accepted into the membership, I will serve as a mentor for this new CPCA member.

The following is a brief summary regarding the applicant: Health to Hope Clinics is 501(c)(3) Federally Qualified Healthcare Center (FQHC) that provides compassionate and comprehensive primary medical and mental healthcare services to homeless individuals and low-income families in and around Riverside County—through its clinics and mobile clinics. If there is further information needed, please contact me at: 909-771-2823.

Sincerely,

  
Nancy Young, President/ Chief Executive Officer  
SAC Health System  
909-771-2823

**SOCIAL ACTION COMMUNITY HEALTH SYSTEM**

SACHS San Bernardino – 909 382 7100  
250 S.G San Bernardino, CA 92410

SACHS Norton – 909 382 7100  
1455 E. 3rd Street, San Bernardino, CA 92410

SACHS Frazee – 909 383 8092  
488 South K Street, San Bernardino, CA 92410

### Attendance at Board Of Directors Meetings Policy

Members of the Board of Directors of the California Primary Care Association (CPCA) have a responsibility to the members who elected them to oversee the management and affairs of the Association and to set policies which guide CPCA in all of its activities.

1. All members of the CPCA Board of Directors have a duty to be present at all official meetings of the Board. The current practice is to have four Board meetings each year, however special Board Meetings may be called as necessary for items that are time sensitive.
2. Per Bylaws, "Directors shall participate in at least 50% of regularly scheduled Board of Directors meetings in a given Board year. Directors who do not participate as so described shall be subject to removal from office by a majority of the Board." A Board year will be considered October through September 30<sup>th</sup>. The Board of Directors Job Description outlines a desire for a higher attendance rate at 75% in order for a Director to act in the best interest of CPCA as a whole and to exercise the legal and financial duties of the organization.
3. All minutes will reflect not only those Directors present, but those absent.
4. The Board Chair at his/her sole discretion, may (a) excuse (i.e., not count as a missed meeting) one (1) absence per Director per year and/or (b) grant a leave of absence for a Director without forfeiture of the Director's Board seat.
5. After one absence by a Director, a letter will be sent by staff to remind them of this policy.
6. After two absences, a call will be made by the Chair of the Board.
7. On the third absence in any given year, continued participation of any board member who has been unable to be present will be put to vote of the Board for removal.
8. Attendance will be tracked and reviewed regularly and a report made to the Governance Committee and Chair. All candidates running for reelection will have their attendance records in the prior year noted in election materials. Directors not meeting the 50% criteria for each year of their prior term will not be eligible to run for re-election.

Board of Directors Attendance

Name	16-Oct	17-Jan	17-May	*17-Jun*	17-Jul	Total Absences
Robin Affrime			X			1
Isabel Becerra	X			X		1
Doreen Bradshaw						
Debra Farmer		X		X	X	2
Benjamin Flores				X		
Cathy Frey				X		
Naomi Fuchs					X	1
Jane Garcia						
John Gressman	X			X		1
Britta Guerrero	X			X		1
Nik Gupta						
Sherry Hirota			X		X	2
Kerry Hydash		X		X		1
Deborah Lerner				X		
Marty Lynch						
Kevin Mattson						
Louise McCarthy				X		
Scott McFarland				X		
Danielle Myers				X		
Christine Noguera				X		
Tracy Ream						
Tim Rine						
Jacqueline Ritacco	X			X		1
Ralph Silber						
Paulo Soares		X		X		1
Graciela Soto-Perez			X			1
Mary Szecsey						
Richard Veloz			X	X	X	2
David B. Vliet			X			1
Paula Wilson						
	4	3	5	N/A	4	16

\*This meeting did not count for attendance as it was held out-of-state\*

## IMPLEMENTATION OF BYLAWS CHANGES

10/12/17

### Article III Members

Section 1 Classes of Membership – removes the Honorary and Affiliate classes of membership **No new applications for Affiliate will be accepted. Present Affiliate class members will be notified within the next few weeks that their membership renewal will not be renewed and Associate structure will be introduced to them. Any inquiries about membership that do not meet new membership requirements will be referred to Associate structure immediately.**

Section 3 Application – adds that the sponsorship for an applicant must be in the applicant’s service area **IMMEDIATELY**

Section 9 a(2) Termination of Membership – adds that an officer of the member corporation may make notice of a resignation. Also, the resignation may be emailed. **IMMEDIATELY**

Section 12 Suspension of Membership – wordsmithing to match other sections, nothing changes **IMMEDIATELY**

### Article V Directors

Section 2 - Number and Qualifications changes wording to “up to 30” voting directors, removed Section 329 funded entities. Adds that there shall not be more than one delegate per member or organization seated on the Board of Directors. **IMMEDIATELY**

Section 3 – wordsmithing, nothing changes **IMMEDIATELY**

Section 4 – Terms of Office – takes away denoting the exact number being elected each year. **IMMEDIATELY**

### Article VI – Officers

Section 2 Qualifications, Election, and Term of office adds that if the Chair-elect resigns or is removed before becoming Chair, the position of Chair shall be selected at the same time as all other officers from amongst the officers. **IMMEDIATELY**



## 2016 CPCA Membership Satisfaction Survey

### 1. What is your job function?

- Clinic Executive Management (CEO/CFO/CIO/COO/CMO/etc)
- Administrative Staff
- Program Staff
- Clinician
- Other clinical staff
- Consortia staff

Other

### 2. How long have you been employed by your health clinic/center?

- less than a year
- 1 - 3 years
- 3 - 5 years
- 5 - 10 years
- 10 or more years

3. Please rate your satisfaction with CPCA's performance in this area using the following scale:

Core Services

	Poor	Below Average	Average	Above Average	Excellent	Don't Know
Legislative policy analysis/advocacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Networking Opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Education/Training seminars/webinars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Technical Regulatory Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Addressing Reimbursement Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conferences (Annual, CEPPN/CAPN/QI and Technology, Billing Managers, CFO)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Website	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Please rate your satisfaction with CPCA's performance in this area using the following scale:

Health System Transformation

	Poor	Below Average	Average	Above Average	Excellent	Don't Know
Payment Reform	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managed Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remaining Uninsured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Systems of Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Please rate your satisfaction with CPCA's performance in this area using the following scale:

Health Center Transformation

	Poor	Below Average	Average	Above Average	Excellent	Don't Know
Finance & Operations Redesign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient Centered Health Home Practice Transformation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Capitation Payment Preparedness Program (CP3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Revenue Cycle Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Management Programs (Health Management+, Financial Management+)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Please rate your satisfaction with CPCA's performance in this area using the following scale:

CaliforniaHealth+

	Poor	Below Average	Average	Above Average	Excellent	Don't Know
Brand Adoption and Recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Overall, how would you rate the effectiveness of the leadership provided by the CPCA Board of Directors?

Poor	Below Average	Average	Above Average	Excellent	Don't Know
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Do you attend CPCA's Annual Conference?

Yes

No

If not why? (Time, Cost, Location, Content, Other)

9. Do you participate on committees/workgroups?

Yes

No

If not why? (Time, Cost, Location, Content, Other)

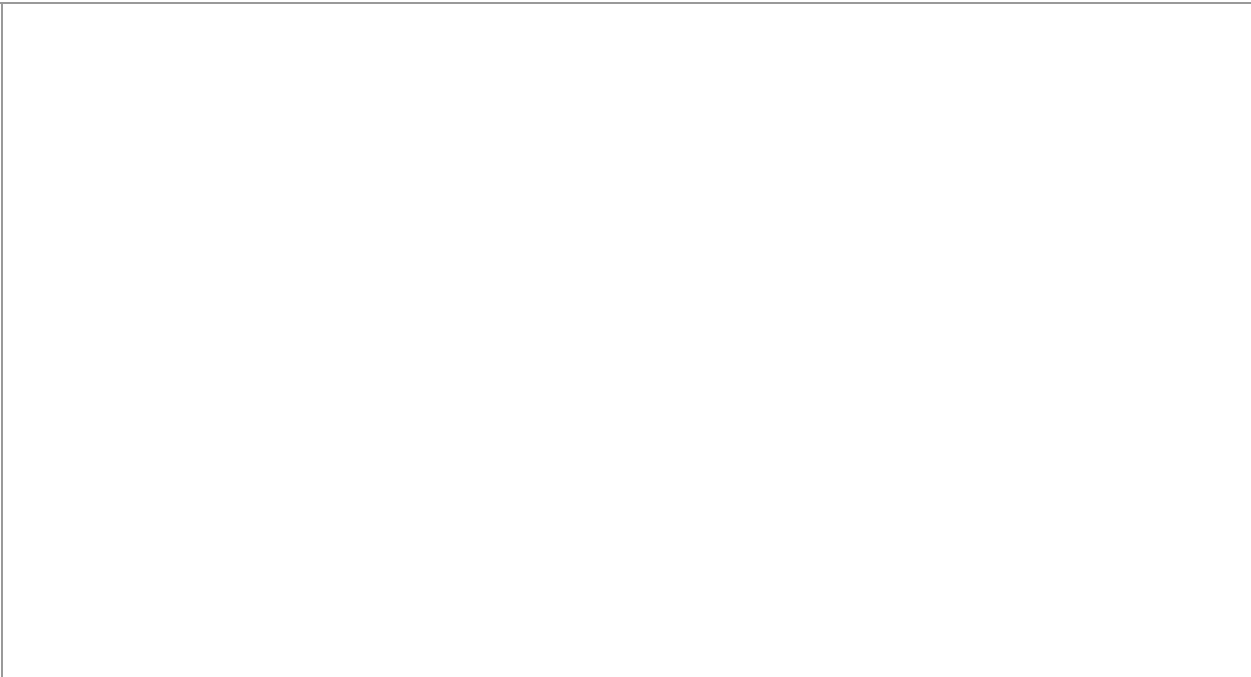
10. Do you or your staff attend CPCA trainings (in-person or webinars)?

Yes

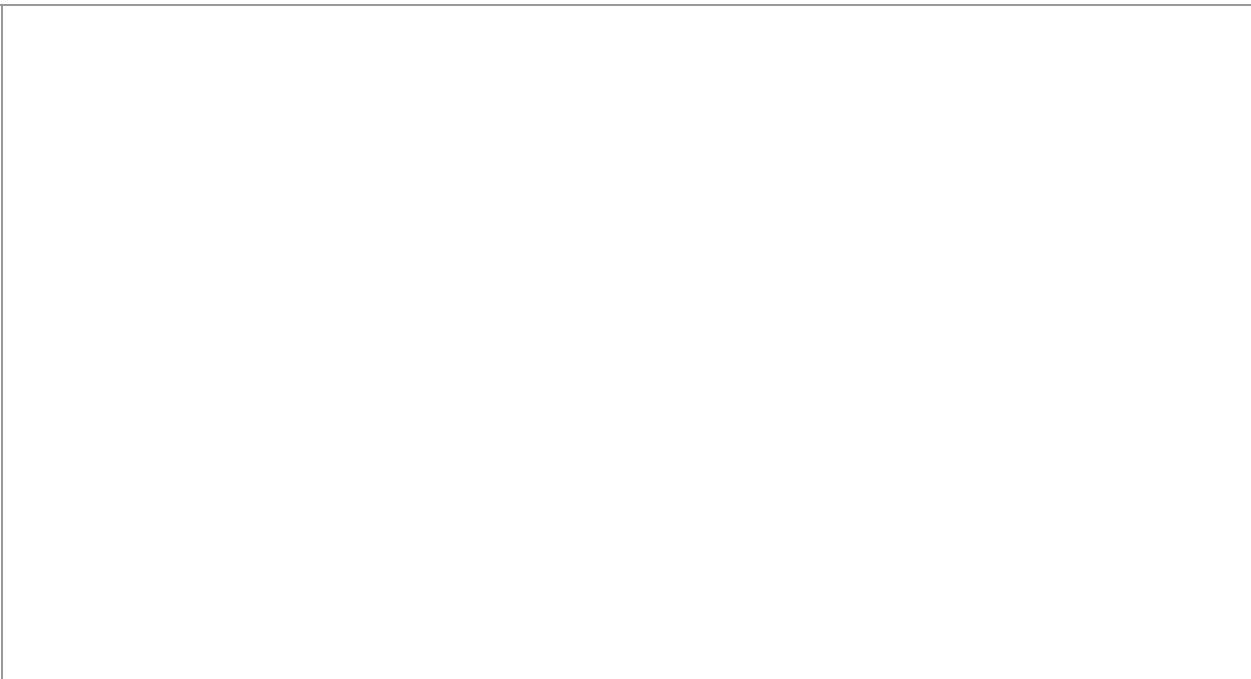
No

If not why? (Time, Cost, Location, Content, Other)

11. Are there any areas you are concerned with CPCA's performance?



12. What are the three main reasons your organization is a member of CPCA?



13. What programs or services that CPCA currently provides do you find most valuable?

14. What service does CPCA NOT provide, but if they did would make a significant positive impact on your organization?

15. On a scale of 1-5, Do you receive the appropriate amount of communication from CPCA?

Inappropriate Not  
Enough

Just Right

Inappropriate Too  
Much

Don't Know

Comments:



**INFORMATION**

Date: October 10, 2017  
To: Governance Committee  
From: Sandy Birkman, Director of Finance and Operations  
Re: 2017 Elections Wrap Up

**MEMORANDUM**

**Background**

The 2017 Board of Director election and Bylaws change ended on September 29<sup>th</sup> with the election of ten new Board Members and several Bylaws changes. 256 of 548 ballots were returned which is a return rate of 47%. There was initial confusion with the new electronic voting method among delegates. A memo was sent out under my email a week before ballots went out alerting delegates about the new voting method. The actual ballots were sent out by “electionbuddy” on September 11, 2017. An email was again sent out during the initial week of voting using my email address to remind delegates to check their email from “electionbuddy” for their ballots and contact me if they had any questions. Automatic reminders were then sent to those who had not completed their ballots each week by the on-line voting system. Additionally, another email was sent out using my email address to those who had not voted a week before the end of the voting. Winners were announced by staff following the closure of voting and Bylaws changes were all adopted.

- Historical rates of return on ballots
- 2017 election – 47%
  - 2016 special election - 47%
  - 2015 election – 52%
  - 2014 election – 57%
  - 2013 election – 61%
  - 2012 election - 63%

**Staff Recommendations**

- 1) Three weeks is too long to have the electronic voting open. Very few ballots were received the last week of September.
- 2) There continued to be confusion as to people having to open multiple emails to vote on each of their ballots. Even after a direct emailing of ballots, some left 1-3 ballots unvoted upon. Weighted ballots would work better. Each delegate would only have to open one email and vote on a ballot that would be worth however many votes they are assigned.



## Ag Worker Health Committee

Tuesday, October 10, 2017

10:00 a.m. – 10:30 a.m.

Leslie McGowan, Chair

### Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Leslie McGowan	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Executive Summary</li> </ul>	Leslie McGowan	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 13, 2017 Minutes</li> </ul>	Leslie McGowan	A
IV. Immigration Update	<ul style="list-style-type: none"> <li><i>See Government Programs</i></li> </ul>	Elizabeth Oseguera	D
V. Access 2020 Campaign		Cathy Frey / Elizabeth Oseguera	D
VI. NACHC CHI Ag Committee Meeting Update		Cathy Frey	I
VII. NWRPCA 2017 Western Forum for Migrant & Community Health		Elizabeth Oseguera	I
VIII. Open Forum <ul style="list-style-type: none"> <li>Merging of Rural and Ag Committee while also adding a focus on Special Populations</li> </ul>		Leslie McGowan	D
IX. Migrant Health Coordinator	<ul style="list-style-type: none"> <li>Memo: Immigration Resources for Members, One California Campaign, Department of Pesticide Regulation and LHA Update</li> </ul>	Elizabeth Oseguera	I
X. Adjourn		Leslie McGowan	A



## *Executive Summary*

Date: September 22, 2017

To: Ag Worker Health Committee

From: Elizabeth Oseguera, Senior Policy Analyst

### MEMORANDUM

#### **Immigration Update**

- CaliforniaHealth+ Advocates has been leading an effort in collaboration with other state PCAs, NACHC, and immigration partners, to develop materials that can help health centers prepare themselves and patients for an encounter with immigration enforcement. Through this effort Ca. Health+ Advocates has developed six sample policies and procedures, Know Your Rights handouts, FAQs and much more.

#### **Access 2020 Campaign**

- CPCA is working with Cathy Frey from the Central Valley Health Network and NCFH to put together an in person training for our health centers regarding the Access 2020 Campaign. We are hoping to host this training in Sacramento in late October or early next year.

#### **NACHC CHI Ag Committee Meeting Update**

- Cathy Frey will provide an update on what was discussed during NACHC's Agricultural committee meeting held during CHI.

#### **NWRPCA 2017 Western Forum for Migrant & Community Health**

- The Migrant and Community Health Forum is an annual conference bringing together health professionals from migrant and community health centers and allied organizations. The Forum will be taking place in Seattle, Washington from February 22-24, 2018.

#### **Open Forum: Merging of Rural and Ag Committee while also adding a focus on Special Populations**

- Given that there is great overlap between the work done in the Ag and Rural Committees, CPCA would like to have these committees merge while also adding an additional focus on special populations.

#### **Migrant Health Coordinator Update**

The update includes policy changes and opportunities to advocate for migrant health.

##### One California Campaign

- In response to the recession of the DACA program, the legislature increased the funding available through One California by \$30 million, bringing the total amount of funding to a historic \$75 million.

##### Latino Health Alliance Moving Forward

- LHA has decided to focus its efforts in creating resources that will help inform migrant workers, including H-2A visa workers, of their health and legal rights and developing a report outlining the impact that the ACA repeal could have in the Latino community.

**CALIFORNIA PRIMARY CARE ASSOCIATION**  
**AG WORKER HEALTH COMMITTEE**  
**July 13, 2017**  
**3:00pm – 3:30pm**

**Members:** Leslie McGowan, Chair, Robin Affrime, Antonio Alatorre, Tanir Ami, Ben Flores, Cathy Frey, Virginia Hedrick, David Lavine, Danielle Myers, Christine Noguera, Justin Preas,

**Guests:** John Price, Melinda Rivera, Suzie Shupe, Rachel Farrell, Lynn Dorroh, Susie Foster, Wanna Mine, Alex Armstrong, Micahel Schaub, Terri Vise, Larry Garcia, Sendy Sanchez, Lucresha Renteria, Meryl Schlingheyde, Trisha Cooke, Timmy Rine, Doreen Bradshaw

**Staff:** Elizabeth Oseguera, Daisy Po’oi, Andie Patterson, Miriam Mendoza, Jarah Heppler, Meghan Nousaine, Ginger Smith, Kristi Diaz, Nataly Diaz

**I. Call to Order**

Ben Flores, Sub-chair for Leslie McGowan, called the meeting to order at 3:09pm.

**II. Approval of Agenda**

A motion was made to approve the agenda as presented. **The motion carried. (T. Rine, C. Frey)**

**III. Approval of Minutes**

A motion was made to approve the minutes of May 4, 2017. **The motion carried. (C. Noguera, C. Frey)**

**IV. Immigration Update**

At the request of members, CPCA has been working with immigrant rights organizations and legal counsel to develop materials that provide information on the legal rights of clinics, and their patients, in regards to Immigration and Customs Enforcement (ICE) actions. CPCA has put together FAQs to help inform members of their rights as it relates to immigration. A sample of the policies and procedures to help clinics prepare for a possible immigration raid was sent out to the Ag committee and immigration workgroup.

**V. Access 2020 Campaign**

Cathy Frey provided an update on training development for California’s health centers to increase Ag worker population numbers and the possible partnership between the Central Valley Health Network (CVHN) and CPCA.

**VI. NACHC P&I Agricultural Worker Health Conference**

Liz Oseguera provided an update on the NACHC Agricultural Worker Health Conference she attended in May where NACHC hosted workshops regarding the Access 2020 Campaign and utilization of CHWs in the migrant agricultural community.

**VII. Advocacy Center of Excellence (ACE) / Hispanic Advocacy Center Excellence (HACE) Program**

Cathy Frey provided the committee with an update on the work that NACHC is doing around the Hispanic Advocacy Center Excellence (HACE), a new iteration of NACHC’s Advocacy Center of Excellence (ACE). Specifically, HACE is an initiative to institutionalize grassroots advocacy at health centers by engaging Hispanic patients and community members in advocacy and giving them a role in the health center movement.

### **VIII. Open Forum**

Members of this committee suggested adding their agenda items to the Govt. Programs or 330 Committees when attendance is high. More member engagement and involvement would be beneficial to these discussions.

### **IX. Migrant Health Coordinator**

Liz Oseguera provided an update on policy changes and opportunities around migrant health and advocacy.

#### One California Campaign

With the help of stakeholder support, the 2017-18 budget includes a historic \$45 million investment to increase and expand services supported by the “One California” Immigration Services Funding. CPCA has supported these efforts in the past and has pledged its commitment to be in support this year as well.

#### Californians for Pesticide Reform

CPCA has been supporting the efforts of Californians for Pesticide Reform by signing onto their organization letter that called on the Governor and the DPR to phase out the use of the insecticide chlorpyrifos, a known neurotoxin.

#### Outreach and Enrollment to H-2A Visa Workers

CPCA and LHA are working in partnership with the North Western PCA to increase outreach efforts to the H-2A visa worker population. This includes reaching out to Mexican Consulates in these states, grower associations and governmental.

### **X. Adjourn**

The meeting was adjourned at 3:28pm.

Respectfully submitted,

Daisy Po’oi  
Meeting Minutes Recorder



**INFORMATIONAL**

Date: June 25, 2017  
To: Ag Worker Health Committee  
From: Elizabeth Oseguera, Senior Policy Analyst  
Re: Migrant Health Coordinator Update

**MEMORANDUM**

**I. NWRPCA 2017 Western Forum for Migrant & Community Health**

CPCA is currently on the planning committee for the Western Forum for Migrant and Community Health. The Migrant and Community Health forum is an annual conference bringing together health professionals from migrant and community health centers and allied organizations. The Forum will be taking place in Seattle, Washington from February 22-24, 2018. For more information please visit <http://www.nwrpca.org/news/358791/Western-Forum-for-Migrant-and-Community-Health-2018.htm>.

CPCA is also working with our immigration partners to develop two workshops regarding immigration. We hope to have one focused on the mental health of immigrants and another on how to prepare clinics for an encounter with immigration, which will include an overview of the sample policies and procedures we've created.

**II. CaliforniaHealth+ Advocates Immigration Resource Page**

CaliforniaHealth+ Advocates has created an immigration resource page where we've compiled materials created by CPCA and our immigrant partners. Among the materials on the immigration resource page are those created by CPCA, including, Frequently Asked Questions (FAQs) document that was prepared in partnership with FTLE and NILC, links to recorded webinars and Know Your Rights materials for patients and clinics. Please contact Liz Oseguera, [loseguera@cpc.org](mailto:loseguera@cpc.org), with any additional resources that could be added to our webpage. Under the resource section please find the link to the immigration resource page.

**III. One California Campaign**

In response to the recession of the DACA program, the legislature increased the funding available through "One California" by \$30 million, bringing the total amount of funding to a historic \$75 million. The One California Campaign is a coalition of diverse stakeholders partnered to advocate for "One California," a state funded program meant to support free and qualified education, outreach and application assistance for immigrants eligible for naturalization or affirmative immigration relief, including those looking to renew their DACA status before the October 5 deadline.

The “One California” Immigration Services Funding, a program administered by the CA Department of Social Services will increase the baseline funding from \$15 million to \$45 million through the 2019-2020 fiscal year, with a \$30 million addition to specifically help DACA recipients. Under this expansion the “One California” program will provide critical immigration expertise for legal service providers across California, application assistance for naturalization, DACA, and other affirmative relief from deportation, legal representation for Californians facing deportation proceedings, including detained immigrants.

On behalf of CPCA, CaliforniaHealth+ Advocates supported these efforts in years past and this year.

#### **IV. Californians for Pesticide Reform**

CaliforniaHealth+ Advocates has continued to support the efforts of Californians for Pesticide Reform by signing onto their organization letter that called on the Governor and the DPR to phase out the use of the insecticide chlorpyrifos, a known neurotoxin. This pesticide has negatively impacted brain development of young children. It is our goal to reduce frontline community exposure to a chemical that is associated with lower IQ test scores and increased rates of autism.

#### **V. Latino Health Alliance Moving Forward**

The Latino Health Alliance (LHA) was created out of a desire to provide a united voice for the Latino community in critical issues affecting the health of Latinos in California. With this in mind, LHA has decided to focus its efforts in creating resources that will help inform migrant workers, including H-2A visa workers, of their health and legal rights and developing a report outlining the impact that the ACA repeal could have in the Latino community.

As a key member of LHA, CPCA is helping to lead the efforts in creating a 1-2 page document explaining the health rights of migrant workers, with a focus on H-2A. We are working with Farmworker Justice, Covered California and the Employment Development Department (EDD) to disseminate the educational materials we create to the migrant community. We are particularly excited to be working with EDD since they oversees labor worker programs, like H-2A, and can help us locate the hardest to reach population, with the help of their 24 outreach workers tasked to provide educational materials to the migrant population.

#### **VI. Resources**

- CaliforniaHealth+ Advocates Immigration Resource Page
  - [http://capca.nationbuilder.com/immigrant\\_resources](http://capca.nationbuilder.com/immigrant_resources)
- Access 2020 Campaign
  - <http://www.ncfh.org/ag-worker-access-2020.html>
  - [Definition of Agriculture and Agricultural Worker](#)
- [LHA Priorities](#)
- [LHA One Pager](#)



**Rural Committee**  
 Tuesday October 10, 2017  
 10:30am – 11:00am

**Lucresha Renteria, Chair**

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Lucresha Renteria	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Executive Summary</li> </ul>	Lucresha Renteria	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 2017 Rural Committee Meeting</li> </ul>	Lucresha Renteria	A
IV. CMSP Update		Laura Sheckler	D
V. HPSA Score Redeterminations: Who has requested, how are they going?		Lucresha Renteria	D
VI. Restructuring the Rural Committee & activating rural participation		Scott McFarland	D
VII. Combating the Opioid Epidemic	<ul style="list-style-type: none"> <li>H&amp;SS Powerpoint</li> <li>Aegis Meeting TPs</li> <li>Principles for FQHC involvement in Hub &amp; Spoke</li> </ul>	Allie Budenz Michael Helmick Meaghan McCamman	D
VIII. Rural and Behavioral Health: - Proposition 63 MHSA - Proposition 64 AUMA	<ul style="list-style-type: none"> <li>PEI and Innovation Comments</li> </ul>	Liz Oseguera Michael Helmick Meaghan McCamman	D
IX. Rural Health Events	<ul style="list-style-type: none"> <li>Running List</li> </ul>	Meaghan McCamman	I
X. Adjourn		Lucresha Renteria	I



*Executive  
Summary*

Date: October 10, 2017  
To: Rural Committee  
From: Meaghan McCamman, Assistant Director of Policy

**MEMORANDUM**

CMSP Update

- Report-out from the CMSP Governing Board Meeting
- Update on CMSP Workforce investment and local grants
- Issues with AMM reservation system

HPSA Score Redeterminations

- Roundtable discussion & report-out from any health center that has requested a HPSA score redetermination

Restructuring the Rural Committee

- Conversation on how to engage more rural members and integrate rural issues with other special populations issues

Combatting the Opioid Epidemic

- The impact of the opioid epidemic in rural America has been garnering national attention
- The \$45 million grant from 21<sup>st</sup> Century Cures act has been awarded and is targeted toward rural SUD
- Report-out from CPCA & member meeting with Aegis, Hub from the rural North
- Next steps & roundtable

Rural Advocacy and Behavioral Health Policy

- Overview of proposed changes to rural reporting requirements for MHSA PEI and Innovation programs
- Update on work of the Proposition 64 AUMA coalition

Rural Health Events List

- This is a list of all rural health events coming up in California

**CALIFORNIA PRIMARY CARE ASSOCIATION**

**RURAL COMMITTEE**

**July 13, 2017**

**3:40pm – 4:10pm**

**Members:** Lucresha Renteria, Chair, Robin Afrime, Tanir Ami, Doreen Bradshaw, Trisha Cooke, Lynn Dorroh-Watson, Ben Flores, Cathy Frey, Virginia Hedrick, David Lavine, Scott McFarland, Danielle Myers, John Price, Tim Rine, Mary Szecey

**Guests:** Melinda Rivera, Christine Noguera, Vernita Todd, Suzie Shupe, Mary Lynch, Rachel Farrell, Susie Foster, Klunna Mine, Michael Schaub, Meryl Schlingheyde, Sendy Sanchez, Cathryn Hyde

**Staff:** Meaghan McCamman, Daisy Po'oi, Andie Patterson, Nataly Diaz, Liz Oseguera, Jana Castillo, Ginger Smith

**I. Call to Order**

Lucresha Renteria, Chair, called the meeting to order at 3:41pm.

**II. Approval of Agenda**

A motion was made to approve the agenda as presented. **The motion carried. (Myers, Bradshaw)**

**III. Approval of Minutes**

A motion was made to approve the minutes of May 4th, 2017. **The motion carried. (Rine, McFarland)**

**IV. Rural Research on Opioid Epidemic**

Meaghan gave an update on the impact of the opioid epidemic in rural America which has been garnering national attention. The \$90 million grant from 21st Century Cures act is targeted toward rural SUD. The Rural committee suggested creating a sub-group to meet with Aegis, the Hub for the rural North, and discuss models of contracting that will work for health centers. The subgroup will meet independently prior to meeting with Aegis.

**V. SAMHSA Hub and Spoke Grant**

CPCA is fielding a lot of interest from Narcotic Treatment Providers (NTPs) interested in working with FQHCs. \$90 million is available for SUD in the state via the Hub-and-Spoke grant. See workplan related to Aegis in issue above.

**VI. CMSP & Whole Person Care**

The whole person care grant was kicked off in Shasta County. Hill Country clinic is involved.

**VII. CBHDA Partnership on Rural Mental Health**

In 2002, then-CMHDA partnered with the Northern Sierra Mental Health Network and the California Institute for Mental Health on a Mental Health Summit that resulted in a final report. Given the attention being placed on rural behavioral health at this time, along with the subsequent federal and state investment, the committee agreed to move forward with a partnership with CBHDA on a revamped rural Mental Health Summit.

**VIII. Rural Health Events & National Health Center Week**

A list of upcoming Rural Health Events was provided to give the committee an opportunity to share and coordinate travel.

**IX. Adjourn**

The meeting was adjourned at 4:12pm.

Respectfully submitted,  
Daisy Po'oi, Meeting Minutes Recorder



# Community Health Centers in the CA Hub and Spoke Services

Allie Budenz

Associate Director of Quality Improvement

California Primary Care Association

[abudenz@cPCA.org](mailto:abudenz@cPCA.org)

# California Primary Care Association

## Mission

- The mission of CPCA is to lead and position community clinics, health centers, and networks through advocacy, education and services as key players in the health care delivery system to improve the health status of their communities.
- CPCA was founded to create a unified, statewide voice for community clinics and health centers.

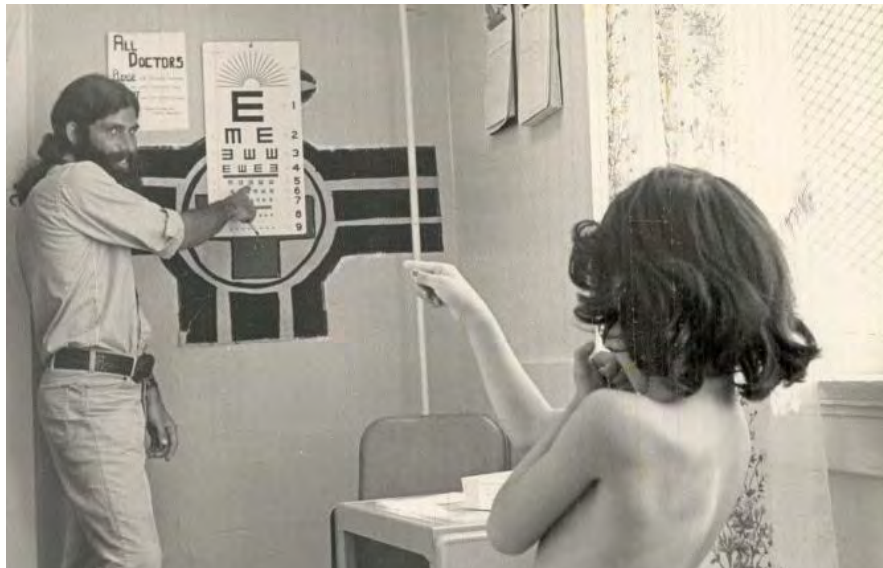
**1,237 Community Clinics and Health Centers (CCHCs) in California**

## Members are comprised of:

- Community Clinics
- Free Clinics
- Federally Qualified Health Centers (FQHCs)
- FQHC Look-Alikes
- Rural Health Clinics
- Migrant Health Centers
- Indian Health Service Clinics
- Planned Parenthood Affiliates of California

# About Health Centers – NACHC.org

- 1960's - Community health and civil rights to address health disparities
- Rooted and responsive to local communities – 51% patient board of directors
- Patient Centered Medical Homes



A FHCS provider conducts a vision screening on a young patient, 1973



AHS General Meeting 2013, utilizing live, simultaneous multilingual translations so that patients can participate in lang. of choice.

# Health Center Services

- Primary care for all ages
  - Pediatrics or family medicine, adult medicine, geriatric medicine
  - Including Medication Assisted Treatment in primary care for opioid use disorder
    - Millions of dollars have gone to CCHC's in the state to augment OUD services; in addition to extensive training and technical assistance (SAMHSA, Project ECHO, CSAM, CHCF, etc.)
- Co-located or integrated behavioral health
  - Some have contracts to provide substance use disorder and specialty mental health
- Enabling services: outreach, education, enrollment, nutrition, social services
- Dental
- Pharmacy
- Specialty care on site or through telemedicine
  - E.g. Office based OB, chiropractic, podiatry, dermatology, ophthalmology, etc.
- School-based clinics

# Prospective Payment System (PPS)

- PPS Scope
- PPS Payment Requirements
  - Face to face encounter
  - Within 4 walls of health center
  - Billable provider (MD, DO, NP, PA, LCSW, Psychologist, MFT in 7/2018)
  - No Medical/BH on the same day
- Options
  - MAT in PPS
  - MAT in DMC-ODS
    - Only a handful of DMC-ODS CHCs in the state



# Questions/Concerns to Anticipate

- What is the value add to CCHCs participating as a spoke?
- How will H&SS model affect communities with developed MAT programs, tailored to the needs of the local populations?
- How does the hub **demonstrate** support for CCHC model of care?
- What happens when the grant ends? What's the sustainability plan?
- For CHC's to answer: How do CHCs partner with NTPs so that programs funded by the grants are clearly excluded from reconciliation.

# Ensuring continuity of care, quality, and access for patients

- What transportation assistance is available for patients?
- What wrap around services are provided at the hub?
- How will hubs measure and sustain quality of care, especially in care coordination between hubs/spokes? How will hubs apprise spokes of their quality scores?
- Providers want to ensure that patients are managed at the right level and that patients looking to abuse the system by seeking methadone and buprenorphine are identified and managed appropriately. How will care coordination work practically? How will we ensure patient safety?



# Human Resources

- How does the hub envision supporting spokes to meet the demand for x-waivered providers in primary care? What training will be provided?
- If hubs will support with staff, who pays the paycheck? Want to make sure the staff is ingrained and accountable to the CCHC.
- Where are hubs going to get their staff, especially in rural areas?
  - Hint: the answer isn't our health centers!
- How can hubs support organizations to address provider stigma and the resistance to patient population and changing culture?

# Reconciling Organizational and Cultural Differences

- CHCs align with a recovery-based culture. Our goal is to graduate patients off of methadone. What is the hub's recovery philosophy? How will the hub step down patients to less intensive therapies?
- What level of care does the hub envision spokes providing? What is the case load they envision each spoke having? Is there a plan for referral and coordination?



# Key Takeaways for Engaging with CHCs

- Start with the relationship, not with the ask;
- If you've seen one health center, you've seen one health center;
- Be honest and flexible;
- **We are here to serve patients first;**
- CCHCs offer patients whole-person care grounded in clinical best practice.



## Introduction CA Hub and Spoke Services (CA H&SS)

Monday, September 18, 2017  
10 a.m. to 12 p.m.

Conference Call: 888-585-9008  
Access Code: 187-697-514

### In attendance:

- *Chapa-De Indian Health Center*
  - Katie Grace Bell
- *Community Medical Centers*
  - Christine Noguera
  - Stanley Cias, Jr.
- *El Dorado CHC*
  - Terri Stratton
  - Gina Anderson
- *Harmony Health*
  - Rachel Farrell
- *Peach Tree Health Center*
  - David Quackenbush
- *Wellspace Health*
  - Jonathan Porteus
  - Sean Benedict
- *Western Sierra Medical Clinic*
  - Scott McFarland
  - Jessica Fraser
- *Cathy Frey, Central Valley Health Network*
- *Allie Budenz, CPCA*
- *Meaghan McCamman, CPCA*
- *Michael Helmick, CPCA*
- *Alex Dodd, CEO*
- *Judson Lea, Northern Regional Clinic Manager*
- *Rebecca Mitchel, Regional Clinic Manager*
- *Sarah Khawaja, CA H&SS Regional Clinic Manager*

### Supporting Materials:

- Google Map: Overlay of Aegis Service Area with CCHC's  
<https://drive.google.com/open?id=1Mu-j8jIV06QOFMUqBPiaB7KSGFs&usp=sharing>

### Agenda:

- I. Welcome and Introductions (40 minutes – no more than 5 minutes per health center)
  - \*CHCs should bring clinic profiles and other marketing materials, if interested
  - a. CPCA and CVHN Introduction
  - b. Health Centers to introduce themselves and their organizations, focusing on:
    - i. History with MAT (including: care management approach, MAT care team members, strengths and gaps in service)
    - ii. Future goals with MAT (what role do you see MAT playing in your operations?)
  - c. What do you hope to gain or learn from this meeting?
- II. Aegis Service Updates (15 minutes)
- III. Challenges and Opportunities of Hub and Spoke Collaboration (50 minutes)
  - a. Ensuring continuity of care, quality, and access for patients
    - i. How will Aegis support patients to travel to hubs?
    - ii. What wrap around services are provided at the MU/NTP?
    - iii. How will hubs measure and sustain quality of care, especially in care coordination between hubs/spokes? How will Aegis keep spokes apprised of their quality levels?
    - iv. Providers want to ensure that patients are managed at the right level and that patients looking to abuse the system by seeking methadone and buprenorphine

are identified and managed appropriately. How will care coordination work practically? How will we ensure patient safety?

- b. Reconciling cultural differences
    - i. CHCs align with a recovery-based culture. Our goal is to graduate patients off of methadone. What is Aegis' recovery philosophy and how do you step down patients to less intensive therapies?
    - ii. What level of care does Aegis envision spokes providing? What is the case load they envision each spoke having? Is there a plan for referral and coordination?
  - c. Human resources
    - i. How does Aegis envision supporting spokes to meet the demand for x-waivered providers in primary care?
    - ii. How can Aegis support organizations to address provider stigma and the resistance to patient population and changing culture?
  - d. What is the value add for CHCs participating in H&SS?
- IV. Next Steps (15 minutes)
- a. Do we need to continue these meetings? How often? Where?
  - b. Individual CHC's to connect with Aegis offline?
  - c. Site visits to CHCs? To Aegis?



## *Principles for CCHC Spoke Involvement in CA MAT Expansion*

The California Department of Health Care Services (DHCS) was awarded \$44.7 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the opioid crisis. California proposed an expansion of the state’s medication assisted treatment (MAT) infrastructure and pledged to curb the rate of opioid related deaths through prevention, improved access to treatment, and a reduction in unmet treatment need.

In July 2017, DHCS sub granted 19 awards in the California Hub & Spoke System (CA H&SS). Each CA H&SS consists of a “Hub” and one or more “Spokes”. In this model, Narcotic Treatment Programs (NTP) or Medication Units will serve as a Hub, serving the most clinical and socially complex patients requiring intensive intervention. “Spokes” are comprised of at least one federally approved Data 2000 prescriber and a MAT team to monitor adherence to treatment, coordinate access to recovery supports and provide counseling. Hubs are beholden to the scope of work outlined by their state contract. Hubs will need to partner with one or multiple spokes to meet demand. Patients can move between the hub and spoke based on clinical severity and need.

Community clinics and health centers (CCHCs) are ideal partners to serve as spokes because most already provide a whole person care approach to treatment, with integrated behavioral and social supports provided to patients and families. CCHCs who already provide MAT services are especially prepared, and should consider partnering with a “Hub” to expand the network of services available to their patients receiving MAT. When approaching a Hub, CCHCs should know that while there are no requirements that Hubs provide funding to spokes, spokes can advocate for support to curb operational or expansion costs.

This document outlines principles for CA H&SS involvement that the California Primary Care Association has developed with input from members. Health centers should consult these principles as a springboard for options when negotiating with hubs.

### **1. CCHCs offer patients whole-person care**

Many CCHCs have several years of experience supporting MAT within an integrated medical and behavioral health model to promote the holistic recovery of patients with opioid use disorder. In the hub and spoke model, CCHCs established care modality should be respected and those CCHCs with established behavioral models should not be utilized exclusively for induction and medication maintenance. Where applicable, hubs should capitalize on the whole-person framework that CCHCs offer and utilize them for medication induction and behavioral health treatment, care management, and other recovery-oriented supports.

**2. We are here to serve patients, first**

CCHCs are non-profit, community-owned and operated businesses with underlying missions dedicated to community service. Partners need to demonstrate a genuine interest in their community with a history of positive social impact. Hubs should have a philanthropic focus to their mission and vision and wish to genuinely partner with spokes to serve the population.

**3. Hubs receive funding for coordination and care management**

DHCS estimates that statewide, each spoke will serve approximately 35-50 patients in year one and 75 patients in year two. Hubs must provide spokes with the requisite financial resources to promote the integrated MAT care model and achieve quality care outcomes. Contractual relationships with CCHC spokes should cover supportive therapeutic and care management costs not covered by Medi-Cal PPS reimbursement.

Hubs have been awarded their grant and proposed budget of up to \$2.6 million and must stay within the limitations of the approved budget. This will affect what the hub is able to offer to the spoke to facilitate partnership and care coordination. CCHCs should understand the limitations and restrictions found in the [Scope of Work](#) for this grant. For example, allowable expenses include:

- a. Medication costs, including all FDA-approved medications for MAT, when no other funding source exists;
- b. Opioid coalition efforts;
- c. Infrastructure costs to expand services or implement the new model; including but not limited to purchasing safes to store buprenorphine or methadone, minor facility improvements necessary for expansion, or similar infrastructure costs. Grants may not be used to purchase or lease a building;
- d. Improvements on data infrastructure, including but not limited to: amending electronic health records, developing shared releases of information, adding electronic forms and/or signatures, or other data infrastructure needs;
- e. Telehealth infrastructure and mobile technology costs;
- f. Tokens or transportation vouchers for CA H&SS patients.

Non allowable expenses include professional service fees, including prescribing physician, physician assistant, and nurse practitioner costs, except in cases where initial start-up costs are required for the first six months, or to cover uninsured patients not eligible for other coverage.

**4. This funding is meant to fill gaps, but is not a new payer**

The CA H&SS funding is intended to be a payer of last resort and provide the care continuum with an infusion of funds that may build the care continuum within the two year grant period. It is absolutely critical for programs to build a care infrastructure that is sustainable without the grant funding. CPCA encourages NTP Hubs and CCHC Spokes to identify and share best practices that leverage the different services and unique payer sources for each provider group. Where feasible, NTPs and CCHCs should consider formalized partnership arrangements, like bi-directional, co-located CCHCs with SUD/OD facilities.

September 28, 2017

Mental Health Services Oversight and Accountability Commission  
Attn: Kayla Landry and Toby Ewing  
1325 J Street, Suite 1700  
Sacramento, CA 95814

**Re: Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations**

Dear Mrs. Kayla Landry and Mr. Toby Ewing,

On behalf of California's more than 1,200 California community clinics and health centers (CCHCs) and the 6 million patients they serve, CaliforniaHealth+ Advocates (Advocates) thanks you for the opportunity to submit written comment on the draft regulations for Prevention and Early Intervention (PEI) and Innovation programs.

Health centers have a long history of providing prevention and early intervention services to underserved and low-income populations through integrated behavioral health and physical health care. In fact, over 85% of our member health centers have successfully integrated primary and mental health care services in order to treat co-occurring physical and mental health conditions. Health centers treat the 'whole person' while keeping the community-based wellness model front and center, providing culturally relevant services in the languages spoken by patients. 36 percent of health center patients speak a language other than English, and 70% are persons of color with a diverse array of racial and ethnic backgrounds.

For years health centers, some of which have partnered with counties through MHSA, have universally screened primary care patients with behavioral assessments to ensure mental health conditions are captured and addressed early, prior to becoming severe. A report done by UCLA Center for Health Policy in 2015 notes that more than 70% of behavioral health conditions are diagnosed and treated within the primary care setting, underscoring just how critical the role of primary care is in linking patients to care for their behavioral health conditions.<sup>i</sup> CCHCs are the best first responders to divert complications of serious mental illness, and are key partners in meeting the needs of communities of color who are otherwise untouched and underserved by the county system.

CaliforniaHealth+ Advocates is extremely concerned that the amended regulations propose to no longer require counties to collect demographic information on children 12 and under who utilize PEI and Innovation funded programs. This means that counties would no longer have the responsibility to collect and report on the race, ethnicity, age, and the primary household language for children receiving PEI and Innovation-funded services. Given that 51% of PEI funds must be used to provide services for patients 0-25, this proposed amendment would prevent the state from ensuring that counties are serving the intended recipients, particularly the most vulnerable, children.

To achieve high-quality, equitable care delivery within MHSAs-funded programs, it is critical to identify health disparities among the population served and work to eliminate such disparities. CCHCs work closely with other health care providers, behavioral health providers, health plans, advocacy groups, and local government, among others, to ensure that health care services are available and accessible for *all* Californians, regardless of race, ethnicity, and primary language. For the OAC to be moving in the opposite direction – to move *away* from a requirement that counties collect this important demographic information – goes against the work that we are doing in the rest of the health care delivery system.

In creating this exemption, the OAC would sacrifice its ability, and the ability of the public, to track and ensure that services are reaching the full spectrum of communities throughout California. Even more alarming is the consideration that counties will no longer need to internally collect this demographic information, creating a potential gap in care for diverse communities – a gap we would not even know about. Ensuring that *all* Californians, regardless of race, ethnicity, or language, are able to equally access services should be a priority for the OAC, the counties, and the MHSAs program. **California Health+ Advocates strongly recommends that the OAC continue to require counties to collect important demographic information for *all* recipients of MHSAs funded services.**

While Advocates believes the collecting and reporting of demographic data is important for children until 12, there is one data element we do not recommend collecting. Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual communities and allies have expressed concerns in asking children 12 and under to provide their sexual orientation because this information is made available to parents and potentially violates patient rights and protections. **We ask that the OAC exempt all counties from collecting information concerning sexual orientation or gender identity for children 12 and under.**

Finally, we wish to express our sincere interest in being at the table for this and other future conversations regarding the MHSAs. If you have any questions please feel free to contact Elizabeth Oseguera at 916-503-9130 or at [liz@healthplusadvocates.org](mailto:liz@healthplusadvocates.org).

Respectfully,

Carmela Castellano-Garcia  
President and CEO  
California Primary Care Association

<sup>i</sup> UCLA Center for Health Policy Research, One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers, January 2015  
<http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/integrationbrief-jan2015.pdf>



Date: October 10, 2017  
To: Rural Committee  
From: Meaghan McCamman, Assistant Director of Policy  
Re: Rural Events 2017-2018

MEMORANDUM

**Educational Conferences**

The CPCA Rural Committee has requested that staff maintain a list of rural-specific conferences in order to ensure that California Rural is represented whenever possible in rural educational, networking, and policy venues. The following is a list of upcoming rural-specific conferences:

National Association of Counties 2017 Rural Action Caucus  
Oct 5 - 7, 2017  
Wise County, TX

9th Annual Rural Behavioral Health Practice Conference  
Oct 6, 2017  
Morris, MN

2017 Annual National Association of Rural Health Clinics Fall Institute  
Oct 17 - 19, 2017  
Indianapolis, IN

NRHA Rural Health Policy Institute  
Feb. 6-8, 2018 in Washington D.C.  
Omni Shoreham Hotel

NRHA Annual Rural Health Conference  
May 8-11, 2018 in New Orleans, La.  
New Orleans Marriott Hotel

NRHA Rural Hospital Innovation Summit  
May 8-11, 2018 in New Orleans, La.  
New Orleans Marriott Hotel

NRHA Health Equity Conference  
May 8, 2018 in New Orleans, La.  
New Orleans Marriott Hotel

NRHA Rural Medical Education Conference  
May 8, 2018 in New Orleans, La.  
New Orleans Marriott Hotel

NRHA Rural Quality and Clinical Conference  
July 18-20, 2018 in Washington D.C.  
Omni Shoreham Hotel

NRHA Rural Health Clinic Conference  
Sept. 25-26, 2018 in Kansas City, Mo.  
Sheraton Kansas City Hotel at Crown Center

NRHA Critical Access Hospital Conference  
Sept. 26-28, 2018 in Kansas City, Mo.  
Sheraton Kansas City Hotel at Crown Center



# Government Programs Committee

Tuesday, October 10, 2017

11:00pm – 12:30pm

Isabel Becerra, Chair

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Isabel Becerra	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Executive Summary</li> </ul>	Isabel Becerra	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July Meeting Minutes</li> </ul>	Isabel Becerra	A
IV. 340B	<ul style="list-style-type: none"> <li>340B Memo</li> <li>NACHC 340B Federal Update</li> </ul>	Andie Patterson	D
V. Licensing	<ul style="list-style-type: none"> <li>Licensing Memo</li> </ul>	Emily Shipman Ginger Smith	I
VI. OSHPD 3	<ul style="list-style-type: none"> <li>OSHPD 3 Memo</li> </ul>	Andie Patterson Michael Helmick	A
VII. Managed Care	<ul style="list-style-type: none"> <li>Managed Care Update               <ul style="list-style-type: none"> <li>Unseen Patients</li> <li>Procurement</li> <li>Mergers</li> </ul> </li> </ul>	Meaghan McCamman Nenick Vu	D
VIII. Behavioral Health	<ul style="list-style-type: none"> <li>BH Update Memo</li> </ul>	Liz Oseguera Michael Helmick Allie Budenz	D
IX. Pharmacy & Adult Immunizations	<ul style="list-style-type: none"> <li>Pharmacy &amp; Adult Immunizations Update</li> </ul>	Meaghan McCamman Allie Budenz	D
X. Lifeline Grant Program	<ul style="list-style-type: none"> <li>Grant Program Memo</li> </ul>	Beth Malinowski	D
XI. Immigration Update	<ul style="list-style-type: none"> <li>Immigration Memo</li> </ul>	Liz Oseguera	I
XII. 2703 PCHH	<ul style="list-style-type: none"> <li>2703 PCHH memo</li> </ul>	Allie Budenz	I
XIII. Oral Health	<ul style="list-style-type: none"> <li>Oral Health Memo</li> </ul>	Beth Malinowski Emili Labass	I
XIV. Adjourn		Isabel Becerra	A



*Executive  
Summary*

Date: October 10, 2017  
To: Government Programs Committee  
From: Meaghan McCamman, Assistant Director of Policy

**MEMORANDUM**

340B

- CPCA met with DHCS staff on how to develop a 340B reporting process for covered entities that utilize contract pharmacies in Medi-Cal managed care.
- The state remains concerned that there is no value to the state to allow contract pharmacies in 340B.
- CPCA is engaging legal counsel to better understand DHCS' assertions regarding the 340B program.

Licensing

- CPCA met with Licensing & Certification leadership in September to go over process improvements related to licensing application checklists, backlog within the Centralized Applications Unit, and licensing process challenges.
- Through this meeting, CPCA successfully established the prioritization of clinic applications and immediate assignment of affiliate and consolidated applications to analysts for processing.
- CPCA will weigh in on the drafted application checklists from L&C with a release date goal of end of October. CPCA & L&C will partner to offer training on licensing processes for clinics.
- L&C will begin posting backlog metrics publically to help track current status and impact of improvement efforts, likely within the next month.

OSHPD 3

- Staff have conducted a legal, regulatory and legislative analysis of OSHPD3 and ascertain there is no quick and easy way to exempt health centers from OSHPD 3 requirements
- Staff have however outlined a multi-pronged approach to help alleviate the challenges of OSHPD 3, all of which help to lay the ground work for a future legislative attempt to exempt health centers

Managed Care

- CPCA's Unseen Patients Workgroup is currently tracking several managed care plan pilots, and is evaluating several policy strategies, each of which could potentially impact a portion of the unseen patient population.
- CPCA is tracking the DHCS commercial Medi-Cal procurement, and is reaching out to each of the impacted health plans to understand their strategy for the procurement and leverage their incentive to improve quality and data reporting.

- CPCA is tracking the investments made as a result of the recent managed care mergers. Opportunities for low-cost loans will be available soon.

### Behavioral Health

- CPCA and CaliforniaHealth+ Advocates have developed a three-pronged approach to meeting our behavioral health goal of supporting CCHCs in providing the behavioral health services needed by their communities
- The approach includes 1) removing regulatory barriers, 2) expanding access to resources, and 3) ensuring health centers are included in all policy discussions.
- This memo provides an update on our full workplan

### Pharmacy and Adult Immunizations

- CPCA will facilitate a short conversation around barriers to FQHCs providing high-cost injectable medications such as Vivitrol and adult immunizations.

### Lifeline Grant Program

- The Budget Act of 2017 established the Community Clinic Lifeline Grant Program (Lifeline Program) within the California State Treasurer’s Health Facilities Financing Authority (CHFFA) for small and rural health clinics suffering financial losses.
- CHFFA is responsible for developing additional selection criteria and a process for awarding the grants, which may not exceed \$250,000 per health facility site.
- Since the enactment of the Budget Act of 2017, CHFFA staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. CPCA is in ongoing communication with CHFFA staff and leadership.
- CPCA is seeking additional member feedback on a variety of implementation areas – maximum awards; eligibility criteria; evaluation criteria; eligible use of grant funds; funding distribution; and emergency regulation triggers.

### Immigration Update

- On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program via a “phase out.”
- During Legislative Committee we will be voting on a number of federal bills related to immigration. Specifically we are asking members to take:
  - A support position on the Dream Act, which would provide young immigrants, including DACA recipients, to have a clear path to citizenship.
  - Oppose position on the RAISE Act, which would radically reduce legal immigration to the United States.
  - Oppose position on the SUCCEED Act, which would force immigrant youth to wait 15 years to be provided an opportunity to apply for citizenship.

### 2703 PCHH Update

- DHCS communicated that Health Homes for Patients with Complex Needs will begin in phase 1 counties in July 2018.

- Pilot must be cost neutral or yield savings within two years in order to keep the health homes benefit into perpetuity.
- CPCA leading effort to convene small workgroup of plans and providers to discuss how to best coordinate the execution and delivery of successful pilot.

#### Oral Health

- CPCA recently participated in the first meeting of the new Medicaid | Medicare | CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing's FQHC Dental Policy Workgroup, a workgroup designed to find national solutions for dental audits and other challenges impacting oral health access for the underserved.

**CALIFORNIA PRIMARY CARE  
ASSOCIATION**

**GOVERNMENT PROGRAMS COMMITTEE**

**July 13, 2017**

**12:30pm – 2:00pm**

**Members:** Isabel Becerra – Chair, Antonio Alatorre, Tanir Ami, Alex Armstrong, Linda Costa, Lucinda Bazile, Doreen Bradshaw, Trisha Cooke, Irma Cota, Lynn Dorroh-Watson, Reymundo Espinoza, Rachel Farrell, Benjamin Flores, Cathy Frey, Jane Garcia, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Haleh Hatami, Virginia Hedrick, Kerry Hydash, Cathryn Hyde, Tina Jagtiani, Deena Lahn, David Lavine, Deborah Lerner, Marty Lynch, Alicia Mardini, Kevin Mattson, Louise McCarthy, Scott McFarland, Leslie McGowan, Danielle Myers, Christine Noguera, Justin Preas, Carole Press, Tim Pusateri, Tracy Ream, Tim Rine, Melinda Rivera, Corinne Sanchez, Suzie Shupe, Paulo Soares, Graciela Soto-Perez, Terri Lee Stratton, Vernita Todd, Henry Tuttle, Christina Velasco, Terri Vise, David Vliet, Paula Wilson

**Guests:** Jason Vega, Anitha Mullangi, Jennifer Hunter, Susie Foster, Sergio Bautista, Jill Damian, Esen Kurdoglu, Maria Paz

**Staff:** Carmela Castellano-Garcia, Andie Patterson, Meaghan McCamman, Daisy Po’oi, Mike Witte, Allie Budenz, Emily Shipman, Nenick Vu, Ginger Smith, Val Sheehan

**I. Call to Order**

Isabel Becerra, Committee Chair, called the meeting to order at 12:32pm.

**II. Approval of Agenda**

A motion was made to approve the agenda as presented. **The motion carried. (K. Mattson, N. Gupta)**

**III. Approval of Minutes**

A motion was made to approve the minutes of January 12<sup>th</sup>, 2017. **The motion carried. (T. Rine, S. McFarland)**

**IV. Medi-Cal Managed Care Procurement**

DHCS has announced plans to re-procure all Medi-Cal Managed Care Commercial plan contracts in 2019/2020. This will affect at least one plan in every county except COHS counties. In procuring all new contracts, DHCS has indicated they will seek to improve the quality of the Medi-Cal managed care program.

**V. Assigned but Unseen Patients**

With the growth of the Medi-Cal program, the problem of assigned patients who do not ever seek care at their assigned PCP is growing. Not only are assigned but unseen patients dragging down HEDIS scores, but in some cases FQHCs are having to reconcile their managed care capitation. CPCA is launching a workgroup to explore solutions to this issue.

**VI. Licensing & OSHPD3**

CPCA asks the committee to evaluate options for streamlining and improving the current licensing process. CPCA has released both the licensing and OSHPD 3 surveys to inform our strategy in both areas. CPCA is working with Deborah Rotenberg, Consultant, on the issues stated in the survey. The results of the survey will be shared with this group in advance of the October board meeting. The committee would like CPCA to put together a written plan of action and timeline of when these issues will be addressed and with whom.

**VII. 340B**

The Governor is expected to sign a state budget that does not include the 340B proposal. CPCA staff will be working with DHCS and other stakeholders to create a process where health centers can continue to use contract pharmacies in 340B.

### **VIII. Behavioral Health**

DHCS is awarding 15 grants to implement the Hub and Spoke services, with particular attention to rural counties. CHCs are ideal partners to serve as outpatient “spokes” in this model because of their integrated medical/behavioral approach to medication assisted treatment. CHCs can sign on after the grants are awarded. CPCA is working with a coalition to thoughtfully build consensus around the use of Prop 64 dollars. This committee will discuss proposed principles and priorities for CPCA to bring to the coalition.

According to the Draft Program Guidelines released by the Department of Housing and Community Development, counties applying for funding under NPLH are required to submit a supportive services plan listing the services that will be provided to tenants. CPCA has been successful in ensuring that as part of these services, counties must include linkage to physical healthcare. In May CPCA submitted a comment letter providing recommendations on how HCD could improve the supportive services offered to tenants benefitting from NPLH.

Under MHSA, counties who do not spend portions of their MHSA funding within three years are required to revert those funds back to the state. Unfortunately this has not been occurring. Thus the OAC has put forth recommendation to ensure counties are reverting unused funds back to the state. The OAC has created a subcommittee that is tasked with revising its PEI and Innovation regulations to accommodate the needs of very tiny counties (counties with a population of 50,000 or less).

### **IX. Immigration Update**

CPCA has been leading the effort in collaborated with other state PCA’s, NACHC, and immigration partners, such as the Nation Immigration Law Center (NILC), to develop an FAQ that provides a detail review on what health centers can do to prepare themselves and their patients for an ICE raid. An Immigration workgroup was created in CPCA to provide members updates on the immigration work we are undertaking and receive input from members on resources, trainings and other technical assistance developed by CPCA. CPCA is planning to host trainings in the summer to provide health centers with guidance on how to protect patients, staff and the health center itself from immigration enforcement. CPCA in coordination with the NWPCA is working to finalize the Policy and Procedures.

### **IX. Adjourn**

The meeting was adjourned at 1:59pm. **The motion carried. (L. McCarthy, N. Gupta)**

Respectfully submitted,

Daisy Po’oi  
Meeting Minutes Recorder



**DISCUSSION**

Date: September 25, 2017  
To: Government Programs Committee  
From: Andie Patterson, Director of Government Affairs  
Re: 340B Update

**MEMORANDUM**

**I. State Budget Proposal**

The passed FY 17-18 budget includes no changes to contract pharmacies or other provisions relating to the 340B Program. Neither the Governor’s May Revised 2017 Budget proposal that would have eliminated the use of contract pharmacies in managed care 340B nor the Governor’s January proposal to eliminate 340B savings in managed care, made it into the final budget deal. Despite losing the budget proposal, DHCS remains concerned that health plans and covered entities are not appropriately reporting 340B drug claims, thus putting the state at risk of duplicate discounts and impairing their ability to secure drug rebates.

**II. Meeting with the State**

CPCA along with the California Hospital Association and the California Association of Public Hospitals met with DHCS to continue discussions in mid-September. The stakeholders’ purpose for the meeting was to begin negotiations on a process that can achieve both the covered entity objective to continue using contract pharmacies in 340B managed care as well as the state’s objective to avoid duplicate discounts. Prioritizing these conversations now will allow stakeholders to be prepared when the legislature returns in January 2018. In particular, if deemed necessary, CaliforniaHealth+ Advocates, working with other stakeholders, may proactively introduce legislation to address this matter.

**A. Challenges for the State**

The state started off the meeting by sharing that they are in the “same place as before,” or, in other words, are not comfortable with contract pharmacy arrangements. Their argument for not liking contract pharmacies is multi-fold:

1. It brings no value to the state, just the providers (i.e. no general fund savings).
2. They can’t track the claims well.
3. They can’t control the program.
4. There is great liability on them for misreporting.

The state is, unsurprisingly, not moved by the “value” health centers or hospitals put back into the delivery system from their 340B savings. The additional services to patients is not a winning argument for them. In their estimation they should be receiving Medi-Cal drug rebates to the

general fund instead of covered entities receiving 340B savings. They are concerned that they are liable for paying back millions of dollars if they unknowingly submit a batch of claims for a Medi-Cal drug rebate where even just one claim was actually a drug purchased at 340B prices but was not coded as such. In these circumstances, according to the state, they have to pay back the full amount of the rebate received from the batch submitted to the manufacturer, not just the one claim. Further, they allege that drug manufacturers are allowed to contest Medi-Cal drug rebate claims back to the start of the 340B program in 1992 so the liability on the state is tremendous.

#### B. 340B Rules

Part of the reason they cannot track claims is because the state has not created the rules to do so. CPCA raised the challenge covered entities face by the lack of rules provided by the state, to which the state contends there are rules. The state is arguing that the FFS rules on 340B also apply to managed care because they are for the Medicaid program writ large. It is their contention that covered entities in FFS are appropriately following the rules but not covered entities in managed care. The state also argued that there are rules for covered entities and HRSA has made them clear.

HRSA issued a notice in the Federal Register in March 2010 that states:

(i) Neither party will use drugs purchased under section 340B to dispense Medicaid prescriptions, unless the covered entity, the contract pharmacy and the State Medicaid agency have established an arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the OPA, HRSA, by the covered entity.

#### C. Approved Models

According to DHCS, the only such approved arrangement is the Partnership Health Plan model. No other contract pharmacy arrangements have been approved and thus are not technically allowed. They acknowledge that they have not set the rules by which approval is done, but contend no other plan or covered entity has reached out for approval. Further, while Partnership Health Plan is the only model they have approved, they cautioned not to use it as a model, insinuating the arrangement could be terminated.

In the Partnership model, the health plan submits claims, including 340B coded claims, every four weeks. In their arrangement a patient goes to Walgreens, for example, and purchases a drug. Walgreens submits a claim to the pharmacy benefits manager (PBM) on behalf of the health plan who then sends it to a third party administrator (TPA) that "matches" health plan data (payments) and pharmacy data (drugs bought at 340b) on a monthly basis. The PBM ultimately aggregates the claims and provides them to the plan who submits to the state. The state then submits quarterly for drug rebates, excluding the Partnership 340B coded claims.

#### D. Reporting

When the stakeholders questioned the state's allowance for in-house pharmacy arrangements, the state argued the rationale was because in-house pharmacies can do point of sale reporting. Most, if not all, contract pharmacy models involve retrospective 340B claims. The reason for this is the pharmacy is not able to tell if the individual picking up a prescription is 340B eligible or not. This tracking must be done retrospectively. The Partnership model presents a methodology where retrospective reporting is done and still protects the state. It is not clear to us why point of sale reporting is desired by the state if they only submit for drug rebates quarterly.

### **III. Next Steps**

The meeting was a success in terms of having an honest conversation and hearing all the elements of the DHCS argument. We left the meeting having made the case that we are valuable partners at the table to create a strong reporting program that will allow contract pharmacies. The state agreed to circle back with the stakeholders after further internal discussions.

DHCS made a number of assertions that require additional research. CPCA has sought legal guidance on a number of them including:

1. Does the FFS SPA for 340B apply to Medi-Cal managed care?
2. Is the law clear that the state must approve an arrangement in order for contract pharmacies to be used for 340B?
3. If so, is there financial exposure for health centers who are or have been utilizing contract pharmacies in the 340B program?

We recognize the questions and the information is of utmost importance and we will be providing the information as quickly as possible.

Additionally, while the state insinuated that the Partnership Health Plan model was not the example to follow, we note that it has been approved, claims are appropriately coded, and it does allow the state to appropriately seek the drug rebates. We will continue exploring this and other models that provide the same protection to covered entities and the state.

CPCA is currently engaging with a wide variety of stakeholders, including many of the statewide associations that united together earlier in 2017 to push back on the administration's budget proposals. In addition to continuing our work with CHA and CAPH, we are also engaging with 340b vendors and contract pharmacies (Walgreens), Apexus, NACHC and other PCA partners for technical assistance and problem solving.

## 340B Federal Policy Update

**As of 8/4/2017**

Developed by NACHC

**340B on the Hill:** While Congress was consumed with repeal and replace for the majority of the past several months, we continue to hear conversations around 340B on the Hill. Specifically:

- House Committee leadership expresses concerns re: program management and audits. In early June, leadership of the House Energy and Commerce Committee wrote a letter to HRSA expressing concerns around 340B program management and requesting information related to audits. Specifically, the letter expressed concerns around the recent growth of the program without additional oversight, the lack of reporting around how savings from the program are used, auditing processes, and concerns related to diversion and duplicate discounts. HRSA submitted the requested information to the Committee just prior to the hearing (see below.)
- House Subcommittee holds oversight hearing: On Tuesday, July 18<sup>th</sup> the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing which focused on HRSA's oversight of the 340B program. Witnesses included a representative from HRSA's Office of Pharmacy Affairs (OPA), which oversees the 340B program, along with representatives from HHS OIG and GAO, both of whom have made recommendations to HRSA about potential areas for improvement within the program.

Overall, throughout the hearing there was broad, bipartisan support for the mission of the 340B program and its commitment to allowing covered entities to stretch scarce federal dollars to provide care to vulnerable populations. However, both the subcommittee and the panel of witnesses expressed general concern over the lack of program transparency and the need for additional oversight. In particular, concerns were raised around:

- the lack of requirements for covered entities – especially hospitals – to report how they use 340B savings,
- the definition of an eligible patient and
- whether HRSA should be given more regulatory authority.

The issue of rising drug costs was also addressed several times, with members noting that increased transparency in drug pricing is critical to controlling drug prices overall. A handful of Democratic committee members stressed that the recent CMS proposed rule, which would reduce Medicare Part B drug reimbursement for hospitals participating in 340B, would significantly reduce support for the program. (See a description of this proposal below.)

In advance of the hearing, NACHC submitted a statement for the record (also attached to this email.)

- NACHC staff meet with staff from House Subcommittee: The day after the hearing, NACHC staff met with staff from the E&C Oversight and Investigations Subcommittee to provide them with information about the importance of the 340B program to health centers, including examples of how health centers use 340B savings to benefit their entire patient population.

**Leaked, draft Executive Order (EO) on drug pricing appears to target multiple contract pharmacy arrangements:** In late June, a draft version of a potential EO on drug pricing was leaked to the press. This draft EO specifically mentioned 340B, calling on HRSA to ensure that 340B savings “primarily

benefit the lower income or otherwise vulnerable Americans for which the program was intended” and to revise or rescind policies that allow benefits to accrue to “entities other than the safety net healthcare providers”. This latter language has been interpreted as directing HRSA to rescind its policy permitting FQHCs and other 340B providers to contract with more than one contract pharmacy. While such a policy change would be very concerning, it is important to note that the draft EO has not been signed, and could be significantly revised before being signed.

**PCAs continue working to protect FQHCs’ ability to retain 340B savings on Medicaid managed care drugs; two PCAs discuss their success to date.** The requirement that Medicaid reimburse no more than the ceiling price for *fee-for-service* drugs purchased under 340B became effective on April 1, with state plans due to CMS not later than June 30. While there is no requirement that state Medicaid agencies take the 340B savings for drugs reimbursed under *managed care*, many states are seeking to do so. Both California and Ohio have had some success in pushing back on these efforts, and spoke about their experiences at the recent 340B conference. Their slides are attached to this email.

**HRSA expected to launch ceiling price database very soon:** HRSA is expected to launch the long-awaited Ceiling Price Database this fall. Since the inception of the 340B program in 1992, there has been no universal, reliable way for providers to determine if they are being charged the correct amount for a 340B drug. The database will address this concern, by creating a central location where manufacturers, providers, state Medicaid agencies, and HRSA can view and verify 340B ceiling prices.

**Fines on manufacturers who overcharge provider scheduled to start on October 1, 2017:** After two delays by the Trump Administration, on October 1, 2017, HRSA is scheduled to receive authority to fine manufacturers who “knowingly and intentionally” overcharge providers for 340B drugs. These fines are officially known as “Civil Monetary Penalties” or CMPs.

**Medicare seeks to reign in what it sees as abuses by 340B hospitals:** Earlier this month, CMS [proposed a regulation](#) outlining how hospital outpatient departments will be reimbursed in 2018. One of their proposals would significantly reduce how much 340B-eligible hospitals are reimbursed for drugs that they purchase under 340B, eliminating much of the 340B savings that these hospitals accrue on their Medicare patients. Note that this proposal:

- does not impact FQHCs. (It’s limited to hospital outpatient departments)
- will not save CMS money. While CMS estimates that the proposal will reduce drug payments to 340B hospitals by as much as \$900 million, all these savings will be used to increase other types of payments. This suggests that CMS’ goal is not cost-savings, but rather to correct what they consider to be abuses caused by the 340B program.

**Over 300 health center staff attend 340B Summer Conference in DC; NACHC hosts three FQHC-specific sessions** From July 10 -12, over 300 health center representatives came to DC to attend the 340B Coalition’s Summer 2017 conference. (The Coalition consists of groups representing 340B providers, including hospitals, HIV/AIDS clinics, and health centers. NACHC is an active member.) Sessions covered a range of issues, including compliance, the loss of 340B revenues to Medicaid and private insurers, and potential efforts to limit the use of contract pharmacies. During the Opening Plenary, NACHC staff spoke about the importance of 340B to health centers and their patients. NACHC then hosted three sessions for health center participants, addressing: general policy updates; developing an in-house pharmacy; and reimbursement issues. In addition, both the California and Ohio PCAs discussed their efforts to push back the states’ efforts to limit their ability to retain 340B savings under Medicaid. (See discussion above, and attached slides.)



INFORMATIONAL

Date: October 10, 2017  
To: Government Programs Committee  
From: Emily Shipman, Senior Program Coordinator of Health Center Operations, CPCA  
Re: Licensing

MEMORANDUM

### I. Background

Since the consolidation of licensing applications from the local L&C offices to the Centralized Applications Unit (CAU) beginning in 2015, the timeline for approval of licensing applications has grown significantly. The latest word from Licensing & Certification is that they have a backlog of at least 3 months. Both the consolidation and application accuracy issues are compounding the delays for health centers.

In response to those challenges, CPCA formed a Licensing Workgroup to identify problem areas, facilitate ongoing dialog with the California Department of Public Health (CDPH), and support reforms. We expanded the staff and contractors involved in this issue to include Deborah Rotenberg, formerly with the Planned Parenthood Affiliates of California and now operating in private practice, to assist in strategizing and pushing our licensing work forward.

### II. Licensing Strategy Update

As discussed during the last Government Programs Committee meeting, CPCA has pursued an aggressive administrative strategy to help push licensing process improvements forward:

- A. Meeting with L&C Leadership:** CPCA met with leadership from the Licensing & Certification division at the end of September to raise our outstanding concerns on the current status of licensing and challenges in working with CAU. Our meeting focused on sharing the compounding consequences faced by clinics when their applications and renewals are delayed; lack of clear guidance in the current application checklists; and need to address the current backlog. We came out of that meeting with promising next steps in our priority areas:
- **Application Checklists:** Current application checklists are unclear, contributing to processing inconsistencies and delays.
    - L&C has a draft checklist document combining all primary care clinic applications together (primary, affiliate, mobile, consolidated, intermittent), that is under internal review and will then be reviewed by CPCA, with the goal of releasing by the end of October.
    - Once the final checklist is agreed upon, CPCA & L&C will partner to offer webinar-based training to interested CHCs statewide that will cover the applications checklist, submitting change requests, and renewals.
  - **Backlog:** For the past year, the Centralized Applications Unit has built up a backlog, due in part to consolidation of district office functions, creating months of delays for applications and even minor change requests.

- New CAU staff have been added and trained on processing primary care clinic applications- given the tremendous role CHCs play in serving Californians, clinic applications (affiliate, consolidated) are being given immediate priority in assignment to an analyst, over applications from other provider types.
  - **CAU Metrics:** To gauge the current impact of the backlog and effects of process improvement efforts, CAU needs to be tracking and sharing data on these timeframes.
    - CAU is working to finalize development of a platform to publically display processing metrics that will show current processing timeframes and specific details around which phase of the process the application is at.
    - The public view is almost ready (within the next 30 days) and will provide a snapshot of where applications are at in the process, how long they have been there, and establish a higher level of accountability overall.
  - **Electronic Applications:** Inefficiencies related to paper applications processing and submission could be addressed through an appropriate electronic application option.
    - L&C has secured a different vendor for this project and is back on track with a promising product in development. The primary care clinic applications will begin being built out soon, based on the finalized applications checklist. CPCA will be involved in user testing once the project is in the final phases.
- B. Quarterly Stakeholder Meetings:** We continue to meet with CAU leadership for quarterly clinic licensing stakeholder meetings. During our most recent meeting (August), we were successful in establishing that full applications will now take priority over the change request workload.

### **III. Consolidated Licensing**

The consolidated clinic licensure option made available through AB 2053 went into effect January 1<sup>st</sup> of this year. As CPCA has worked with the California Department of Public Health (CDPH) to implement this bill and educate members on the process, guidance has been sent informing members that consolidated clinic sites may choose to bill under a parent PPS rate or alternatively, may opt to go through the rate-setting process. Unfortunately, we have recently learned that the Department of Health Care Services (DHCS) does not interpret the bill's provisions to allow for billing under a parent, and instead is requiring all consolidated sites to secure their own PPS rate through the traditional rate-setting process. We have looked at the language in the licensing and PPS statutes, and have confirmed that DHCS is correct in their interpretation. To allow for consolidated sites to bill under a parent's rate as the bill intended, we need additional legislation. We have already begun conversations with DHCS to amend the necessary sections as soon as possible, but we do not know that we can accomplish the change in 2017.

For community health centers with an existing licensed site, the consolidated licensure option remains the most streamlined way to license an adjacent site, with a 30-day timeframe for review by the Centralized Applications Unit and exemption from full licensure application. Our focus with AB2053 was solving the licensing challenge, and it was an oversight not to ensure PPS rates were appropriately impacted. We are focused on resolving it as soon as possible.

Any questions about this matter can be directed to Andie Patterson, [apatterson@cpc.org](mailto:apatterson@cpc.org). If you have questions about the consolidated licensing process, please contact Emily Shipman at [eshipman@cpc.org](mailto:eshipman@cpc.org).



**ACTION**

Date: September 26, 2017  
To: Government Programs Committee  
From: Andie Patterson, Director of Government Affairs  
Re: OSHPD 3- Options for Relief

**MEMORANDUM**

**I. Overview**

Since the onset of the OSHPD 3 building standards, health centers have been challenged by the associated increased costs and time delays. CPCA has conducted surveys to better understand the challenges and explored a political strategy with the goal of exempting health centers from the OSHPD 3 standards. None of these efforts however have yet resulted in a change to the standards or the challenges faced by members. As such, CPCA staff have conducted a full vetting of what we believe to be all possible options in order to determine if there are any measures, short or long term or both that can help to alleviate the challenges for health centers.

While the research has resulted in additional avenues we can pursue, we have concluded that there is no quick and easy way to alleviate the challenges health centers face with OSHPD 3. There are no legal remedies, the regulatory options are scarce and still a bit unknown, and the politics for a legislative strategy are complicated because the Building Trades lobby is strong and committed to the OSHPD 3 standards. To prevail, we have to pursue a strategy that is multifaceted and uses short term strategies to achieve long term gains.

**II. Process: OSHPD 3 and the Building Standards Commission**

OSHPD 3 are the minimum construction standards for licensed clinics and any freestanding building under a hospital license where outpatient clinical services are provided. Among the facilities that are regulated under these standards are outpatient services of a hospital, primary care clinics, and specialty clinics. Specialty clinics include surgical clinics, chronic dialysis clinics, rehab clinics, and alternative birth centers. Code changes are proposed and promulgated by OSHPD, but the California Building Standards Commission (CBSC) is the entity with jurisdiction to finalize any changes.

OSHPD has a triennial adoption cycle where they work to bring California Building Standards Code (CA Code of Regulations Title 24) (Codes) into compliance with Federal model code, as established by Federal Guidelines Institute (FGI). First, OSHPD works with their inter-agency committees to determine where, or if, California needs to propose changes to be in compliance with FGI standards. Second, recommendations are sent to the Code Advisory committees at the CBSC for review. Third,

the codes enter into a 45 day public comment period on the recommended changes. Lastly, the codes are sent to the CBSC for final approval and publishing.

The most recent code adoption cycle began in April of 2015 and was finalized with the publication of the 2016 Codes in January of 2017. Currently, OSHPD is entering into a new code adoption cycle which began September of 2017 and will conclude with the publication of the 2019 Codes.

The responsibility for licensing and certification of OSHPD 3 facilities is given to the California Department of Public Health (CDPH) in accordance with Title 22, CA Code of Regulations. The review, permitting, and inspection of clinics, however, is under the jurisdiction of the local building official.

### **III. Potential Options—Refer to the attached chart**

#### **IV. Proposal**

After reviewing the array of options, staff conclude that there are no quick solutions to alleviate the challenges of OSHPD 3. Ultimately to alleviate the challenges we need either the Building Standards Commission or the Legislature to exempt us from OSHPD 3 standards or licensing altogether. None of this can be done immediately. The political strength of the Building Trades Lobby is too formidable and there is no external, non-biased evidence or research demonstrating that the current process is not working. We have to build up our political capital, initiate objective research, engage and deepen relationships within OSHPD and CBSC, and test a few methods to remove OSHPD 3 requirements to demonstrate public health and services can be maintained without the standards in place.

As immediate next steps, staff recommend the following:

- External research
  - o Our first choice would be to have the Little Hoover Commission explore OSHPD 3 standards. We acknowledge that we cannot necessarily control the outcome of such research but we strongly believe an external, respected, and objective voice must weigh in in order to begin to meaningfully engage the legislature on these issues. The Little Hoover Commission reports and recommendations do not carry force of law but they are respected and can help initiate public legislative hearings on the issues.
- OSHPD
  - o The next Triennial has just commenced and staff are engaging with the process and working to build up credibility as thoughtful and engaged partners.
  - o There are OSHPD 3 exemption opportunities that we do not believe health centers are using optimally. Both flex requests and alternate methods of compliance ought to be utilized as appropriate. We recommend better understanding how the hospitals have so readily used these options and learn from the architects who have secured the exemptions. Our goal would be to work with a few health centers concertedly to help them through the process and see if we can get exemptions. Lessons learned would be spread to all health centers.
- California Building Standards Commission
  - o There is an open seat on the commission that we aim to fill with a health center friendly perspective.

- 1206g licensure exemption
  - o There exist a few exemption categories in the clinic licensing code. We believe the 1206g - Operated or affiliated with an institution of higher learning of healing arts- is an opportunity to explore with a subset of health centers interested. CPCA would work with these clinics to fill out the paperwork and then handle the Medi-Cal enrollment procedures. The goal would be to better understand the process and obstacles to learn lessons to spread to other health centers.

**v. Resources**

- [OSHPD 3 Options Chart](#)



Date: October 10, 2017  
To: Government Programs Committee  
From: Meaghan McCamman, Assistant Director of Policy  
Re: Medi-Cal Managed Care Update

**MEMORANDUM**

**I. Unseen Patients**

“Unseen patients” or “shadow patients” are those enrollees who have been assigned to a community clinic or health center (CCHC) as their primary care provider (PCP), but do not actually seek care at the health center. Since the Medicaid Expansion under the ACA, this issue has grown in importance, as a population that has historically foregone care or sought care in emergency rooms has moved into a managed health system. In addition, the move toward value-based payment means that the state and managed care plans are putting greater pressure upon assigned PCPs to provide population health management through preventive and primary care. Assigned members who do not utilize their PCP drive down quality scores, increase costs to the health system, and forego many of the care coordination benefits available to managed care enrollees.

CPCA has developed an Unseen Patients subgroup which reports to the Managed Care Task Force to explore possible solutions. The subgroup has met twice and the next meeting is scheduled for October 23rd.

Workplan Development

Two distinct member populations have been identified that may fit the criteria of “unseen patients.” Each may have unique solutions:

- a) Assigned members who are seeking care elsewhere; and
- b) Assigned members who are healthy and do not utilize care, even if they do identify the CCHC as PCP.

*a) Potential Solutions: Assigned members who are seeking care elsewhere*

One of the reasons that patients may be seeking care elsewhere is that they were default assigned to a health center who is not their usual source of care.

- o Meet with Maximus to explore possible mechanisms for selecting a provider at the point of enrollment and ensuring better contact information to mitigate problems associated with default patient assignment and poor patient contact information.
- o Explore the removal of regulatory barriers that prevent reassignment if patients are utilizing care at other sites/clinics. This includes dual eligible patients who seek primary care at their Medicare provider but are still assigned by the managed care plan to a Medi-Cal PCP, as well as some rules, meant as patient protections, which prevent managed care plans from transferring patients from one PCP to another without the patient’s active request.

*b) Potential Solutions: Assigned members who are healthy and not seeking care at all*  
These patients may not seek care, but may be incentivized to utilize preventive care if they can be reached via updated and accurate contact information.

- Develop pilot programs with health plans to use updated patient contact information to locate and engage patients. Contact information from recent encounter data, such as hospital or pharmacy data sources, is often more recent and accurate than information provided by the member at the point of enrollment. A motivated health plan could find ways to share updated contact information with a PCP, or even work on contacting the patient and incentivizing them to come in for a visit themselves.

We are also exploring the possibility of policies that remove unseen members from the denominator when calculating quality scores.

### Managed Care Plan Pilots

The Unseen Patients Workgroup is currently monitoring three efforts to develop local solutions to address Unseen Patients.

- Arroyo Vista Health Center has just finished a 3 year survey of their Unseen Patient Population in partnership with their IPA to determine the cause of underutilization. The survey revealed that 17% of unseen patients were seeking care at another PCP. Interestingly, many were dual eligible patients that were assigned to Arroyo Vista but sought care at a Medicare PCP. Arroyo Vista continues to monitor its unseen patient population with its IPA on a quarterly basis, identifying “members without office visits, and the topic of unseen patients is a standing item on monthly QI/HEDIS calls. CPCA staff will be documenting Arroyo Vista’s partnership to develop best practices that may be replicated by other health centers to develop formalized processes for member management with their managed care partners.
- Integrated Health Partners is continuing to pilot with Molina Health Plan a formalized process to report assigned patients with poor or outdated contact information back to the health plan for increased outreach and engagement services. This pilot has led to interest from Molina’s VP of Quality, Dr. Ellen Rudy to engage with Nathan Nau, DHCS Chief for Managed Care Quality and Monitoring conversations about exploring changes to how quality measures are impacted by the unseen patient population. Dr. Rudy is interested in coordinating advocacy with CPCA to develop solutions to the problem, which will be explored in CPCA’s upcoming quarterly meeting with Molina on October 25th.
- Community Health Center Network has just finalized a strategy with their health plan to develop an algorithm to validate that patients are utilizing care where they are assigned. The pilot will analyze claims data to determine where patients are seeking care and compare that data to the clinic where the patient is assigned. If there is a lack of alignment between patient utilization of care and patient assignment, the data will allow for the health plan to develop processes to reassign patients where they are seeking care. CPCA will monitor the development of this algorithm to develop a best practice model for other health plans to replicate a similar strategy to use claims data to validate patient assignment and create momentum for patient reassignment to reflect utilization.

### Statewide Partners

Realizing that CCHCs are unlikely to be the only provider type impacted by this change in Medi-Cal demographic, CPCA has reached out to the California Association of Provider Groups (CAPG) and the California Association of Public Hospitals (CAPH) on the issue of Unseen Patients. CAPG recognizes the problem and is open to supporting CPCA's efforts in developing solutions. CAPH has recently developed a workgroup that is working on the issue of Unseen Patients as well, and is open to combining efforts with CPCA's workgroup to develop solutions.

### **II. Medi-Cal Managed Care Commercial Contract Procurement:**

Early in 2017, the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) announced plans to re-procure all Medi-Cal Managed Care commercial contracts by 2020. Since that time, the procurement timeline for some commercial contracts has been pushed back. Specifically, Anthem has negotiated with DHCS to put the regional model counties (Anthem/California Health and Wellness counties of the rural north) and San Benito (Anthem/FFS) on a longer procurement timeline than the rest of the state, to be implemented in 2024. This is reflected in the most recent version of the procurement timeline, which is linked to the resources section of this memo and summarized below.

Procurement timeline summary – current

- Most of the state will see an RFP in late 2019/early 2020, with an implementation date of July 2021.
- Kern, San Joaquin, Stanislaus, Tulare counties – RFP in 2021, implementation 2023
- “regional model” & San Benito (Anthem) counties – RFP in 2020/2021, implementation 2024.

CPCA has reached out to each of the state's commercial health plans, seeking the opportunity to learn more about their plans for the procurement. Due to the competitive nature of the procurement, commercial plans seeking contracts may have an incentive to develop robust quality partnerships with their provider networks, which we will explore during these meetings.

Meetings with commercial plans participating in the procurements will take place throughout the rest of 2017.

### **III. Health Plan Mergers**

In 2014 and 2015, four major health plan mergers were announced: Blue Shield/Care1st, Centene/HealthNet, Anthem/Cigna, and Aetna/Humana. Of the four, only the Blue Shield/Care1st and Centene/HealthNet mergers were eventually approved by federal and state regulators.

As a part of the merger approval process, the state Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) required that the surviving health plans undertake specific investments in the state health care delivery system.

Blue Shield/Care1st was required to provide:

- \$140 million over ten years to the Blue Shield Foundation or other DMHC-approved organization;
- \$50 million toward a statewide provider directory and all-payor claims database; and
- \$10 million toward Medi-Cal outreach and enrollment.

Blue Shield has begun to distribute these funds, via ~\$35 million per year contributions to the Blue Shield of California Foundation, grants to the Legal Aid Society of San Diego and Health Consumer Alliance, and significant work with IHA on standardizing a provider directory and claims database.

Centene/HealthNet was required to provide \$340 million in community investments over 5 years, including:

- \$5 million for consumer assistance
- \$10 million to improve enrollee health outcomes in rural/underserved areas
- \$50 million to strengthen the Medi-Cal delivery system
- \$75 million infrastructure investment to provide capital to entities in underserved areas
- \$200 million to build a service center and create 300 jobs

The distribution and use of these funds is guided by two advisory committees, including the Community Investment Advisory Committee to advise on the development and implementation of the \$5 million consumer assistance grant program; \$10 million health outcomes grant program; and \$50 million delivery system grant programs; and the Infrastructure Investment Advisory Committee to advise on the development and implementation for the \$75 million in infrastructure investments.

Undertaking 29	Purpose	Target Region(s)
Community Investments \$65M	a) Locally-based consumer assistance programs (\$5M over 5 years)	Statewide
	b) Improved health outcomes in rural and/or underserved communities (\$10M over 5 years)	Statewide with focus on Central Valley: Kern, Kings, Fresno, Madera, Merced, Tulare, Stanislaus, San Joaquin
	c) Improved completeness & accuracy of encounter data (\$50M over 5 years)	Statewide
Infrastructure Investments \$75M	g) Capital investments for health care infrastructure and care delivery improvements	Statewide

*Community Investment Grant Program - \$65 million*

The community investment grant program advisory committee consists of the following members:

- Patrick Johnston, Committee Chairman and Former State Senator
- Sean Atha, SVP Business & Network Development for River City Medical Group
- Jennifer Kent, Director of the California Department of Health Care Services

- Carol Kim, Vice President of Community Investments & Public Affairs for Health Net
- Jim Lott, Management Consultant, former Chief Strategy Officer of MLK Community Hospital
- Louise McCarthy, President & CEO of Community Clinic Association of LA County
- Chris Perrone, Director of Improving Access of California Health Care Foundation
- Shelley Rouillard, Director of the California Department of Managed Health Care
- Stephen Schilling, Chief Executive Officer of Clinica Sierra Vista

Awards to date under the Community Investment Grant program include many CCHCs. The grants are beginning slowly; the award totals will increase in future years.

Enhanced Access: Outreach, Enrollment & Retention \$1M total over 18-months		Culture of Quality: Quality Improvement Technical Assistance \$500K total over 18-months	
NORTHERN CALIFORNIA	Ampla Health	GRANTEE	• Bridget Cole, Institute for High Quality Care
	Sacramento Covered		• Bobbie Wunsch, Pacific Health Consulting Group
CENTRAL VALLEY	Community Health Initiative of Kern County	SCOPE OF WORK	• Assess QI Capacity for 6-10 PCPs/ FQHCs
	Centro La Familia Advocacy Services		• Create improvement roadmap for each
SOUTHERN CALIFORNIA	East Valley Community Health Center	COUNTIES	• Sacramento
	Maternal and Child Health Access		• San Joaquin
	Northeast Valley Health Corporation		• Los Angeles
	Southside Coalition of Community Health Centers	HEDIS MEASURES	• Cervical Cancer Screening
	The Children's Clinic		• Childhood Immunizations
			• Prenatal Care

#### Infrastructure Investment Grant Program

The Centene/HealthNet leadership has yet to announce the names of participants on the Infrastructure Investment advisory Committee, but we understand that at least a few CCHC-friendly representatives will take part. The first committee meeting is scheduled for early October. The Infrastructure Investment is a *loan* program, rather than a grant program, but is one we would like CPCA members to benefit from.

#### IV. Discussion:

- Are there outstanding low-interest loan needs that CCHCs would like the committee to consider as they're building the parameters for their \$75 million loan program?
  - Ex: setting aside X million for low-cost loans to CCHCs in case of delays in HRSA 330 grants due to federal legislation.

#### V. Resources

- a. [DHCS Procurement Timeline](#)



Date: October 10, 2017  
To: Government Programs Committee  
From: Meaghan McCamman, Assistant Director of Policy, Allie Budenz, Associate Director of Quality Improvement, Liz Oseguera, Senior Policy Analyst, Michael Helmick, Senior Policy Analyst  
Re: Behavioral Health Update

**MEMORANDUM**

**I. Behavioral Health Framework**

To meet the needs of California’s Medi-Cal population, it is imperative for all three parts of the behavioral health delivery system (Managed Care, Specialty Mental Health, Drug Medi-Cal) to understand and leverage CCHCs in order to ensure that patients have access to high-quality, culturally competent, cost-effective and patient-centered care. It is CPCA’s goal to support CCHCs in providing the behavioral health services needed by their communities by removing regulatory barriers, expanding access to resources, and ensuring health centers are included in all policy discussions. This memo provides an update on the various efforts and successes CPCA, and our affiliate, CaliforniaHealth+ Advocates, have had in supporting health center’s behavioral health integration.

**II. Removing Regulatory Barriers**

CPCA’s goal in this space is to remove barriers to CCHC participation and reimbursement for the full spectrum of behavioral health care.

*SB 323 (Mitchell)*

CaliforniaHealth+ Advocates sponsored SB 323, a bill which clarifies that FQHCs may provide behavioral health services within their PPS rate, or may elect to carve out specialty mental health and/or Drug Medi-Cal and provide those services under contract with the county mental health plan (MHP) and/or the Drug Medi-Cal system. This bill was in direct response to a change in policy at DHCS A&I, which had suddenly begun to disallow FQHC reimbursement for services provided as a part of the SMI and DMC delivery systems. The bill is on the Governor’s desk awaiting signature.

*Billing for MFTs (AB 1863)*

CaliforniaHealth+ Advocates continues the work to implement AB 1863 no later than July 2018, which allows FQHCs to utilize and bill for MFT services for Medi-Cal enrollees. After Advocate’s success with AB 1863, the California Association of Licensed Professional Clinical Counselors sponsored AB 1591 (Berman), which is awaiting possible signature by the Governor and would add licensed professional clinical counselors (LPCCs) to the list of FQHC billable providers on the same timeline as the addition of MFTs.

### Confidentiality Regulations and Guidance

Along with SUD providers around the country, CPCA successfully advocated for federal changes to 42 CFR Part 2, which streamline data sharing requirements between SUD providers and other physical, behavioral, and social service providers. Additionally, CPCA was a reviewer for the CalOHI State Health Information Guidance on Sharing Sensitive Health Information. This document provides state level guidance in plain language that explains when, where, and why mental health and SUD information can be exchanged and also provides clarification on state and federal laws. Both 42 CFR Part 2 and CalOHI guidance can be found in the *resources* section, below.

### President's Commission on Drug Addiction and the Opioid Crisis

The Commission recently released a DRAFT report that recommends that all FQHCs be *mandated* to require all of their physician, NP, and PA providers hold an X-waiver to prescribe buprenorphine as an attempt to increase the amount of Medication Assisted Treatment (MAT) providers. CaliforniaHealth+ Advocates is working with NACHC to ensure that the recommendation is removed from the final report. CaliforniaHealth+ Advocates is also exploring the possibility and appetite for a federal advocacy strategy that would remove some or all of the training requirements for providers to hold an X-waivered license.

### **III. Expanding Access to Resources**

CPCA's goal is to ensure that FQHCs receive the resources necessary to support the provision of behavioral health services. Historically, counties have received the bulk of BH funding in California and have had great flexibility in their expenditure and use of funds, with little reporting and even less accountability. CPCA's advocacy priorities in this space include ensuring that FQHCs are able to pull down resources requisite to their participation in the BH system, and ensuring that counties are held accountable to use their funds to provide robust access and thorough coordination of care within and outside of the county system.

### Proposition 64

CaliforniaHealth+ Advocates, along with the California Association of Alcohol and Drug Program Executives (CAADPE) is playing a leadership role in the development of programs funded under Proposition 64, the Adult Use of Marijuana Act (AUMA). CaliforniaHealth+ Advocates has developed a set of recommendations around workforce investment that seek to ensure primary care providers serving underserved communities are leveraged as a part of the youth SUD spectrum of care, especially around education, prevention, and early intervention. CPCA's initial funding proposals are included as an attachment in the *resources* section, below.

### No Place Like Home (NPLH)

The 2016 initiative dedicates a portion of Mental Health Services Act (MHSA) funds to secure \$2 billion in bond proceeds to support the construction and rehabilitation of permanent supportive housing for individuals who are in need of mental health services and are homeless, chronically homeless, or at-risk of homelessness. The program is administered by the State Department of Housing and Community Development (HCD). CaliforniaHealth+ Advocates has successfully engaged with HCD, both through meetings and comment letters, to ensure that the

application for NPLH funds includes a requirement that residents of the supportive housing be linked to a primary care provider.

#### California Hub and Spoke Services (H&SS) Funds

Under the 21<sup>st</sup> Century CURES Act, California was awarded \$90 million in grants over two years to curb the opioid epidemic by improving access to MAT. Eighteen Narcotic Treatment Programs and one FQHC around the state were awarded grant funds to develop a network of Hubs and Spokes designed to coordinate care for opioid addicted patients in underserved and rural communities with the high rates of drug overdose deaths. CPCA is actively involved in the H&SS steering committee and has coordinated conversations between Hubs and CCHCs. CPCA is also referring CCHCs to training and technical assistance for MAT program development through partners like CHCF's Treating Addiction in Primary Care, SAMHSA, and Project ECHO.

#### SB 82 - Triage Grants work

SB 82 passed in 2013 and provides for three year grants, administered by the MHSOAC and the California Health Facilities Financing Authority (CHFFA), to counties to provide triage services. The goals of these programs are to ensure that patients have access to the BH delivery system, improve the overall capacity of the BH system, and divert patients away from law enforcement and emergency departments, when appropriate. While many CCHCs around the state run successful triage programs, only a few are funded through this county-run funding stream. As part of our efforts, we have worked with CaliforniaHealth+ Advocates to meet with, and submit written comment to, the MHSOAC to request that the next RFA award additional points to counties who partner with FQHCs and to include language which incentivizes county collaboration with CCHCs. In addition, CPCA has had the MHSOAC and California Behavioral Health Director's Association (CBHDA) present during our Behavioral Health Peer Network meeting to speak on improving collaborations between counties and FQHCs when it comes to MHSOAC and Triage grants.

#### PCP/Psych and Addiction Medicine Fellowships

The University of California, Davis (UCD) and University of California, Irvine (UCI) offer two fellowship programs meant to provide mentorship and training in the area of primary care psychiatry and addiction medicine. CPCA has developed a robust partnership with the University of CA teams, and have provided presentations and information to MCPs and counties on funding PCPs in their network to attend the fellowships, thereby enhancing access in areas where psychiatry may be unavailable. More information on fellowships, including CPCA-created supporting materials for CCHCs, are available in the *resources* section.

#### Innovation and PEI Regulations

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is revising regulations that enhance reporting requirements for county expenditures of PEI and Innovation funds under then Mental Health Services Act (MHSO). CaliforniaHealth+ Advocates is actively participating in these conversations with the goal of ensuring that counties report robust information on their expenditure of MHSO funds, especially around demographic information.

#### **IV. Raising awareness**

In California, the behavioral health delivery system is not only divided into three distinct parts, but is largely administered and funded at a county level, with very little state oversight. Much of our work to increase the visibility and awareness of CCHCs in behavioral health must be done in close concert with our members and with other statewide organizations representing other parts of the local county delivery systems. Much of our work seeks to support CCHCs in their own conversations with their counties and to encourage counties to leverage their CCHC networks. Below, we list a few of the statewide conversations through which we address larger delivery system issues while recognizing that the *real* work of behavioral health must grow from local partnerships

##### *Statewide Partnerships*

CPCA and CaliforniaHealth+ Advocates are focused on ensuring that the critical role of CCHCs is recognized and leveraged by the counties and the state. CaliforniaHealth+ Advocates staff has been appointed to serve on California's Mental Health Planning Council (CMHPC), an advisory body staffed by DHCS which informs the Administration and the Legislature on priority issues and feedback on mental health policy and regulations. In addition to CMHPC, California Health+ Advocates has grown our participation in a variety of venues in order to expand our influence in behavioral health policy in the Capitol, including participation in the California Hub and Spoke Steering Committee, the California Access Coalition, monthly Irregulars meetings of behavioral health lobbyists, and active participation in MHSOAC committees and the MHSA forum.

In particular, we note a success in the recognition of the importance of integrated behavioral health and primary care in the amendments included in AB 1315 (Mullin), which creates a new Early Psychosis and Mood Disorder Detection and Intervention program at counties, overseen by the MHSOAC. The bill's authors accepted a number of amendments offered by California Health+ Advocates, and the bill, as passed, requires that the advisory committee include a primary care provider from a clinic with an integrated behavioral health and requires that awards made under the program include a core objective of increasing coordination of medical and mental health care and increasing physical health. This bill, along with a broad partnership of behavioral health organizations who worked together to support California Health+ Advocates' sponsored bill, SB 323 (Mitchell), are concrete examples of the growing partnership between CPCA, CaliforniaHealth+ Advocates, and behavioral health policy makers.

CPCA staff are proactively engaged with DHCS SUD division to ensure that CCHC spokes are recognized in the H&SS care continuum and are able to receive and retain resources necessary to support their efforts. We have presented at the Statewide SUD Conference and to the H&SS Steering Committee about the role of FQHC's in MAT and considerations that NTPs need to acknowledge for CCHCs. We have also connected NTP/Hubs with CHC/Spokes in various service areas, including the coordination of a meeting between Aegis (NTP) and CCHCs in the central valley to provide an open forum to work through opportunities and challenges between these new partner entities.

CPCA is engaged with the DHCS Pharmacy Division to identify how CCHCs may begin to diversify their MAT programs by prescribing long acting injectable naltrexone (Vivitrol).

CaliforniaHealth+ Advocates continues to provide written and public comment at MHSOAC meetings, including subcommittee meetings, to ensure that clinics role in providing behavioral health services is recognized and leveraged. These efforts are amplified through our legislative advocacy and our relationship building efforts with the behavioral health community.

## **V. Conclusion**

To truly meet the needs of California's Medi-Cal population, it is imperative for all three parts of the behavioral health delivery system to understand and leverage CCHCs and ensure that patients have access to high-quality, culturally competent, cost-effective and patient-centered care.

## **VI. Resources**

- [Little Hoover Commission: Promises Still to Keep: A Decade of the Mental Health Services Act.](#)
- [Updates in Substance and Opioid Use Disorder Programming](#)
- [42 CFR Part 2 Final Rule and Health Center Compliance](#)
- [State Health Information Guidance \(SHIG\) on Sharing Sensitive Health Information](#)
- [Potential youth SUD workforce funding recommendations under Prop 64](#)
- [No Place Like Home Comment Letter](#)
- [SB 82 Comment Letter to MHSOAC](#)
- [SB 82 One-Pager](#)



**DISCUSSION**

Date: October 2, 2017  
To: Government Programs Committee  
From: Meaghan McCamman, Assistant Director of Policy  
Re: Pharmacy and Adult Immunizations

**MEMORANDUM**

**I. Overview**

CPCA staff have been approached in two separate venues about the barriers to FQHC provision of expensive injectable medications. Proponents of the medication Vivitrol (naltrexone), used to treat opioid and alcohol use disorders, have asked CPCA to determine why FQHCs are unable to utilize the drug, costs of which run approximately \$1,000 per month. Similarly, the California Department of Public Health has sought CPCA’s opinion about the barriers to increasing the use of adult immunizations at FQHCs. After some internal independent research, CPCA staff posits that the barriers to both the use of Vivitrol and the use of adult immunizations stem from the inability of FQHCs who do not have an onsite pharmacy to bill for the drugs outside of the PPS rate. The high cost of the drugs – both vivitrol and adult immunizations – make it cost prohibitive to provide those drugs with only PPS reimbursement.

**II. Discussion**

With this memo, CPCA staff hopes to facilitate a discussion around the barriers to FQHC provision of injectable Vivitrol and injectable adult immunizations. We hope to:

- 1) Ensure that our understanding is correct that the greatest barrier to FQHC provision of injectable medications is their high cost and inability to be reimbursed outside the PPS rate;
- 2) Confirm that an FQHC with an onsite pharmacy is able to bill separately for these drugs and therefore would not encounter these barriers; and
- 3) Discuss with the Committee whether CPCA should be leveraging the expanded interest in treating opioid disorders with Vivitrol, and CDPH’s interest in expanding the use of adult immunizations, to explore with DHCS the possibility of creating a process whereby FQHCs without an onsite pharmacy are able to bill for certain injectable medications outside of the PPS billable visit.



Date: October 3, 2017  
To: Government Programs Committee  
From: Beth Malinowski, Deputy Director of Government Affairs and Michael Helmick, Senior Policy Analyst  
Re: Community Clinic Lifeline Grant Program – Implementation

**MEMORANDUM**

**I. Background**

The Clinic Lifeline Act of 2017 (the “Act”), signed into law by Governor Jerry Brown on July 10, 2017, established the Lifeline Grant Program (the “Program”). The Program, within the California State Treasurer’s Health Facilities Financing Authority (CHFFA) assists small and rural health facilities, including CHCs, that may be adversely affected financially by a reduction or elimination of federal government assistance and that have little to no access to working capital.

The budget appropriates \$20 million from the Health Expansion Loan Program (HELP II) fund for this one-time purpose. Funds must be used to support health facilities that meet certain eligibility criteria. Under the Act, health facilities must either be a tax-exempt nonprofit licensed health facility with an annual gross revenue not exceeding \$10,000,000, a tax-exempt nonprofit licensed health facility located in a rural medical service study area (MSSA), or a clinic operated by a district hospital or health care district.

CHFFA is responsible for developing additional selection criteria and a process for awarding the grants, which may not exceed \$250,000 per health facility site. Since the enactment of the Budget Act of 2017, California State Treasurer’s office has moved forward with implementation-related activities and discussion to meet the core objectives of the program.

CPCA is working with CHFFA staff on the implementation of the program.

**I. Current Considerations**

California Health Facilities Financing Authority (CHFFA) staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. CHFFA has hosted two stakeholder webinars where they’ve begun to outline their perspective on a variety of key issues. Among the current considerations are the following:

- Max Awards: With a commitment to provide awards on a per facility basis (\$250,000 per health facility), staff are currently considering if there should be a maximum or cap placed on the number of awards that can be received by each parent organization. Currently, staff are leaning towards having no maximum award. This means that a parent organization with

multiple sites meeting the determined criteria could apply for, and receive, multiple awards across its sites.

- Eligibility Criteria: In addition to the statutorily required criteria, CHFFA is considering program eligibility criteria that relates to individuals served, geographic location, types of services provided, utilization of grant funds, and ability to leverage additional funding:
  - Population Served: CHFFA is recommending an additional eligibility criteria – 50% or more of the individuals served participate in Medi-Cal. CHFFA, and CPCA, have already received feedback that this would undermine the ability of frontier and rural health center to participate in this program. CHFFA is open to considering different criteria for rural or frontier communities. On a recent call, CPCA reiterated that CHFFA consider the uninsured population and CPCA will continue to advocate for eligibility criteria that meets the unique needs of our rural and frontier communities.
  - Services Provided: In their initial webinar, CHFFA had recommended creating an additional requirement that all facilities, with the exception of those in MSSA, must show proof of providing services beyond medical services. On a recent phone call, CHFFA stated that they are no longer looking to pursue this criteria.
  
- Evaluation Criteria: Once an entity has met all eligibility criteria, CHFFA is currently considering evaluating grants on a points scale (100 point max). These points will be dependent on health facility location, service provided, overall patient needs, proposed use of grant funds, populations served (percent Medi-Cal, uninsured, etc.), planning and sustainability. No information has been provided yet on how CHFFA plans to collect this information through the application process or how points will be distributed across these areas. CPCA will provide recommendations to CHFFA on their broad evaluation criteria, including identifying ways to align this program’s evaluation criteria with prior funding evaluation metrics and data already submitted to state entities like OSHPD.
  
- Eligible Use of Grant Funds: Recognizing that these funds are for facilities that are in need of immediate core operations support, we are concerned that CHFFA has articulated a desire to see “innovative uses” for these funds. While we have not seen a clear definition of “innovation,” and are generally committed to innovation too, we also recognize that these funds are critical for health centers that have working capital (example: payroll/leases/utility bills) and/or small capital expenditure needs (example: critical facility repairs). We look forward to further engagement on this item and striking the right balance.
  
- Funding Distribution: CHFFA is currently considering three different distribution plans to guarantee funds are well distributed across the state:
  - Option 1: Applications with the highest rank
  - Option 2: Application with the highest rank with geographical distribution limitations. This option would aim to account for county population and breaks funding into four regions (Central - \$4,500,000; LA/Ventura – \$6,000,000; Northern - \$4,000,000; and Southern \$5,500,000).
  - Option 3: Application with the highest rank with annual gross revenue limitations. This option would aim to create an inverse relationship between gross revenue and Lifeline funding, the higher the gross revenue the fewer overall grants will be provided.

CPCA aims to provide feedback on these funding distribution options as each option has unique benefits and limitations. While all three of these options can be seen as meeting elements of statutory goals, option #2 does appear to be most aligned with the Lifeline Program's core objectives. We look forward to getting additional member feedback on this item on the 10/17 webinar and have already seen some preference to option #2 from our rural partners.

- Emergency Regulations and Application Triggers: On a recent call, CPCA staff learned that CHFFA staff are interpreting the statutory language to be requiring of a "triggering event" to fully execute the program. In particular, they believe federal funding reductions are a formal trigger for this program – both a trigger for the Office of Administrative Law's review of the program's administrative regulations and a trigger for launching the application window. CPCA is working to better understand this statutory interpretation and, in the interim, are intending to propose federal funding trigger language that is representative of the various federal funding threats.

## II. Next Steps

In the last week of October (Thursday, 10/26), the Authority's board will discuss CHFFA's staff recommendations for selection criteria, application process, and other implementation-related items. The Authority's board is not expected to take action on that day, but will likely be taking action at the Authority's December meeting.

While CPCA has had ongoing dialog with staff since August, CPCA is aiming to submit formal comments to the Authority in advance of their 10/26 board meeting.

### Lifeline Grant Program Webinar:

On Tuesday, October 17 at 11:00 a.m., CPCA staff will host an important webinar to provide updates on The Clinic Lifeline Act of 2017, discuss CPCA's engagement with California Health Facilities Financing Authority (CHFFA) staff, and solicit your feedback on CPCA's proposed comments to the Authority. If you have immediate questions or feedback on the Lifeline Grant Program please e-mail Michael Helmick at [mhelmick@cpc.org](mailto:mhelmick@cpc.org).

To learn more about the Lifeline Grant Program, please visit CHFFA's website at <http://www.treasurer.ca.gov/chffa/clg/index.asp>

Please register for the Clinic Lifeline Grant Program Webinar on Tuesday, October 17, 2017 11:00 AM - 12:00 PM PDT at: <https://attendee.gototraining.com/r/8821061118056466177>

## III. Resources

- CHFFA Lifeline Grant Program Website: <http://www.treasurer.ca.gov/chffa/clg/index.asp>



INFORMATIONAL

Date: September 25, 2017  
To: Government Programs  
From: Elizabeth Oseguera, Senior Policy Analyst  
Re: Immigration Update

MEMORANDUM

## I. Federal Immigration Update

The Trump Administration has severely impacted the immigrant community through several executive orders (EO) that have been issued or rescinded.

### Executive Orders

- *Deferred Action for Childhood Arrivals (DACA)*  
On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program via a "phase out." All properly filed DACA applications and renewals that were accepted by the Department of Homeland Security (DHS) on or before September 5 will be processed. For more information about the details for the proposal and resources for employers, please see the resource section below.

The President has met with Democratic leaders, including house minority leader, Nancy Pelosi, to discuss possibly moving legislation that codifies the DACA program into law before its expiration date on March 5, 2018, but nothing has yet been decided. However, the President has asked democratic leaders to consider adding portions of the RAISE Act into the DACA bill. In the meantime, the California Attorney General as well as the University of California system have filed lawsuits against the administration for ending the DACA program.

### Federal Legislation

- *Reforming American Immigration for Strong Economy Act (RAISE Act)*  
On August 2, Senators David Perdue (R-GA) and Tom Cotton (R-AR), alongside the President, introduced the RAISE Act (S. 354), which proposes to radically reduce legal immigration to the United States. The bill would need 60 votes in the Senate to pass. Since the measure will be seen as extreme by all Democrats and even some Republicans, it is unlikely that it would achieve the necessary 60 votes. For more information on the RAISE Act, please see the resources section below.

*Action Item: Would CPCA members like to take an oppose position on this bill?*

- *Dream Act*  
Senators Richard Durbin, D-Ill., and Lindsey Graham, R-S.C., have introduced the Dream Act. The Act would offer a path to permanent legal status to people who arrived in the U.S. as children, can pass a background check, and otherwise fit the DACA criteria. This bill has not yet been taken up by the Senate, and thus has not moved.

*Action Item: Would CPCA members like to take a support position on this bill?*

- *SUCCEED Act*  
On September 25 Republican Senators Thom Tillis, James Lankford and Orrin Hatch have introduced the SUCCEED Act (Solution for Undocumented Children through Careers Employment Education and Defending our nation) to provide a pathway to citizenship for immigrant youth. However, the SUCCEED Act would make eligible immigrant youth wait 15 years to become U.S. citizens and would prevent them from sponsoring family members to the United States. It would also force them to forgo due process rights, place conditions on their ability to stay and live in the U.S., and bar them from seeking other forms of immigration relief for which they could become eligible. It is likely that the SUCCEED Act will be paired with a border security bill to appease requests by the White House.

*Action Item: Would CPCA members like to take an oppose position on this bill?*

#### Executive Orders on Immigration

- *Travel Ban*  
Per the executive order, the Department of Homeland Security has submitted a study on the available security and intelligence information in countries worldwide. Based on the findings, the Trump administration issued a proclamation, "Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats," that indefinitely bans travel from Iran, Libya, Syria, Yemen, Somalia, Chad and North Korea. Certain government officials from Venezuela will also be barred. This proclamation was signed on September 24, 2017, when the 90 day travel ban for the six Muslim countries was due to expire. It is very likely that lawsuits will be filed against the new travel ban, but considering that a study was conducted to place these countries on the list, which now includes non-Muslim countries, it will be more difficulty to prove that this proclamation is discriminatory against Muslims.

Prior to the proclamation being signed and in response to lower court rulings blocking portions of the revised travel ban executive order, the Supreme Court had decided to hear the administration's appeal and allowed parts of the travel ban to go into effect during the interim. Specifically the Supreme Court allowed the ban to go into effect for foreign nationals who lack any "bona fide relationship with any person or entity in the United States." At this time, only non-citizens with relationships with persons or entities in the United States can enter the country (this applies to the proclamation as well).

On September 12, 2017 the Supreme Court issued an order blocking the Ninth Circuit Court of Appeal's September 7, 2017 ruling that would have allowed refugees who have agreements with U.S. settlement agencies to qualify as having a bona fide relationship, and therefore qualify to enter the country (this portion of the executive order is due to expire on October 24). However,

the Supreme Court did not disturb the Ninth Circuit's ruling allowing grandparents, grandchildren, brothers-in-law, sisters-in-law, aunts, uncles, nieces, nephews, and cousins to qualify as having a bona fide relationship, allowing these folks to continue entering the country.

Additionally, since the President has signed a proclamation that created new provisions around the travel ban, the Supreme Court has decided to postpone the hearing originally scheduled for October 10.

- *Sanctuary Jurisdictions*

On September 15, 2017 U.S. District Judge Harry Leinenweber ruled that the Trump administration may not withhold public-safety grants to so-called sanctuary cities / jurisdictions.

The judge issued a temporary nationwide injunction that prevents the Justice Department from withholding grant money until there is a final determination in the lawsuit, which could take months.

## **II. State Legislative Update**

CaliforniaHealth+ Advocates is closely monitoring legislation that impacts immigrants and is working with our immigration advocacy partners to support policy that ensures California has in place the proper safeguards to prevent patient information collected by a health center or public benefit programs from being shared with immigration enforcement. SB 244 (Lara, 2017) and SB 54 (De Leon, 2016) help to accomplish this goal.

- SB 244, (Lara, 2017)
  - Reinforces "good government" by ensuring that agencies elicit and record only the information necessary to administer a program or service, and disclose the information only for the purpose of administering the program or service.
  - This bill no longer contains language to protect patient health information, however the author has made this a two year bill to allow more time to work out issues with the Department of Health Care Services.
  - CPCA holds a support position on this bill.
- SB 54 (De Leon, 2016) The California Values Act
  - Builds upon the TRUST Act and increases protections for Californians from landing into the deportation pipeline, and sets a minimum standard restricting law enforcement interaction with ICE.
  - Requires specified health facilities operated by the state, and encourage other health facilities, such as FQHCs, to establish policies that limit immigration enforcement on their premises. CaliforniaHealth+ Advocates has been a proud supporter of SB 54 and the protections it allocates to Californian's immigrant community. Please contact your legislative member and voice your support.
  - Passed out of the Legislature and is going to the Governor's Desk for signature.
  - CPCA holds a support position on this bill.

### III. CPCA Strategy to Address Immigration Issues

At the direction of members, CPCA in collaboration with CaliforniaHealth+ Advocates, has been working diligently to develop materials that provide information on the legal rights of clinics, and their patients, in regards to immigration enforcement.

#### Immigration Resources for Patients and Clinics

CPCA, in collaboration with CaliforniaHealth+ Advocates, has been leading an effort in collaboration with other state PCAs, NACHC, and immigration partners, to develop materials that can help health centers prepare themselves and patients for an encounter with immigration enforcement. Through this effort CPCA has developed six sample policies and procedures, Know Your Rights handouts, FAQs and much more. These documents can be found in the resource section below.

#### Immigration Peer Network

CPCA has created an Immigration peer network to help gather member feedback on the immigration resources that we are developing as well as guide the policy work we are undertaking. This is also a great space for members to share the resources they've gathered/produced and to ask any questions that may be coming up for clinics and their patients.

Please contact Daisy Po'oi at [dpooi@cpc.org](mailto:dpooi@cpc.org) if you would like to join the peer network.

#### Provider Survey: The Mental Health of Immigrant Children and their Parents

CPCA, in collaboration with Children's Partnership is evaluating the data collected through our provider survey to capture the mental health of immigrant children and their parents. We've also collaborated with various behavioral health partners, including The California Association of Social Rehabilitation Agencies, Mental Health America, the California Mental Health Planning Council, and California Association of Marriage and Family Therapists, to have this survey shared with their members.

#### Upcoming Immigration Trainings for Members

In response to requests from members, CPCA has hosted 3 webinars that were part of the immigration webinar series. The first webinar, which took place in June, provided an overview of the FAQs and best practices for implementing the recommendations included in the FAQs. The two subsequent webinars, held on September 13 and September 20, provided an in depth overview of the sample policies and procedures.

Below is more information on the remaining webinars for the immigration series this year. To register please visit [CPCA's webinar registration page](#).

- Utilizing Community Health Workers to reduce fears in immigrant patients
- The Mental Health of Immigrant Children and their Parents
- Behavioral Health Services for Immigrant Patients

### IV. Resources

- [DACA Phase Out: Background and Talking Points](#)
- [Guidance for DACA Employers and DACA Recipients](#)
- [Background on the RAISE Act](#)
- [Immigration Bill List](#)
- [Sample Policies and Procedures](#)
- [Immigration Patient FAQs](#)



**INFORMATIONAL**

Date: October 10, 2017  
To: Government Programs Committee  
From: Allie Budenz, Associate Director of Quality Improvement  
Re: Section 2703/Health Home Program Update

**MEMORANDUM**

**HHP Status Update**

In August, DHCS announced in a stakeholder communication update that they are moving forward with a state plan amendment (SPA) to implement ACA Section 2703 Health Homes for Patients with Complex Needs (HHP) and are targeting July 2018 implementation for 11 counties in phase 1 of 3.

**HHP Savings Strategy**

The state has stated on numerous occasions that the HHP benefit will not continue post the pilot if the pilot does not yield savings within two years to the state. Experts generally agree that savings in this short of a time frame is nearly impossible. However, some plans and providers have been testing out the HHP model already and have yielded savings. It is CPCA's contention that a small and contained pilot of expert plans and providers can yield savings thus positioning the pilot for success, and laying the foundation for a benefit for all Medi-Cal beneficiaries and the opportunity for all health centers to offer additional services to their patients.

To this end, CPCA has taken the lead with the health plan associations- the California Association and Health Plans and the Local Health Plans of California- to convene a small workgroup of plans and providers deeply invested in the HHP to discuss how to best to coordinate the execution and delivery of a successful pilot. CPCA is hoping to convince the plans in phase one to be very selective about the providers participating, to limit the size of the pilot, and to coordinate with their colleagues across county lines. The small workgroup will design a larger stakeholder engagement strategy that will be deployed to CHC's and health plans in the three implementation counties. Should the small workgroup agree on the strategy and desire a larger stakeholder convening, CPCA will invite possible health center community based care management entities (CB-CME's) to participate.

**Technical Assistance Update**

DHCS has contracted with Harbage Consulting to provide technical assistance on outreach, education, and communications to managed care plans, providers, CB-CMEs, eligible Medi-Cal beneficiaries, and other stakeholders through all 3 implementation phases of the HHP. Harbage's approach will be to release toolkits for these specific audiences with plan-specific information. CPCA is coordinating member review of these documents.

Date: October 11, 2017

To: Government Programs Committee

From: Beth Malinowski, Deputy Director of Government Affairs; and Emili LaBass, Senior Program Coordinator of Health Center Operations

Re: Oral Health Update

MEMORANDUM

### **MSDA Medicaid-FQHC Dental Policy Workgroup**

CPCA recently participated in the first meeting of the new MSDA Medicaid - FQHC Dental Policy Workgroup. This workgroup is being convened over the next eighteen months by the Medicaid | Medicare | CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing; an organization with a broad interest in advancing Medicaid dental policy and oral healthcare for FQHC beneficiaries. Launched in response to recent FQHC dental services' payment issues, the goal of the workgroup is to study existing federal and state legislation, regulation, policies and practices as they relate to the delivery and billing of dental services by FQHCs; and develop guidelines for use by state Medicaid dental programs aimed at improving Medicaid-FQHC dental program policy and administration.

This initial meeting, held in Washington D.C. on September 18, was attended by over two dozen federal, state, and health center leaders by MSDA invitation. Angie Melton of the Margolin Group, attended in person on behalf of CPCA. Additional attendees included representatives of National Network of Oral Health Access (NNOHA), CMS, HRSA, DHCS and other state Medicaid agencies, NACHC and other PCA representatives, and California dental leaders from Asian Health Services, Borrego Health, Clinica Sierra Vista, and La Clinica de la Raza.

While the stated intent of the group was rather broad, the initial meeting was nearly solely focused on dental program audits. The agenda, aimed at laying the groundwork for future dialog, was dedicated to reviewing federal and state authority and guidance relevant to dental services-related audits, including Medicaid Integrity Contractor (MIC), Payment Error Rate Measurement (PERM), and Recovery Audit Contractors (RAC) audits. Emerging issues, including definition of "standard of care" and FQHC Medicaid Audits, were given particular attention. While a variety of state and provider perspectives were introduced, particular attention was given to the recent audit situation in California – challenges with the process, auditors, and findings. There was general consensus that providers, state, and federal partners must work together to create a more consistent auditing environment. Furthermore, there was general agreement that there are gaps in policy and guidance. As MSDA pursues its interest in developing solutions, CPCA looks forward to continuing to participate in any and all discussions that could benefit the audit environment in California.

Lastly, it is important to note that while the MSDA workgroup compliments the efforts that will take place with DHCS A&I, it is in fact completely independent from the workgroup CMS has asked DHCS to create for California's specific dental related issues that arose from the 2016 Medicaid Integrity Program (MIP) audits.

In the coming months, we will continue to bring any new developments to the Dental Directors Peer Network.

# Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order			A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>• Agenda</li> <li>• Executive Summary</li> </ul>	Dean Germano	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>• July 13 Meeting Minutes</li> </ul>	Dean Germano	A
IV. California Future Health Workforce Commission	<i>Guest Speaker</i>	Jeff Oxendine <i>Co-Director of the CA Future Health Workforce Commission</i>	D
V. Goal 7: Serving as a Catalyst and Coordinator	<ul style="list-style-type: none"> <li>• UCSF HealthForce Research Update</li> <li>• CPCA Convening Update and Educational Campaign Concept</li> </ul>	Beth Malinowski	D
VI. Goal 6: Growing and Diversifying Health Center Professions	<i>Guest Speaker:</i> A.T. Still Partnership and Grow Your Own Commitment	Nicole Mosqueda, <i>Director of Programs &amp; Development at Camarena Health</i>	D
VII. Adjourn		Dean Germano	A

Date: September 28, 2017

To: Workforce Committee

**WORKFORCE COMMITTEE / EXECUTIVE SUMMARY**

**Workforce Strategic Plan Activities**

- California Future Health Workforce Commission
  - CPCA's close relationship with California's leading health philanthropies contributed to the development of a California Future Health Workforce Commission. Among the Commission participants are Dean Germano and Jane Garcia.
- Goal 7: Serving as a Catalyst and Coordinator
  - UCSF HealthForce Research Update - Report #3, *Primary Care Workforce Strategies*, a look at promising practices from across the country, is still in draft form, but will hopefully be released by October 2017.
- CPCA Convening Update and Educational Campaign Concept
  - As reported in July, members of the Workforce Policy Coalition agreed to prioritize the following three workforce policy areas and formed subcommittees to further discuss possible policy solutions in each area: Priming the Primary Care Pipeline; Residency Redesign; and Advocacy
  - The full Healthcare Workforce Policy Coalition will meet one final time this calendar year on Monday, November 6.
- Goal 3: Recruitment and Goal 5: Retention - Salary Survey Update
  - Nearly 140 community health centers participated in the 2017 Compensation and Benefits Survey, an 11% increase from last year. Survey data is currently being reviewed and analyzed by Gallagher Surveys.
- Federal Policy – NHSC
  - At time of writing, Congress is yet to take sufficient action to sustain the National Health Service Corp. NHSC program funding expired on 9-30-2017.
- Goal 2: Advancing Primary Care Training - Song-Brown Update
  - With 48 family medicine and 29 PCR (IM, OB/GYN, and Peds) applications received this year, OSHPD staff have confirmed that this is the largest number of applications the Song-Brown Program has ever received.
- Federal Policy Update - Teaching Health Centers
  - At time of writing, Congress is yet to take sufficient action to sustain the Teaching Health Center Graduate Medical Education (THCGME) program. THCGME program funding expired on 9-30-2017.
- Goal 1: Promoting Community-based Primary Care - Kaiser Medical School Update
  - Kaiser Permanente School of Medicine (KP SOM) recently appointed Mark A. Schuster as their Founding Dean and CEO.

CALIFORNIA PRIMARY CARE ASSOCIATION

Workforce Committee

July 13, 2017

2:00 – 3:00 PM

**Members:** **Jane Garcia – Substitute Chair**, Antonio Alatorre, Doreen Bradshaw, Trisha Cooke, Lynne Dorroh-Watson, Cathy Frey, Nik Gupta, Deena Lahn, David Lavine, Deborah Lerner, Louise McCarthy, Scott McFarland, Nicole Mosqueda, Danielle Myers, Christine Noguera, Carole Press, Tim Rine, Melinda Rivera, Corinne Sanchez, Mary Szecsey, David B. Vliet

**Guests:** Robin Affrime, Steve Heath, Tanir Ami, Greg Garrett, Rachel Farrell, Kevin Mattson, Ellen Pierad, Wunna Mine, Britta Guerrero, Susie Foster, S Bautista, Alicia Mardini, Terri Stratton, Alex Armstrong, Terri Vise, Tracy Ream, Jill Damian, Lucinda Bazile, Rose Tam, Esen Kurdoglu, Maria Paz

**Staff:** Carmela Castellano-Garcia, Beth Malinowski, Nataly Diaz, Kelley Aldrich, Andie Patterson, Victor Christy, Andrea Chavez, Liz Oseguera, Jana Castillo, Jodi Samuels

**Call to Order**

The meeting was called to order by the chair at 2:05 pm.

**Approval of Agenda**

A motion was made and seconded to approve the agenda as written. **The motion carried.**

**Approval of Minutes**

A motion was made and seconded to approve the minutes as written. **The motion carried.**

**Workforce Priority 3 – Partnerships – California Board of Registered Nursing: Building Relationships and Addressing Licensing Challenges**

Nataly Diaz introduced guest speaker Joseph Morris, Director of the California Board of Registered Nursing.

Mr. Morris spoke to the committee about how the California Board of Registered Nursing (BRN) is developing a relationship with CPCA to address the provider licensing challenges that health centers have encountered while recruiting both new and out-of-state nurses.

Mr. Morris is very committed to the following:

- improving the licensing process (minimum 30 days)
- helping health agencies gear up with job opportunities
- prioritizing feedback on how to improve processes
- to be 100% compliant with schools
- looking into issues with out of state institutions
  - tracking documentation/transcripts

- improving the time it takes for fingerprinting with both DOJ and FBI
  - fraud
- Transitioning from the plastic nursing card to the BreEZe System (online Google platform).

**Workforce Priority 8 – Workforce Policy Convening**

Beth Malinowski gave members an update on the successful workforce policy (re) convening that took place on June 15 and focused on further refinement of the identified policy solutions and initial conversations on the early steps of the three subcommittees.

**Workforce Priority 2 – 2017 Statewide Community Clinic and Health Center Workforce Evaluation**

Nataly updated members on the ongoing work of RAC and CPCA’s Workforce Committee, who are currently working with the University of California, Davis (UCD) to conduct a second community clinic and health center workforce evaluation to understand workforce priorities, staffing needs, health professions training, and retention/recruitment challenges in California community health centers. This workforce evaluation will utilize a mixed method approach to obtain a better understanding of CHC workforce priorities, needs, and challenges. Consortia and UCD CDHW staff will conduct qualitative interviews with various community health center leaders located in urban and rural medically underserved areas.

**Workforce Priority 3 – Partnerships – California Community Colleges**

Shadi Kanaan explained to members how CPCA is looking to bring the community college partnership to a new level by exploring ways to improve the Medical Assistant curriculum and programs across its campuses; develop a community college to medical school pipeline, and contribute to the Community College Strategic Plan.

**Workforce Priority 4 – Residency Training**

Beth Malinowski was happy to announce that thanks to a strong coalition effort, led by CaliforniaHealth+ Advocates, The California State Budget (FY17-18) passed by the legislature includes a recommitment to primary care residency funding with the reinstatement of the three year \$100 million investment.

**Workforce Priority 6 – Medical School**

Mike Witte shared that California’s regional clinic consortia and the California Primary Care Association (CPCA) are working with the University of California, Davis (UCD) to conduct a second community clinic and health center workforce evaluation to understand workforce priorities, staffing needs, health professions training, and retention/recruitment challenges in California community health centers.

**Adjourn**

The meeting was adjourned at 3:06 pm.

Submitted by Kelley Aldrich

Date: September 22, 2017

To: Workforce Committee

From: Nataly Diaz, Senior Program Coordinator; Beth Malinowski, Deputy Director of Government Affairs; Val Sheehan, Development and External Relations Director; Christina Hicks, Deputy Director of Program Development and Evaluation; Bao Xiong, Associate Director of Health Center Operations; and Liz Oseguera, Senior Policy Analyst

Re: Workforce Strategic Plan Update

## I. Introduction

In May, the CPCA Board of Directors approved the 2017-2020 Strategic Plan, which includes a strong commitment to develop of a robust healthcare workforce that is responsive to and reflective of California's diverse communities. The work plan includes several goals that are incorporated as headers in this new workforce committee memo template.

## II. CPCA Workforce Strategic Plan Activities

### • Promoting Community-Based Primary Care Workforce Visibility

#### ○ UCSF Primary Care Workforce Research

CPCA continues to work with UCSF's Healthforce Center on a series of primary care workforce reports funded by Kaiser Permanente Community Benefit. Report #1, *Overview of Primary Care Workforce in California Today*, a snapshot of California's primary care workforce, was published in Feb. 2017. Report #2, *Forecast of Primary Care Workforce in California for years 2021 and 2026*, a projection of primary care providers in the next decade, was released on August 15, 2017. The release of the second report and its findings were picked up by the following media: SF Business Times and San Jose Mercury News/Bay Area News Group. CPCA President and CEO, Carmela Castellano-Garcia, was interviewed by the SF Business Times. Both KCBS radio and KTVU TV aired stories about the report's findings as well. Report #3, *Primary Care Workforce Strategies*, a look at promising practices from across the country, is still in draft form, but will hopefully be released by October 2017.

#### ○ California Community Colleges

In collaboration with the Chancellor's Office and Young Invincibles, the Foundation for California Community Colleges created *Here to Career*. This mobile application helps low-income students and their families find high-demand career opportunities and tools to be successful. Users can view salary information and find a local community college with a program to help them achieve their goals. CPCA is working with Young Invincibles to disseminate information about the mobile application and encourages health centers to share this resource with their staff and community.

- **Advancing Primary Care Provider and Staff Training**

- **Federal Advocacy – THCGME Program**

Unless Congress enacts new legislation, the Teaching Health Center Graduate Medical Education (THCGME) program will expire on September 30, 2017.

Three bills have been introduced to address the funding cliff facing the THCGME program. None of these bills are currently expected to pass, but all of them are seen as important vehicles for conversation.

The Training the Next Generation of Primary Care Doctors Act of 2017, H.R. 3394 (McMorris Rodgers-Tsongas), and S. 1754 (Collins-Tester), its companion bill in the Senate, are aimed at sustaining this important program. These bills were introduced shortly before the August recess and, at time of writing, they have 68 bipartisan cosponsors in the House (H.R. 3394) and 8 (S. 1754) in the Senate. These two bills reauthorize THCGME for three years (FY2018-FY2020) and are intended to preserve the current level of residents at the 57 existing Teaching Health Centers. The bills appropriate \$116.5 million/year for three years for training residents (based on proposed \$157,000 per resident allocation for all 742 current THC GME residency slots). This funding is more than what was provided in MACRA (2015), which inadequately funded the residencies and led many Centers to reduce or eliminate new recruitment. The bills also appropriate \$29 million over two years to permit establishment of new Teaching Health Centers and new programs at existing Teaching Health Centers. Priority will be given to applicants in health professional shortage areas, medically underserved areas, and rural areas. Expansion funding will cover up to a total of 60 new residents in FY2019 and 120 new residents in FY2020 (two classes of 60 residents).

In addition to these bill efforts, it should also be noted that Congressman Jeff Denham (R-Modesto) introduced the Comprehensive Additional Residency Expansion Act (HR 3451), with the support of California Medical Association, just days after HR 3394 (McMorris Rodgers-Tsongas) was introduced. Aimed at building onto HR 3394, this bill would add an additional 240 residency slots to train new physicians and authorize 10 new teaching health centers. Focused on investments in communities across the country that are like California's Central Valley, it would also require the new teaching health centers be located in areas with a disproportionate share (35% or higher) of Medicaid patients.

As Congress continues to work towards an agreement on a permanent legislative solution for the program, some in Congress have proposed using other vehicles to provide temporary funding. Among the temporary funding being considered, is a three month extension of funding for the program at the current funding level (\$60 million).

The American Association of Teaching Health Centers (AATHC) continues to stress that a three month extension at the current funding level is not sustainable. Our partners at the American Association of Teaching Health Centers are urging you, and your resident, to participate in these important advocacy efforts – sustainable per resident funding is

needed now. For more information on this development or find out how you can get involved, contact Nataly Diaz at [ndiaz@cpc.org](mailto:ndiaz@cpc.org).

- **2017 Song Brown Family Medicine and Primary Care Residency Application**

The Song-Brown Healthcare Workforce Training Program received a \$33M installment of new funds this year due to a strong coalition effort led by CaliforniaHealth+ Advocates. The Family Medicine/Primary Care Residency application opened mid-August and closed mid-September. Seventy-seven Primary Care Residency applications were received, which included ten applications for new programs. With 48 family medicine and 29 PCR (IM, OB/GYN, and Peds) applications received this year, OSHPD staff have confirmed that this is the largest number of applications the program has ever received.

Awards will be determined during the November 29-30, 2017 Song Brown meeting in Southern California.

- **Expanding Recruitment Support**

- **Federal Advocacy – National Health Service Corp Program**

Today, the program is funded at \$310 million, but these funds will expire on September 30, 2017. Congress is yet to take action to extend funding and the NHSC trust fund now faces elimination. This September, we are calling on congress to take crucial actions to continue to fund and grow NHSC to ensure access to care for millions of people living in shortage areas. Representatives Chris Stewart (R-UT) and G.K. Butterfield (D-NC) sent a bipartisan letter to the House Energy & Commerce Committee leadership in support of the National Health Service Corps Program (NHSC). The letter was cosigned by 47 House Members. Thank you to all our advocates who urged their Representative to sign on. At time of writing, legislation is yet to move to support continued funding for NHSC. Without new funding, no new awards will be allocated. Funds will continue for those persons currently in the program.

- **Reducing Recruitment Barriers Associated with Primary Care Providers**

- **J-1 and H1-B Visas**

At the direction of members, CPCA partnered with Sid Chary from the Chary Law Firm P.C. to develop an informational document regarding J-1 and H1-B Visas. Specifically, this document informs members of the different programs that a health center can utilize when applying to hire providers through a J-1 and H1-B visa. For more information, please refer the resource section below.

- **Supporting Effective Retention Strategies**

- **2017 Gallagher Integrated Physician Compensation Survey**

The 2017 Gallagher Integrated Physician Compensation and Production Survey was distributed to all 26 participating community health centers that participated in the spring survey. This survey was separate and distinct from the 2017 CPCA Salary Survey. The final report provides valuable insight regarding clinical and total cash compensation paid, productivity, pay practices, and market trends relating to physician compensation. Gallagher Integrated is currently working on a custom, California health center physician compensation report based on the data that was collected by the 26 participating health

centers. This custom report will be distributed to participating health center organizations in October 2017.

- **2017 CPCA Salary Survey**

Survey participation and response rates have been steadily increasing over the past few years and reached an all-time high this year. Nearly 140 community health centers participated in the 2017 Compensation and Benefits Survey, an 11% increase from last year. Survey data is currently being reviewed and analyzed by Gallagher Surveys. Participating health center organizations will receive a complimentary copy of the statewide report, in addition to an individualized report that will show their compensation data compared to the whole sample, their consortium, their region and operating budget group. Both the individual and statewide reports will be distributed accordingly in December 2017. The final statewide report will be available for purchase by non-participants on the CPCA website once it is released.

- **Growing and Diversifying the Health Professions**

- **Kaiser Permanente School of Medicine**

Kaiser Permanente School of Medicine (KP SOM) recently appointed Mark A. Schuster as their Founding Dean and CEO. As a Professor of Pediatrics, researcher, educator and health policy expert, he will oversee the day-to-day operations and school's unique direction of developing community health physician leaders. CPCA was invited to attend the KP SOM Founding Dean Welcome Reception, and will discuss with Mark the importance of health center partnerships. During this reception, CPCA will also meet the new members of the KP SOM Board of Directors, which includes multidisciplinary professionals from inside and outside Kaiser Permanente.

- **Area Health Education Centers (AHEC)**

The CA Area Health Education Center (AHEC) received federal funding for FY2017-2018 to continue pipeline development program activities and develop a California AHEC Community Health Experience (CACHE). CACHE will bring together teams of health professions students for a longitudinal clinical experience at a community health center. CPCA continues to support the CA AHEC and the regional centers with the renewal of a MOU between CPCA, AHEC, the Office of Statewide Health Planning and Development (OSHPD), and the Statewide Office of Rural Health. This MOU is intended to foster 1) collaboration; 2) technical assistance to community organizations wishing to expand access to primary care for underserved populations; 3) assessment of needs and sharing data; 4) workforce development for the National Health Service Corps and health center network; and 5) supporting shortage area designation.

- **Association of Clinicians for the Underserved (ACU)**

With the support of HRSA's Bureau of Primary Health Care, the Association of Clinicians for the Underserved is fielding a short assessment to gather information on health centers' current experiences with health professions training activities. The information collected will help ACU identify potential areas for resources, training, and technical assistance. This assessment takes approximately 15 minutes to complete and should be completed by all health centers regardless of whether or not they are currently training health professions

students or residents. Please complete the assessment online by Friday, September 22, 2017. The link to the ACU assessment can be found in the resources section of this memo.

- **Serving as Catalyst and Coordinator Between Local, Statewide, and National Workforce Efforts**

- **Workforce Policy Coalition**

As reported in July, members of the Workforce Policy Coalition agreed to prioritize the following three workforce policy areas and formed subcommittees to further discuss possible policy solutions in each area:

- Priming the Primary Care Pipeline
- Residency Redesign
- Advocacy

The *Advocacy subcommittee* was the first to meet after the July Coalition meeting, and discussed creating a joint Talking Points document that could be used to unify messaging about the primary care workforce shortage with a variety of constituents. CPCA staff collected comments from five members of the subcommittee and is currently drafting the talking points document for review.

The *Priming the Primary Care Pipeline subcommittee* decided to break into three smaller subcommittees to focus on 1) conducting a pipeline program inventory, 2) fostering relationships with workforce development boards, and 3) increasing collegiate support and developing state funding sources for California post-baccalaureate programs. Each of these smaller groups will be reporting back to the Pipeline subcommittee on October 16.

Finally the *Residency Redesign subcommittee*, over the course of two conference calls, has agreed to prioritize an educational campaign around the importance of residency redesign. On the most recent conference call, subcommittee members reviewed a potential educational campaign structure that at the core, emphasizes the primary care workforce shortage, and seeks to tie together discussions at the pipeline and advocacy subcommittee levels. The campaign would not only highlight residency redesign programs, but also highlight increased pipeline exposure, and general efforts to expand the healthcare workforce as strategies to address the workforce shortage. Staff will make edits to this campaign structure and will bring together the Residency Subcommittee one more time in October to finalize. This campaign structure will also be shared with each of the other two subcommittees to 1) garner buy-in to the model and 2) generate feedback on specific messaging pertinent to their discussions, and 3) determine resources available for such an endeavor.

The full Healthcare Workforce Policy Coalition will meet one final time this calendar year on Monday, November 6. The goal of this meeting is to hear about issues that have been prioritized by each of the three subcommittees, further discuss an educational campaign strategy, and to subsequently identify possible legislative action that the Coalition would like to draft/sponsor in 2018.

○ **California Future Health Workforce Commission BM**

CPCA's close relationship with California's leading health philanthropies contributed to the development of a California Future Health Workforce Commission. This Commission compliments our Workforce Policy Convening work, and will draft a statewide blueprint to bolster the health workforce. CPCA and our health centers will play an active role on the Commission and Technical Advisory Committee, and share their expertise to inform dialogue and decision-making of the Commission. Among the Commission participants are Dean Germano (Shasta Community Health Center) and Jane Garcia (La Clinica de la Raza). Beth Malinowski also serves as a member of their Technical Advisory Committee (TAC). The TAC held its first meeting in August and the Commission will be holding its first meeting this fall.

**III. Resources**

- California Future Health Workforce Commission - <https://futurehealthworkforce.org/>
- ACU Assessment of Health Professions Training in Health Centers - <https://www.surveymonkey.com/r/7F3NVKL>
- Foreign Provider Visa Program: J-1 and H1-B Visa Overview - [https://d3n8a8pro7vhmx.cloudfront.net/capca/pages/2108/attachments/original/1507053397/2017.10.03\\_Visa\\_2\\_Pager\\_-\\_Final.pdf?1507053397](https://d3n8a8pro7vhmx.cloudfront.net/capca/pages/2108/attachments/original/1507053397/2017.10.03_Visa_2_Pager_-_Final.pdf?1507053397)



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

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Corinne Sanchez	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Executive Summary</li> </ul>	Corinne Sanchez	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 2017</li> </ul>	Corinne Sanchez	A
IV. Payment Reform	<ul style="list-style-type: none"> <li>Memo: Status Update</li> </ul>	Andie Patterson	D
V. Pay-for-Performance	<ul style="list-style-type: none"> <li>Memo: Status Update</li> </ul>	Meaghan McCamman	A
VI. Proposed State Plan Amendment	<ul style="list-style-type: none"> <li>Memo: SPA process update</li> </ul>	Ginger Smith	I
VII. A&I Challenges – Progress Update	<ul style="list-style-type: none"> <li>Draft standards document</li> </ul>	Andie Patterson Ginger Smith	D
VIII. DHCS Update	<ul style="list-style-type: none"> <li>Memo: DHCS Update</li> </ul>	Ginger Smith	I
IX. HRSA Notes	<ul style="list-style-type: none"> <li>Notes from CPCA meeting with HRSA at NACHC CHI</li> </ul>	Andie Patterson	D
X. Prop 56	<ul style="list-style-type: none"> <li>Memo: Impact on FQHCs</li> </ul>	Beth Malinowski	I
XI. Legal Update: Retrospective Dental Claims Litigation	<ul style="list-style-type: none"> <li>Memo: Legal Update</li> </ul>	Andie Patterson	I
XII. Emergency Preparedness Final Rule	<ul style="list-style-type: none"> <li>Memo: EP Final Rule</li> <li>Compliance Checklist</li> </ul>	Emili LaBass	I
XIII. Adjourn		Corinne Sanchez	A



*Executive  
Summary*

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

**MEMORANDUM**

Payment Reform

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

P4P

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

Proposed State Plan Amendment

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

A&I Challenges – Progress Update

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

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

#### DHCS Update

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

#### HRSA Notes

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

#### Prop 56

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

#### Legal Update: Retrospective Dental Claims Litigation

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

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

#### EP Final Rule

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

**CALIFORNIA PRIMARY CARE  
ASSOCIATION**

**330 COMMITTEE**

**July 13, 2017**

**9:00am – 10:00am**

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

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

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

**I. Call to Order**

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

**II. Approval of Agenda**

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

**III. Approval of Minutes**

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

**IV. Pay-for-Performance**

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

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

**V. A&I Challenges**

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

**VI. Payment Reform**

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

### **VII. Proposed State Plan Amendment**

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

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

### **VIII. Legal Update**

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

### **IX. Adjourn**

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

Respectfully submitted,

Daisy Po'oi  
Meeting Minutes Recorder



**DISCUSSION**

**Date:** September 21, 2017  
**To:** 330 Committee  
**From:** Andie Patterson, Director Government Affairs  
**Re:** Status of Payment Reform Work

**MEMORANDUM**

**Status of CA APM**

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

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

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

**Next Steps**

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

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

*Today, health centers can enter into contractual arrangements with managed care plans or third party payers to receive “incentives” should they meet certain criteria or objectives. We often refer to these as P4P or pay for performance. These incentives are held outside of reconciliation. While never done, health centers could also voluntarily enter into contractual relationships with managed care plans where they agree to take risk if they do not meet certain criteria. This risk would also be held outside of reconciliation.*

*The new idea we briefly discussed with the Wrap Cap WG and DHCS was for the CA APM to be amended to remove the risk triggers and be implemented through a State Plan Amendment. If we did this, and visits from base year went up for the FQHC, at the end of the year the state and the plans would make the health center “whole.” To meet the state’s objectives for risk or “having skin in the game” the health center would take on risk with the plans. In this model, if we crafted it so that health centers were penalized for visits going up (as it is in the APM currently) then the health center would pay back the managed care plan. Ultimately we believe the state, who pays the plans, could make up for their additional costs of making the health center whole by figuring subtracting the cost from the next rate with the plan.*

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

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



**ACTION**

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

**MEMORANDUM**

**Overview**

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

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

**Current Efforts**

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

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

**Updated Workgroup Recommendation**

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

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

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

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

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

#### **Questions to the Committee**

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

#### **Resources**

- [CPCA’s P4P White Paper](#)



INFORMATIONAL

Date: September 18, 2017  
To: 330 Committee  
From: Ginger Smith, Director of Health Center Operations  
Re: Medicaid State Plan Amendment - Proposed Changes to the Prospective Payment Reimbursement: Productivity Standards, 90-Day Requirement, and Change in Scope of Service Request

MEMORANDUM

### I. Background

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

### II. Issues

#### **Productivity Standards and 90-Day Requirement**

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

#### **CSOSR**

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

### III. Resources

- The SPA notice can be found here: [http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001\\_PN.pdf](http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001_PN.pdf)
- When SPA language is available, it will be posted here: [http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro\\_SPA.aspx](http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx)
- Once submitted to CMS, the SPA will be posted in the "Pending" category here: [http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending\\_2017.aspx](http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending_2017.aspx)

**Allowability of Costs for an FQHC**  
**Initial Rate Setting or Change in Scope of Services**

September 27, 2017

Version 1

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

**Basic Rules**

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

**Definitions**

A. Core Services

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

FQHCs are required to provide, either on-site or through arrangement with other providers or service providers<sup>2</sup>:

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

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<sup>1</sup> From the Health Resources and Services Administration (HRSA) "[Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs.](#)"

<sup>2</sup> Contracting restrictions for FQHC services is not a part of this paper.

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

## B. Allowable Costs

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

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

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

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

Cost topics often discussed and causing much confusion are:

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

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

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

<sup>5</sup> As of January 1, 2014, [psychology services](#) are no longer subject to the two-per-month limit.

<sup>6</sup> Tests of reasonableness as the Secretary prescribes in [regulations](#)<sup>6</sup>.

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

### C. Non Allowable Costs

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

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

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

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

### D. Interaction of Allowable and Non Allowable Costs

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

### E. Reasonableness

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

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

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

### **Documentation**

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

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

Agreed upon rules:

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

### **Appendix A. Regulatory Sources**

#### **I. FEDERAL**

Social Security Act:

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

Medicare Regulatory Requirements:

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

Medicaid Statute:

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

Required primary health services for FQHCs:

- [42 USC Section 254b\(b\)\(1\)](#)

Federal Cost Principles:

- [Publication 15-1: The Provider Reimbursement Manual – Part 1](#)

## I. STATE

California State Plan and Related Amendments

- [California State Plan](#)
- [Approved State Plan Amendments](#)

California Code of Regulations:

- [Title 22, Division 3, Subdivision 1. California Medical Assistance Program](#)

Medi-Cal Provider Manual, Part 2:

- [Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\)](#)

PPS Rate Setting Cost Report:

- [DHCS 3090i \(Medi-Cal Freestanding PPS Rate Setting Cost Report\)](#)

Medi-Cal Provider Bulletin:

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

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

- FY 15-16 Change in scope rate setting clinic did not abate all investment income against interest expense, only abated interest income. Interest expense is an allowable cost only for the net amount of interest and investment income earned minus interest expense. The department auditors were correct and clinic conceded to auditor's findings.
- FY 13-14 Change in scope rate setting for OB clinic Site clinic did not use the correct depreciation amount for fixed assets. Clinic took too much depreciation expense based on 2008 edition of the "AHA Estimated Useful Lives of Depreciable Hospital Assets". Clinic conceded to auditor's findings.

### **Appendix C. Examples of Costs INCORRECTLY disallowed**

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

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

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

**Example 2: Removal of Behavioral Health Clinician and Fringe Benefits**

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

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

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

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

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

CMS Pub 15-1 Section 2102.3.:

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

*Such costs are not allowable in computing reimbursable costs and include, for example:*

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



INFORMATIONAL

Date: September 27, 2017  
To: 330 Committee  
From: Ginger Smith, Director of Health Center Operations  
Re: Department of Health Care Services (DHCS) Updates

MEMORANDUM

**I. Background**

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

**II. Issues**

**EHR as Qualifying Event for CSOSR**

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

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

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

### **Contracting with Private Dental Providers**

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

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

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

### **2017 MEI Rate Increase**

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

### **III. Resources**

- [DHCS Memo on Contracting with Private Dentist](#)



NACHC CHI 2017

CPCA Meeting with Jim Macrae, et al, HRSA

With NOTES from 8-26 meeting

**I. HRSA – 2017 Direction and Goals**

- Uncertainty continues. We have a few questions to better understand the environment you are working within.
  - ⇒ Is there anything you can share on the funding cliff? Plans for health centers not being made whole? Plans for Congress missing the Sept 30 deadline?
  - ⇒ Could you share any information you have about future grant funding, aside from the funding cliff, including capital grants?
  - ⇒ Can you share new developments since March under the new Administration, and how it has or has not changed the direction and goals for HRSA?
  - ⇒ We understand that Secretary Price has identified three priorities: Obesity, telehealth and the opioid epidemic. How is this impacting HRSA? How can health centers better prove their ROI in these three areas?
  - ⇒ If the ACA is not repealed do you have any insights on the flexibility Secretary Price intends to exercise with the states and Medicaid?

**Notes**

HRSA is making plans to go over the primary care funding cliff

3 scenarios they are planning for

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

Secretary of Health and Human Services, Tom Price, visited a health center during national health center week and wrote a [very positive blog](#)

The Administrator of the Health Resources and Services Administration, George Sigounas, is very supportive of health centers. He wants health centers and BPHC to be further recognized for their amazing work. Also interested in expanding the footprint of health centers (at this point not with new money), as well as better understand the value of the investment.

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

Jim pushed at other meetings during the CHI the importance of health centers being engaged in education and training. If a health center doesn't want to be a teaching health center they should at least be training to "grow their own."

Also a big push for health centers to do a fuller range of services (med/dental/bh/vision/enabling)

With a particular focus on substance abuse (because Secretary Price has this as a priority)

## II. 340B

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

⇒ Do you have an update on what will happen with the 340B program? Will HRSA have more of a role to play in accountability for the program and what is done with the savings?

⇒ How can we continue to participate safely?

⇒ Any advice as we continue our negotiations with the state?

## NOTES

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

## III. Workforce

### HRSA PATIENT TARGETS

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

- And educational health centers that focus on training clinicians to bring into our system, experience a downward effect on productivity, and they are then penalized by the HRSA patient targets.
  - With all we are doing to address workforce, we think we can turn this around, but not right away
  - Another challenge are the higher no-show rates for immigrant patients created by the culture of fear under the new federal administration.
  - It doesn't seem appropriate to penalize health centers with less resources to support their communities under these trying circumstances.
- ⇒ Lastly, the three priorities of Secretary Price (obesity, telehealth and opioids), are all high intensity visits- and not necessarily supportive of the volume HRSA seeks through the Patient Targets strategy. How can we reconcile the two goals? How can we effectively capture patients through telehealth?
- We maintain the Patient Targets effort is fundamentally flawed and would continue to request that HRSA work with CA on a more nuanced approach to achieve both the health center goals and the Bureau's goals.
  - Health centers shouldn't be penalized when things like the culture of fear and the workforce crisis are outside of health centers control.
- ⇒ The last time we met you shared that you were looking at other ways of capturing what health centers are really doing. Have you come up with any new approaches?
- ⇒ We want to be partners with HRSA in this undertaking? How can we help?

## NOTES

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

## HPSA

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

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

## **CALIFORNIA'S PROGRESS**

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

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

#### **IV. STATE ISSUES**

##### **Budget**

- In March, we were very disappointed to share with you that the \$100 M we were able to secure last year for residency had been zeroed out in the Governor’s proposed budget in January.
- Through heavy advocacy, we are excited to report that the final FY 17-18 Budget for California that took effect on July 1<sup>st</sup> is a testament to our advocacy and perseverance during challenging times
- The Budget Act of 2017 reflects California’s commitment to creating a healthy California.
- In particular, CaliforniaHealth+ Advocates is proud to share that this budget reflects strong support of health centers and the patients we serve. Through successful lobbying and advocacy, and with the tremendous leadership of our health centers and a wide array of advocacy partners, we are excited to share the following news on our top priorities:
- \$100 Million Workforce Funding Reinstated: The legislature reinstated \$100 million to support primary care residency, including teaching health centers, and loan repayment. The budget act appropriates \$33.3 million, the 17-18 portion of those funds. Consistent with the Budget Act of 2016, these are to allocated through Song-Brown in the following manner:
  - Existing Programs: \$18,668,000 is available to grant awards for existing primary care residency programs
  - Teaching Health Centers: \$5,667,000 is available to fund primary care residency slots for existing teaching health center programs
    - These funds, similar to the existing programs funds, will be dispersed to programs based on the total number of residents incoming in 2018.
  - New Slots: \$3,333,000 is available to fund new primary care residency slots at existing primary care residency programs
  - New Programs: \$3,333,000 is available to fund newly accredited primary care residency programs
  - Loan Repayment: Of the funds appropriated, \$333,000 is available for the State Loan Repayment Program (SLRP)
  - The funds appropriated in this item shall continue to be available for encumbrance or expenditure until June 30, 2023.
  - It is important to note that these funds are in no way a replacement of the necessary federal investments.

- New \$20 Million Community Clinic Lifeline Grant Program: Establishes the Community Clinic Lifeline Grant Program within the California Health Facilities Financing Authority (CHFFA) for small and rural health clinics suffering financial losses, and appropriates \$20 million from the Health Expansion Loan Program (HELP II) fund one-time for this purpose. CHFFA will develop selection criteria and a process for awarding the grants, which may not exceed \$250,000 each, in the coming months.
- 340B Drug Discount Program Untouched: The passed budget includes no changes to contract pharmacies or other provisions relating to the 340B Program.
- Newly Qualified Immigrant (NQI) Wrap No More: The signed budget adopts the Governor’s May Revise proposal to halt the implementation of the NQI Affordability and Benefit Program (Wrap), allowing newly qualified immigrants to continue to receive care through the Medi-Cal program.
- MFT Implementation Greenlighted: Delays AB 1863 (Wood, Chapter 610, Statutes of 2016) implementation from January 1, 2017 to **no later than** July 1, 2018, allowing FQHCs and RHCs to include MFTs as Medi-Cal billable providers at that time.

### **STATE LEGISLATION**

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

### **STATE PLAN AMENDMENT**

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

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

### **PAYMENT REFORM**

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

### **CP3**

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

### **DENTAL/ MIP AUDITS**

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

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

## NOTES- DID NOT RAISE

### LICENSING/OSHPD 3 STANDARDS

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

### **V. Immigration**

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

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

## NOTES

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

## VI. Administrative Issues

### EHB

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

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

### CONSORTIA STANDING & HEALTH CENTER TA

- In California, because we are so big, we have the unique structure of a statewide PCA, and in essence regional PCAs.
  - Health centers locally depend heavily on their local consortia for support.
  - Unfortunately, as the consortia do not receive direct HRSA TA grants, consortia are not deemed to have standing in helping a health center.
  - This limits the support a health center can receive and an important voice in the conversation.
- ⇒ Is there anything that can be done to resolve this challenge?
- ⇒ Last time we met you shared you would look into the matter. Is there anything to report?

NOTES- THEY ARE REVIEWING AND WELCOME SUGGESTIONS



Date: September 24, 2017  
To: 330 Committee  
From: Beth Malinowski, Deputy Director of Government Affairs  
Re: Proposition 56 Supplemental Payments

MEMORANDUM

**Overview**

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

- **Commitment to Medi-Cal Providers:** Supplemental payments, totaling \$546 million, will be divided among five groups of providers – Physicians (up to \$325 million), Dentists (up to \$140 million), Women’s Health Providers (up to \$50 million), Developmental Disability Providers (up to \$27 million), and HIV/AIDS Providers (up to \$4 million).
- **Medi-Cal Stabilization:** Funds that are allocated to Medi-Cal, and not utilized for rate increases (approx \$711 million), will be allocated for spending growth that would typically be paid for by General Fund dollars.
- **Supporting State Oral Health Plan:** \$30 million ongoing allocation to the state dental director’s office.

**FQHCs and Supplemental Payments**

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

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

FQHCs will not be eligible for any other supplemental payments, including Medi-Cal and/or Denti-Cal fee-for-service or managed care supplemental payments that could have caused challenges during reconciliation.

It is important to note that these supplemental payments will be in jeopardy if CMS approvals are not received and/or federal support for the Medi-Cal program is reduced.

### **Resources**

- [Proposition 56 Supplemental Payment Methodologies \(DHCS\)](#)
- [Notice of Proposed Change to the Medi-Cal Program \(DHCS\)](#)



**INFORMATIONAL**

Date: October 10, 2017  
To: 330 Committee  
From: Andie Patterson  
Re: Legal Update: Retrospective Dental Claims Litigation

**MEMORANDUM**

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

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

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

Date: September 20, 2017

To: 330 Committee

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

Re: Emergency Preparedness Final Rule

MEMORANDUM

Emergency Preparedness Final Rule - Background:

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

CPCA Activities:

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

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

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

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

# CMS EMERGENCY PREPAREDNESS RULE COMPLIANCE CHECKLIST

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

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



# RISK ASSESSMENT & EMERGENCY PLANNING

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(a)	<ul style="list-style-type: none"> <li>Develop and maintain an emergency preparedness plan</li> <li>Review and update emergency preparedness plans at least annually</li> </ul>	Emergency plans designed in accordance with risk assessment results and that include processes that provide the most comprehensive response to a broad range of emergencies	<p>Review and update emergency preparedness plans using the risk assessment results and guidance provided in the Final Rule. Plan must address the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The most likely risks to the institution based on risk assessment</li> <li><input type="checkbox"/> Patient populations, including, but not limited to the type of services the FQHC has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans</li> <li><input type="checkbox"/> Include a process for cooperation and collaboration with local, tribal, regional, state, and Federal emergency preparedness <b>officials' effort to maintain and integrate</b> response during a disaster or emergency situation</li> <li><input type="checkbox"/> Be reviewed and updated at least annually</li> </ul>	<p>CPCA's <a href="#">Continuity of Operations Plan (COOP) Toolkit</a> can aid clinics in developing a COOP customized to their facilities and business plan. Visit the CPCA store to purchase the toolkit.</p> <p>CPCA's <a href="#">Emergency Operations Plan Template</a> is an excellent resource to help clinics get started in creating emergency preparedness policies and procedures.</p>
Section 491.12(a)(1)	<ul style="list-style-type: none"> <li>Develop a documented, facility- and community-based risk assessment utilizing an all-hazards approach</li> <li>Identify the medical and non-medical emergency events likely to occur at the facility and in the surrounding area</li> </ul>	<p>Identifying key components of a healthcare facility's emergency plan that apply to a full range of disasters or emergencies</p> <p>An all-hazards approach is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies &amp; disasters</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Update existing risk assessments using the guidance of the Final Rule and document the work</li> <li><input type="checkbox"/> If you do not have a risk assessment to start from, collaborate with your local emergency management, public health, and health care coalition planning partners to access the <b>jurisdiction's Threat and Hazard Identification and Risk Assessment (THIRA)</b> or other <b>agencies' Hazard Vulnerability Analyses (HVA)</b> to work from.</li> <li><input type="checkbox"/> Perform a risk assessment using an all-hazards approach to identify hazards that are most likely to occur at the facility and in the surrounding area</li> </ul>	<p><a href="#">Kaiser Permanente Hazard Vulnerability Analysis (HVA)</a> is a great tool to help clinics identify likely hazards.</p> <p>For those who do not prefer the HVA format, the <a href="#">Hazard Risk Assessment Instrument (HRAI)</a> guide and worksheets can also be used to complete a risk assessment. <a href="#">ASPR TRACIE</a> has a resource comparing the purpose, benefits, and limitations of various hazard vulnerability assessment tools.</p>

# POLICIES & PROCEDURES

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(b)	<ul style="list-style-type: none"> <li>▪ Develop and implement emergency preparedness policies and procedures based on the emergency plans, risk assessments, and communication plans</li> <li>▪ Review and update policies and procedures at least annually</li> </ul>	Healthcare institutions must define and document policies and procedures for their emergency program and its associated emergency plans	<ul style="list-style-type: none"> <li><input type="checkbox"/> Revise and/or develop policies and procedures that support the execution of an emergency response plan</li> <li><input type="checkbox"/> Policies and procedures must respond to the risks identified in the risk assessment</li> <li><input type="checkbox"/> Policies and procedures must be identified in writing, and current regulations stipulate that a physician, in conjunction with a nurse practitioner or physician's assistant, develop the facility's written policies</li> <li><input type="checkbox"/> Policies and procedures must address the following:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Safe evacuation (including staff responsibilities and patient needs)</li> <li><input type="checkbox"/> A means to shelter in place for patients, staff, and volunteers, who remain in the facility</li> <li><input type="checkbox"/> A system of medical documentation (paper-based, electronic, or ideally both) that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records</li> <li><input type="checkbox"/> The use of volunteers in emergency or other emergency staffing strategies, including the process for integration of State and Federal designated health center professionals to address surge needs during an emergency</li> <li><input type="checkbox"/> Integration and overlap between the facility's EOP and response partners emergency plans within the community</li> <li><input type="checkbox"/> Review policies and procedures at least annually</li> </ul> </li> </ul>	<p>CPCA's <a href="#">Emergency Operations Plan Template</a> is an excellent resource to help clinics get started in creating emergency preparedness policies and procedures. Additional resources include an <a href="#">Evacuation Plan Template</a> and <a href="#">Shelter in Place Plan Template</a>.</p> <p>This <a href="#">Emergency Preparedness Toolkit for Primary Care Providers</a> is a useful resource to access for additional, hazard-specific fact sheets to include in your plan, as well as links to trainings, exercise resources, and some sample Tabletop Exercise scripts.</p>

# COMMUNICATIONS PLAN

Reference	Requirements	What it Means	Tips for Compliance	Resources
Section 491.12(c)	<ul style="list-style-type: none"> <li>▪ Develop and maintain an emergency preparedness communication plan that complies with both federal and state law</li> <li>▪ Review and update plans at least annually</li> </ul>	<p>A system to communicate with all relevant internal and external parties, all in compliance with federal and state laws</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Develop and document a formal communications plan for emergencies (if one does not already exist) that conforms to the CMS requirements               <ul style="list-style-type: none"> <li><input type="checkbox"/> Communications plan that provides the broadest and most timely notification of an emergency.</li> <li><input type="checkbox"/> Maintain list name and contact information for staff, entities providing services under mutual aid arrangements, physicians, other FQHCs, and volunteers</li> <li><input type="checkbox"/> Maintain contact information for Federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance</li> <li><input type="checkbox"/> A system to communicate with all relevant parties, all in compliance with federal, state, and local laws</li> <li><input type="checkbox"/> Identify alternate communications systems in the event that their standard communications systems become unavailable</li> <li><input type="checkbox"/> Cross-functional plan to coordinate patient care issues within the facility</li> <li><input type="checkbox"/> A means of providing information about the general condition and location patients under the facility's care as permitted under the HIPPA Privacy Rule</li> <li><input type="checkbox"/> A means of providing information about the FQHC needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee</li> <li><input type="checkbox"/> Review and update plans at least annual</li> </ul> </li> </ul>	<p>CPCA's <a href="#">Communication Plan Template</a> offers tools and guidance designed to help prepare clinics to communicate effectively in a crisis.</p>

Reference	Requirements	What it Means	Tips for Compliance	Resources
491.12(d)	<ul style="list-style-type: none"> <li>Develop and maintain emergency preparedness training and testing programs</li> <li>Review and update training programs at least annually</li> </ul>	Training and testing programs ensure all employees and emergency teams are prepared to execute their duties in an emergency, and receive regular refresher training and testing.	<ul style="list-style-type: none"> <li><input type="checkbox"/> Develop and/or update training and testing activities that ensure all employees and emergency teams are fully trained in their roles and duties</li> <li><input type="checkbox"/> Review and update programs at least annually</li> </ul>	While not required, we recommend creating a Multi-Year Training and Exercise Plan (MYTEP) either for your facility or for your coalition and community that outlines your planned schedule of trainings and exercises for the next 3 – 5 years. A sample MYTEP template can be found <a href="#">here</a> .
491.12(d)(1)	<ul style="list-style-type: none"> <li>Provide initial training in EP policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation</li> </ul>	See section 491.12(d)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Update policies and procedures to include initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement (such as vendors), and volunteers, consistent with their expected roles according to your Emergency Plan</li> <li><input type="checkbox"/> Ensure staff could demonstrate knowledge of emergency preparedness and document knowledge outcomes from trainings</li> <li><input type="checkbox"/> Maintain documentation of training conduct, such as sign-in sheets and Feedback Forms, as well as training curricula</li> <li><input type="checkbox"/> Provide emergency preparedness training at least annually</li> </ul>	CPCA's <a href="#">Training Pre and Post-Test Template</a> can be used and customized to create pre and post-tests for all staff trainings to help demonstrate knowledge outcomes.

Reference	Requirements	What it Means	Tips for Compliance	Resources
491.12(d)(2)	<ul style="list-style-type: none"> <li>▪ Participate in a community-based exercise at least annually and an additional testing exercise (e.g., paper-based tabletop exercise) at least annually</li> </ul>	See section 491.12(d)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Participate in a community-based exercise annually (if a community-based exercise is not possible or feasible, a facility-based exercise may be substituted if proper justification is provided). If the FQHC has to activate its emergency plan, it can be exempt from the requirement of an exercise for one year following the onset of the event, with proper documentation of the incident and the response. FQHC is still required to conduct a tabletop exercise at least annually.</li> <li><input type="checkbox"/> Conduct an additional exercise that may include, but is not limited to, a second full-scale exercise that is community- or facility-based or a table top exercise including a group discussion led by a facilitator</li> <li><input type="checkbox"/> Analyze the FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the emergency plan as needed</li> </ul>	<p>Participation in your local healthcare coalition is highly encouraged. Refer to the <a href="#">healthcare coalition listing</a> to find out who your healthcare coalition is and how to contact them.</p> <p>The <a href="#">California Statewide Medical and Health Exercise</a> website can offer a wealth of exercise documentation templates to be tailored and used for your facility to both participate in and create a community-based exercise.</p> <p>Additional training for health care facilities on the Homeland Security Exercise and Evaluation Program (HSEEP), sample After Action Reports, Exercise Checklists, and more can be found at the <a href="#">Wisconsin Department of Health Services Website</a>.</p> <p>At a minimum, we recommend the following documents for conduct of a <a href="#">full-scale</a> or <a href="#">tabletop exercise</a> within your facility:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Exercise Objectives</li> <li><input type="checkbox"/> Exercise Scenario</li> <li><input type="checkbox"/> Exercise Plan (the previous two may be included in this document)</li> <li><input type="checkbox"/> Exercise Sign-In Sheets/Participant List</li> <li><input type="checkbox"/> Exercise Feedback Forms and Evaluator Notes (sometimes called Exercise Evaluation Guides)</li> <li><input type="checkbox"/> After Action Report and Improvement Plan</li> </ul>



# Consortia Policy Group Peer Network

Tuesday – October 10, 2017

3:40 – 4:40 PM

4<sup>th</sup> Floor/San Clemente, Hilton Anaheim

Vernita Todd, Facilitator

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Vernita Todd	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Agenda</li> </ul>	Vernita Todd	A
III. Policy Prioritization – Process Review and Next Steps	<i>Please see materials in Legislative Committee</i>	Andie Patterson	D
IV. Federal Advocacy – advocacy engagement with members		Joanne Preece	D
V. NACHCs Policy & Issues Forum 2018	<ul style="list-style-type: none"> <li>P&amp;I Planning and Expectations</li> </ul>	Vernita Todd	D
VI. State Politics, Legislation & Advocacy	<i>Please see materials in Legislative Committee</i>	Beth Malinowski	D
VII. Adjourn		Vernita Todd	A

Click on the link below to access the CPG Dropbox:

[https://www.dropbox.com/sh/z92kwh99bigqaw/AAAVuwlSnhvph3L2iUO\\_Qo71a?dl=0](https://www.dropbox.com/sh/z92kwh99bigqaw/AAAVuwlSnhvph3L2iUO_Qo71a?dl=0)



**INFORMATIONAL**

Date: September 25, 2017  
To: Consortia Policy Group  
From: Kelley Aldrich, Senior Administrative Coordinator  
Re: NACHC's 2018 Policy & Issues Forum – Planning and Expectations

**NACHC Policy & Issues Forum  
Marriott Wardman Park Hotel / Washington, DC  
March 14 - 18, 2018  
Committee Meetings: March 17-18, 2018**

The Policy & Issues Forum (P&I) is the largest gathering of health center clinicians, executive directors, State and Regional Primary Care partners, board members and advocates on record. This event focuses on the latest in state and federal government policies affecting Community Health Centers and health care for millions of Americans.

**October/November 2017**

Reserve your hotel room – *the host hotel and surrounding hotels sell out very early!*

**January 2018**

CaliforniaHealth+ Advocates registration forms and NACHC information including the schedule are typically released mid-January.

*\*\*\*Please encourage your members to register with CaliforniaHealth+ Advocates in addition to NACHC and/your individual consortia. We cannot accurately prepare materials or reserve delegation meeting space without being notified of your attendance.*

**Meetings with Members of Congress**

Each consortia will take the lead in scheduling meetings with members of congress. *“Taking the lead”* means scheduling the meeting, coordinating with the overlapping consortia on attendees, and notifying CaliforniaHealth+ Advocates of all confirmed meetings so they can be included in the master grid. *CaliforniaHealth+ Advocates maintains a master grid for three reasons; 1.) NACHC requests a copy each and every year, 2.) We must have accurate numbers for grant reporting and 3.) Every year we have members come to us the night of the delegation meeting and throughout P&I asking when and where their meetings are.*

CaliforniaHealth+ Advocates will develop and circulate a CPG Overlap Grid in January to help facilitate coordinated planning.

**By Thursday, March 8 (one week prior to our hill visits)** all congressional meetings need to be confirmed so we can finalize and print the master grid for both our members and NACHC.

*\*\*\* We recognize that some schedulers do not calendar meetings until a week or two out, so if you're a week out and still having issues scheduling visits, please contact Kelley Aldrich or Angie Buckingham Melton for assistance.*

### **Meetings with California Senators**

Angie Buckingham Melton, CaliforniaHealth+ Advocates DC lobbyist, will take the lead on scheduling the Senate meetings on behalf of the California delegation. Carmela extends an invitation to attend these meetings and if we do not hit our capacity, a sign-up sheet will then be made available at the delegation meeting on Wednesday, March 14th.

### **Materials**

All members who register with Advocates will receive the following materials via e-mail on week prior to P&I:

- California State Profile
  - California Specific Policy Papers/Fact Sheets
  - Member Talking Points
  - NACHC Policy Papers
- Congressional District Profiles – *available in the CPG Dropbox*

CaliforniaHealth+ Advocates will host a webinar prior to P&I where we'll discuss the materials listed above, logistics and answer any questions. The date and time of the webinar will be advertised in the weekly update and sent to everyone that registers with Advocates.

### **California Delegation Meeting**

We encourage everyone, both the consortia and members, to join us on Wednesday, March 14<sup>th</sup> (time & room TBD) to pick up meeting materials and hear from both CaliforniaHealth+ Advocates and NACHC representatives. As always, CaliforniaHealth+ Advocates will provide appetizers and refreshments. Participants are encouraged to make dinner plans after the delegation meeting.

*\*\*\*If you have meetings scheduled with members of congress prior to the designated Hill Visit date of March 15<sup>th</sup>, please make arrangements with Kelley Aldrich to pick up your meeting materials on Tuesday evening or Wednesday morning at the Marriott Wardman Park.*



## Executive Committee

Tuesday, October 10, 2017

3:40-4:40p

CPCA Conference Room

Naomi Fuchs, Chair

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Naomi Fuchs, Chair	A
II. Approval of Agenda		Naomi Fuchs, Chair	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>Minutes from July 13, 2017</li> </ul>	Naomi Fuchs, Chair	A
IV. CEO Report	<ul style="list-style-type: none"> <li>Final 2018 Board Meeting Schedule (see <i>Board of Directors packet</i>)</li> </ul>	Carmela Castellano-Garcia	I/D
V. Update on Epic Partnership	<ul style="list-style-type: none"> <li>(See <i>Board of Directors packet for materials</i>)</li> </ul>	Carmela Castellano-Garcia with Andy Principe and Robert Beaudry	I/D/A
VI. CaliforniaHealth+ Advocates Board Seats	<ul style="list-style-type: none"> <li>(See <i>Board of Directors packet for related memo</i>)</li> </ul>	Carmela Castellano-Garcia	I/D/A
VII. Adjourn		Naomi Fuchs, Chair	A

## EXECUTIVE COMMITTEE MEETING

July 13, 2017

### Meeting Minutes

**Members Present :** Scott McFarland (Chair elect), Sherry Hirota, Kerry Hydash, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, and David Vliet

**Members Absent:** Naomi Fuchs

**Guests:** Cathy Frey, Marty Lynch, Tony Weber, Jane Garcia, Robin Affrime, Mary Szecsey

**Staff:** Carmela Castellano-Garcia, Robert Beaudry, Mike Witte, Heather Barclay

#### **1. Call to Order**

Scott McFarland, Chair-elect, called the meeting to order at 4:12p.

#### **2. Approval of Agenda**

##### **Motion**

A motion was made and seconded to approve the agenda as presented. (McCarthy/Noguera). **The motion carried.**

#### **3. Approval of Minutes**

##### **Motion**

A motion was made and seconded to approve the minutes from the May 4, 2017, meeting as presented. (Myers/Ream). **The motion carried.**

#### **4. CEO Report**

Carmela provided a brief CEO report and gave kudos to the CPCA staff for recent Legislative victories.

#### **5. California Health+ Advocates Board**

Carmela detailed the related memo in the meeting packet. As Advocates Board Chair Tracy Ream is retiring later this year, her role will need to be filled and it was suggested that Steve Schilling, who while also retiring will still have a clinic role, take her place. Members were reminded that Advocates Board members do NOT need to be a clinic CEO. Action will be taken on this item in October, for now this is informational.

#### **6. Update on Epic Partnership**

Carmela noted today's discussion is meant to be a general overview and no decision-making is necessary at this time. Business plan-related PowerPoint slides were included in the meeting packet to guide discussion. At tomorrow's Board meeting, guidance will be sought on a few important items in order to move forward with next steps in the related Business Plan and to prepare the related counter-proposal to Epic. It was agreed that the Executive Committee would take the lead on finalizing a Business Plan. It was noted that Technical Advisory Group (TAG) had an in-person meeting with Epic and the 9 health centers who are most interested were represented. The TAG would be the vehicle to have a leadership role in the product, but the Board would have ultimate oversight of the partnership.

The four (4) main goals of a CPCA/Epic partnership were reviewed, but ultimately is to position CPCA more strongly in the overall EMR arena:

1. Offer the best possible terms and conditions for acquiring the Epic HIT platform
2. Build a California-specific standard configuration to reduce total cost of ownership.
3. Deliver the HIT platform with professional configuration, implementation, hosting and management.
4. Seek opportunities to leverage shared HIT Platform for enhanced strategic positioning.

So far, there are 24 member health centers interested in Epic, representing 13% of the total membership of 170 total clinic corporations. As of now, legal counsel does not advise forming a separate company as it would do little to limit potential liabilities. The Business Plan Process and Goals slides were discussed in further detail. An initial cohort is already somewhat in place with 9 interested clinics. It was noted that practice management details have yet to be flushed out.

Epic will be scheduling product-related webinars for all interested parties. Robert Beaudry, COO, noted that at some point we'll need to select a management partner and issue an RFP for the implementation component. He noted there would also be a dedicated CPCA staff person. A pro forma was developed using some initial pricing from Epic, but there has been no formal counter proposal or negotiation yet and there are still cost unknowns, including the implementation cost allocations.

The Financial Analysis slides were reviewed by Robert, who noted that the first cohort would likely include 2-3 health centers representing close to 800k encounters, then more clinics would be added in the next cohort, getting closer to 3M encounters. What would be included in the standard configuration was the main basis of the most recent Epic visit. Robert also addressed staffing-related questions (both Association and clinic-related) and also noted there are roles that Epic would manage from their WI headquarters. Some roles could be contracted, and a professional management firm could be called on to assist with implementation roles. Over time, staff could be used to support other EMR products, but outlined today are the current needs specific to Epic. Robert clarified that Epic would be the host, and would provide direct TA. He noted that per the draft pro forma, we'd reach a cost break-even at the end of year 3 and the total cost per encounter is currently estimated at \$6 (including everything – hosting, staffing, etc.). There was discussion about other avenues to Epic's product offering, including a discussion of other available EMR vendors and options for clinics.

Questions/topics for additional consideration included: hosting fees, encounter pricing, need for a separate company, staffing model and other purchasing options. Presuming the Board approves CPCA to move forward with the next steps in the negotiation process, a counter proposal would be prepared and brought back to this Committee. The Board would approve the structure and concept, but the Executive Committee will have review/approval authority of the counter proposal before it's submitted to Epic.

## **7. Executive/Closed Session**

Chair-elect called the meeting into Closed Session for the purpose of discussing the annual CEO Assessment for 2017.

## **8. Adjourn**

The meeting was adjourned by the Chair-elect at approximately 5:00p.



## Clinicians Committee

Wednesday, October 11, 2017

8:30 a.m. - 10:00 a.m.

**Anitha Mullangi, Chair**

**Ellen Piernot, Co-Chair**

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Anitha Mullangi	A
II. Approval of Agenda		Anitha Mullangi	A
III. Approval of Minutes		Anitha Mullangi	A
IV. CPCA CMO Report	<ul style="list-style-type: none"> <li>Memo</li> </ul>	Mike Witte	I
V. CP3 & Data Report	<ul style="list-style-type: none"> <li>Memo</li> </ul>	Cindy Keltner	I
VI. Integrated Care/Behavioral Health	<ul style="list-style-type: none"> <li>Memo</li> </ul>		I
VII. Legislative Update	<ul style="list-style-type: none"> <li>Refer to Legislative Committee packet</li> </ul>	Beth Malinowski	I
VIII. Workforce Update	<ul style="list-style-type: none"> <li>Refer to Workforce Committee packet</li> </ul>		I
IX. Tele-dentistry	Guest Speaker	Paul Glassman	I/D
X. Adjourn			A

**CALIFORNIA PRIMARY CARE ASSOCIATION  
CLINICIANS COMMITTEE  
July 14<sup>th</sup>, 2017  
8:30am-10:00am**

**Members:** Anitha Mullangi, Chair, Ellen Piernot, Chair-elect, Cathy Frey, Deborah Lerner, Danielle Myers, Graciela Soto-Perez, Doug Lewis, Lynn Dorroh-Watson, Susie Foster, David Lavine, Robert Moore

**Guests:** Nik Gupta, Mary Szecsey, Doreen Bradshaw, Scott McFarland, Tim Rine, Britta Guerrero, Christine Noguera, Trisha Cooke, Cynthia Carmona

**Staff:** Carmela Castellano, Garcia, Dr. Mike Witte, Lucy Moreno, Nataly Diaz, Ginger Smith, Jodi Samuels, Allie Budenz, Shadi Kanaan, Andie Patterson, Nenick Vu, Cindy Keltner, Tina Canupp, Meaghan McCamman, Meghan Nousaine, Victor Christy, Kearsten Shepherd, Sarah Heppler

**I. Call to Order**

Anitha Mullangi, Chair, called the meeting to order at 8:34am.

**II. Approval of Agenda**

A motion was made to approve the agenda as presented. **The motion carried. (Myers/Piernot)**

**III. Approval of Minutes**

A motion was made to approve the minutes of May 5<sup>th</sup>, 2017. **The motion carried. (Myers, Lerner)**

**IV. CMO Report**

Mike Witte reviewed his CMO report with priorities of focus being integrating blended care and SDOH.

**V. CP3 & Data Report**

Lucy Moreno provided an update on the non-traditional touch of call in/video appointments and the coding work that is being established to further this option. First managed care training will be in Los Angeles with two additional trainings to follow and will be open to membership and not just CP3 sites.

**VI. Integrated Care/Behavioral Health**

Allie Budenz provided a brief update on the work of the behavioral health peer network and goal to establish provider and peer training for a common practice.

**VII. Legislative Update**

Andie Patterson gave an update on the current bills we are in favor of along with those we have been asked to take a stance on. It was requested from the committee that any bills pertaining directly to clinicians be brought to the committee before a position was taken.

**VIII. Workforce**

Nataly Diaz gave an update on the Workforce Committee goals with a focus on bringing back retirees as advisors.

**IX. Psychiatry in the Primary Care**

Guest speaker Shannon Suo gave a presentation on the UC Davis TNT PCP Fellowship. Group discussed working with Behavioral Health committee to find funding for more attendees to participate in the fellowship in hopes of integrating more blended care.

**X. Adjourn**

The meeting was adjourned at 10:05am.

Respectfully submitted,  
Janelle Mollgaard, Meeting Minutes Recorder

# CMO Quarterly Report

DATE: October 11, 2017

CLINICIANS COMMITTEE

From: Dr. Mike Witte

## CMO Guiding Principle:

Working together, each member organization, each consortium, and CPCA—can strategically manage our opportunities to move our Health Centers to become centers of excellence in this new world of primary healthcare, and community health.

## UPDATED PRIORITY AREAS:

- **Workforce:**
  - Pipeline development of our future healthcare teams.
  - Building teams for the future primary care workforce.
- **Provider and Employer of Choice:**
  - Recruiting, Training, and Retaining the best workforce under a value-based care model of work.
  - Build on the concept of resiliency and joy in the workplace, as an antidote to burnout.
- **Increasing Outreach To Safety-Net Clinicians:**
  - Develop meaningful involvement of increased numbers of clinicians in managing change as we work toward health center and health system transformation.

## Updated Strategic Directions for 2017:

1. Continue to develop the concept of a **Clinician Peer Network**, as an expansion of the concept of the Clinicians Committee of the Board.
  - a. Expand our **clinician data base**.
  - b. Define our "universe" of clinicians. **How do we define what a clinician is, as we evolve into team care?**
    - i. MD/DO/RN/PA/NP/CNM/DDS/BH providers, etc.
    - ii. Identify Clinician Leaders: Behavioral, Dental, Medical, Specialty Services
    - iii. Reach out to and meet with Clinical Leaders in the Regional Associations.
    - iv. Enhance networking possibilities: conferences, in-the-field outreach, webinars, etc.
2. Develop trainings and other ways to reach out to clinicians, based on feedback.
3. Expand work in partnership with **State AHEC** to further support the 13 regional AHECs.
4. Research and develop partnership with best available **MA training/certification programs** for CHC's MA role.
5. Identify best practices in **integrating** medical, dental and behavioral health.
6. Develop **new workflows** with providers in CP3 pilots—value-based, team care.
7. Incorporate **Social Determinants of Health** into primary care:
  - a. Best practices in working with Community Based Organizations.
8. Survey best practices in the use of scribes. Consider the development of a **Scribe Academy**.

9. Develop **shared decision making and patient engagement**, using the principles developed in the workshops developed by AHRQ.
10. Support Motivational Interviewing Training, for all CHC staff.
11. Develop New Partnerships/relationships in the primary care world:
12. Who are our potential partners:
  - a. State Agencies: DHCS, DMHC, CDPH, MBC, BRN
  - a. CMA, CAFP
  - b. AT Still University
  - c. Sutter Medical Foundation, Dignity, Et Al.
  - d. Kaiser
  - e. Academic Centers: UCSF, UC Davis
  - f. Managed Care Medi-Cal and other Payers.
  - g. Weitzman Institute
13. Work toward development of a training Academy at CPCA, to make workforce training available to all CPCA member organizations and their staff.

**ACTIVITY AREAS DURING THIS PAST QUARTER:**

**Human Diagnosis Project:** Drs. Seiji Hayashi and Shantanu Nundy are leaders of the Human Diagnosis Project, a transformative resource which uses the principle of crowd sourced learning to make multiple expert opinions available to practicing clinicians.

I heard Dr. Nundy describe “Human Dx” this summer at the ACU Annual Conference. The principle behind this tool is a simple, yet too often ignored concept: gathering five or more expert opinions provides markedly improved accuracy in diagnosis and effective management of complex clinical problems. And the use of electronic tools makes this possible in a timely and affordable way.

In the 21<sup>st</sup> century, our best clinicians will use “group think” from two very important sources:

1. The evolving algorithms of machine intelligence should continually assist us with often very complex decision-making.
2. And, crowd-sourced learning, or “group thought”, can provide remarkably accurate and highly valuable information as well.

Dr. Hayashi will be describing this tool as our Keynote speaker at our March 1-2 Quality Care Conference in Sacramento, next year.

**Medical Assistant Scope of Care:** There is often confusion among our members regarding the range of activities that our MA’s can provide under regulations. I would recommend copying these sites into your Policies Manual as a reference.

**CA Business and Professions (B&P)**

**Code §§ (Sections) 2069-2071**

- **CA Code of Regulations**

**Title 16 §§ 1366–1366.4; 1366.31-33**

- **Medical Board of California**

**([www.mbc.ca.gov/allied](http://www.mbc.ca.gov/allied))**

MAs are regulated by the Medical Board of California, under the Department of Consumer Affairs. But what also becomes readily apparent, is that each Health Center site has developed its own implied scope for non-licensed personnel, importantly including MA's. Often, procedures that are within MA scope have been the responsibility of others, such as LVNs or RNs. A common example of this is intra-muscular and subcutaneous injections. Changing the workflow and responsibility for this, involves careful development of protocols and buy-in from all staff affected by any changes made.

**Adult Immunization Program:** We have been working with the vaccine division at the California Department of Public Health (CDPH) to help to develop improved access for adult vaccines to both un-insured patients and those on MediCal.

The focus for un-insured is provision of Pneumococcal-23 vaccine to adult un-insured diabetics, and hepatitis A vaccine to all un-insured adults. For those on MediCal, the focus is on Hepatitis A, since this is an expensive vaccine and apparently beyond the financial reach of many of our sites. It is an unpaid benefit and encroaches on our MediCal reimbursement.

Additionally, CDPH is focusing on providing Tdap in pregnancy. There is wide variation in the number of women receiving this important vaccine in pregnancy. The ideal timing for Tdap in pregnancy is between 28 to 35 weeks.

**Telehealth (ECHO PLUS):** We have been working with UCSF and UC Davis on a unique collaboration they have developed, combining ECHO tele-health curriculum (UCSF) for hepatitis C care, with eConsult (UC Davis) for chronic pain management. The focus of these programs is on areas with little or no access to specialists or experts in these fields.

**Palliative Care:** I have been participating in developing an on-line curriculum for palliative care called "Essential Palliative Care Skills for Every Clinician". This has involved reviewing the 9 course modules for content and language, and meeting with a panel of authors and editors to finalize the course. Our Centers continue to have increased numbers of patients with chronic illnesses and patients over 65, an on Medicare. 45 of our 158 FQHC organizations have 10% or more of their patients on Medicare. Our fastest growing age group numbers are in the 44 to 64 year population.

We will be well-served to develop enhanced skills in care for these populations. Palliative care is at the center of this skill set, and will allow us to maintain a vulnerable group of patients in our care.

**Pain Management and X-waivers:** We are very fortunate in California to have several of our CHCs as recipients of HRSA grants to develop Medically Assisted Treatment programs for opiate use disorders. CPCA is working with organizations delivering the content of these programs to act as a "hub and spoke" for current and future development of this critical resource to curb the opiate epidemic. **There is movement afoot nationally to make the X-waiver mandatory for "VA physicians and physicians working in FQHCs."**

**Association of Clinicians for the Underserved:** We work regularly with trainers from ACU regarding recruitment and retention of providers. This summer, our senior workforce coordinator, Nataly Diaz and I, along with Janelle Sauz from Lifelong Health Center, presented as a panel on local, regional, and State advocacy programs, focused on Social Determinants of Health, using Homelessness, Soda Tax, and Alternative Payment as cases in point.

**Kaiser Permanente School of Medicine:** I have participated in several meetings with the Kaiser team developing the curriculum for the Kaiser Medical School, to open in Pasadena in 2019. Last Friday, Louise McCarthy, CEO of CCALAC, and I attended the reception for the founding Dean of the Kaiser Permanente Medical School. His name is Mark A. Schuster, MD, most recently Chief of Pediatrics at Harvard. My take-away statement from the reception: “The pride Kaiser will take from creating this School, is NOT as a pathway to more Kaiser physicians, but as a new and unique educational model to identify and train physicians to meet the greatest needs in our communities.”

**AHEC/CPCA partnership:** CPCA has signed a partnership agreement with the State AHEC (Area Health Education Center) and is working actively with their staff to enhance the relationship and funding opportunities for the 13 regional AHECs. The new grant is equivalent to the previous one, providing funding for current educational programs in each of the 13 regional AHECs.

**Office of Health Equity Advisory Committee:** I am continuing to meet regularly with CDPH Office of Health Equity Advisory Committee. This is large diverse group from around California that meets quarterly to investigate ways to improve equity for all populations in California, with an emphasis on underserved and at-risk communities and people of color. This group naturally works on social determinants of health as its core strategy. Our meeting last week was at one of our member sites, Marin Health and Wellness in Marin City, an enclave of African Americans in Marin County. They have accomplished amazing work in housing, education, fresh foods, parks, and jobs, besides an FQHC providing a full scope of medical care.

**MediCal P4P Committee:** The Integrated Health Association facilitates and organizes regular meetings among MediCal Managed Care Organizations, State Agencies, and Chief Medical Officers who meet regularly to reach agreement on “Core Measures” for Quality Incentives for MediCal Managed Care. The payers have agreed on nine core measures and are developing supplemental and “developmental” measures to continually assess and re-assess value as data is developed.

**CMA Mode of Practice Forum:** I am working with staff and with CMA’s VP of Strategic Development, Jay Hansen, to evaluate the possibility of increasing membership in CMA among our physicians, with the intention of development of a Mode of Practice for CHC physicians within CMA. Our meeting in San Diego on July 26 was very successful. Our goal now is to identify at least 500 of our physicians who either are or could become members of CMA.

**Physician Retraining and Re-entry Program:** We continue to work with the principals who have developed this San Diego-based 6 month-plus on-site and on-line training program for previously retired specialists. The curriculum, developed by UCSD School of Medicine, certifies graduates in providing a full scope of adult primary care. We are working with PRR to see if MCO’s might recognize and credential these seasoned physicians to provide primary care in our CHCs.

**IMPORTANT EVENT DATES TO HOLD:**

**CPCA QUALITY CARE CONFERENCE:** March 1-2, 2018 (Sacramento Hyatt)

**REGION 9 CLINICAL EXCELLENCE CONFERENCE:** June 3-5, 2018 at the Sheraton Grand at Wild Horse Pass in Chandler, Arizona.

Date: October 11, 2017  
To: Clinicians  
From: Lucy Moreno, Data Informaticist  
Re: CP3 Update: Payment Reform Readiness

## MEMORANDUM

### **I. State Update**

CPCA believes strongly in the Alternative Payment Methodology (APM) and will continue to push DHCS to ask CMS to move forward with the APM in California as a state plan amendment. DHCS prefers going through the State Plan Amendment route for the APM, but they just were not able to move legal counsel at CMS to allow this. CPCA has engaged legal counsel to fully understand the risks and opportunities of pursuing an APM in a waiver. This research is estimated to be completed by the end of October. Upon receiving the research we will circle back with the state about next steps.

### **II. Technical Assistance**

CPCA's Capitation Payment Preparedness Program (CP3) will continue to support health centers in well-positioning themselves for payment reform by strengthening internal and external systems. CPCA will continue to provide technical assistance to CP3 sites through a number of electronic and in-person mediums. For example, CP3 will be launching a series of podcasts interviews between CP3 Health Centers and content experts like Curt Degenfelder and Andy Principe along with clinic staff. These short podcasts will talk through implementation challenges and readiness efforts that are most relevant to health centers.

### **Re-Assessment:**

A little over a year ago, health centers in the CP3 program went through their first readiness assessment process. The assessment process asked a series of questions across seven domains to assess health center's readiness in key value-based readiness areas (e.g. Leadership, Learning Organization, Technology, Financial Infrastructure, Population Management, Patient Centered Care, and Access Innovations). The time has come to re-complete these assessments again and measure health center progress. CP3 staff will be working with health centers to complete the readiness assessment and measure performance across 2016 baseline performance. The re-assessment responses will also support identification of new strategies and efforts to re-populate the health centers APM readiness workplan.

### **Non-Traditional Services**

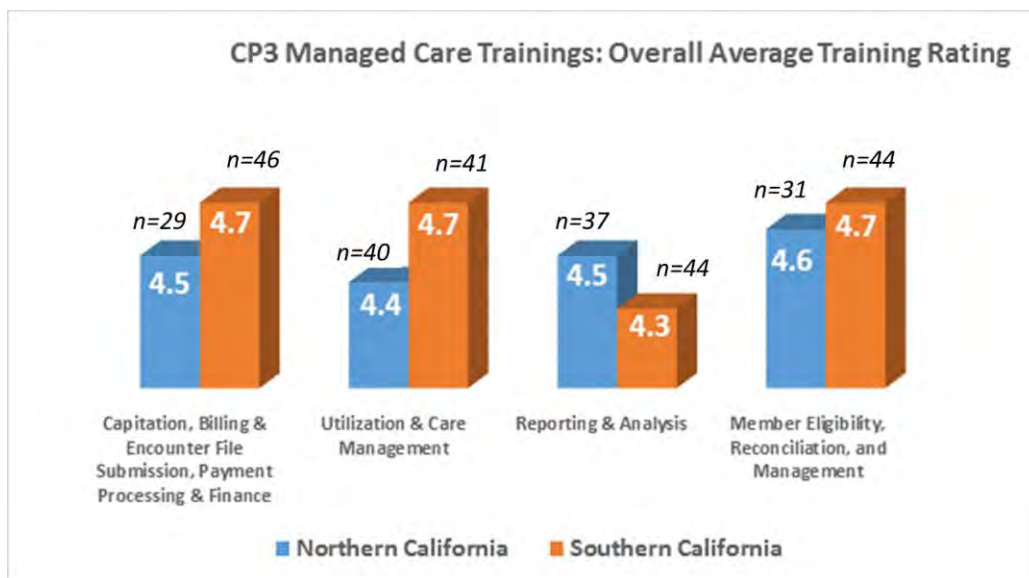
Non-Traditional services will allow health centers to provide an alternative form of interacting with patients. Health centers within the pilot have the opportunity to provide these types of services with a variety of care team members. In collaboration with CP3 organizations and a certified coder, CPCA was able to identify potential codes to be used in the pilot for non-traditional services. This analysis resulted in 174 usable codes. Several volunteer health centers have met with CPCA and begun to conduct the final review of the list. In addition, we are also trying to link these codes with the enabling services codes used by PRAPARE. Lastly, we are also partnering with the California Association of Public Health

Hospitals (CAPH) to review codes from their work and align as much as possible. This analysis will help us to develop a final list to send to DHCS.

## Managed Care

### Trainings

CPCA's CP3 team launched a series of managed care trainings in June of 2017 and will complete the series this month to train health centers on capitation, billing and encounter file submission, payment processing and financing. The operational areas will be offered that will enhance health centers' readiness to be successful in payment reform. These trainings were delivered in a series of sessions (each offered in both Northern and Southern CA) that brought together interdisciplinary clinic teams. The idea is that health centers bring key members of the team and take lessons and action plans back to the site/organization for implementation and to refine processes. The trainings have been very successful with an average rating of 4.5 out of a 5.0 scoring system.



### Health Plans

Although CMS has not approve the SPA for the APM Pilot, efforts are still continuing to address structural managed care issues related to payment models. As part of the reassessment process, a new domain has been added to assess CP3 sites' managed care arrangements to determine the need for additional technical assistance regarding managed care. The reassessment targets managed care arrangements including patient assignment, regularly updated member assignment lists, and gap in care reports as three areas that can support health centers improve member management.

CP3 staff have begun efforts to support health centers with patients assigned to individual providers. A letter is being drafted to articulate and enforce statute Section 14087.325(b) of the Welfare and Institutions Code, which mandates that patients must be assigned to FQHCs, not individual providers. This letter and additional supports will be made available to all CP3 sites and their managed care partners that are assigning patients by provider.

### Monthly CP3 site check-ins

CP3 staff and RAC coaches continue to conduct site check-ins to discuss progress and identify areas of need for training and technical assistance. Currently, additional sites have shown an interest in

participating in the preparedness project. We anticipate an increased number of sites completing the readiness assessment and participating in the pilot. Currently we have 84 interested and enrolled sites in the CP3 project.

#### **Social Determinants of Health (SDOH)**

CP3 will be working with the pilot sites with the goal of sharing SDOH information and resources initially with other sites in the pilot but ultimately share lessons learned with the entire CPCA membership. The CP3 team is developing a draft workplan and timeline to be shared with the pilot sites in November.

The CP3 team, in collaboration with NACHC, AAPCHO and regional association consortia's, continues to work on the PRAPARE implementation grant funded by Blue Shield. CP3 lead, Lucy Moreno participates in the project planning calls and has been largely involved in scanning of the SDOH collection efforts across CP3 sites that are outside of the project Consortia. All CPCA members' feedback was solicited via a survey link to collect information on screening of social risk factors. The majority of health center respondents confirmed that they were screening for social risk factors. The analysis is being included in the NACHC roadmap that is a deliverable of this planning grant.

#### **Health Information Technology and the Electronic Health Record (EHR)**

CPCA's Capitation Payment Preparedness Program (CP3) recognizes the ongoing need for fostering a collaborative approach with EHR vendors to prepare them to meet the new functional requirements and move in the direction of payment reform. The CP3 team continues to meet with eClinical Works and NextGen Healthcare to collaborate and prepare for readiness of the EHR.

#### **III. Hand Out(s)**

- None



Date: October 11, 2017  
To: 330 Committee  
From: Emili LaBass, Senior Program Coordinator of Health Center Operations  
Re: Emergency Preparedness Final Rule

MEMORANDUM

**Emergency Preparedness Final Rule - Background:**

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

**CPCA Activities:**

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

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

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

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

# Increasing Access to Oral Health

A Technical Assistance Guide for California Health Centers



The development of this resource guide was supported by a subcontract from the Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry under a contract from the California Department of Public Health, #11-10206. Initial funding for this contract was from Health Resources and Services Administration (HRSA) State Oral Health Workforce Grant #T12HPI4666.

CPCA would also like to acknowledge the guidance and contribution of staff from the Pacific Center for Special Care to the development of this resource guide.

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# The Need for Community Based Dental Care

## Introduction

This resource guide provides a basic overview of models that can be used in California community health centers and clinics to increase access to oral health. It will walk readers through the landscape of oral health and dental care across the country, the role health centers and community clinics play in providing oral health to vulnerable populations and provide an in depth overview of delivery service models that can increase access to oral health services. It is our hope that this guide will provide insight to many frequently asked questions regarding: nontraditional sites (intermittent clinics, school based health centers, virtual dental homes), federal and state regulations, and billing practices. If you have additional questions following the review of this resource, please contact the California Primary Care Association.

Oral health is a gateway into the health of the entire individual.<sup>1</sup> Maintaining good oral health is important as research suggests that a variety of conditions may be linked to it. “Heart disease, clogged arteries and stroke may be linked to oral bacteria, possibly due to chronic inflammation from periodontitis” and gum disease has been linked to premature birth and low birth weight.<sup>2</sup> The state of a person’s oral health can dramatically affect people of all ages including seniors, adults, children and infants. Nationally, dental caries is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever.<sup>1,3</sup> Over 50 percent of five to nine year old children have at least one cavity or filling, and that proportion increases to 78 percent among 17 year olds.<sup>1</sup> Priority 32 of Healthy People 2020 is to “prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care”.<sup>4</sup> Tooth decay is a preventable disease, but when people do not have adequate access to dental care they are less likely to get the preventive services and early diagnosis and interventions that can stop or slow down the progress of most oral diseases.

Across the state of California many people suffer from dental disease and are unable to get the care that they need. Numerous studies show that certain populations face significant barriers to obtaining dental care and as a result have significantly worse oral health than other segments of the population. These populations include individuals who are low-income; racial or ethnic minorities; pregnant women; older adults; those with special needs; and residents who live in rural communities. Lack of access to oral health prevention and treatment can exacerbate health status, it can lead to not only pain, infection and tooth loss, but also increases the risk for heart disease, diabetes, poor birth outcomes, and at worst death. Assuring adequate access to oral health is important for both rural and urban communities.

Dental care is the most common unmet need of children in the United States and yet early childhood caries (ECC) is the most prevalent preventable childhood disease.<sup>5,6</sup> This disease disproportionately affects children in the lowest income brackets. Children who have dental problems early in life are also at greater risk for having more complicated dental problems later in life due. This is due to the lack of access to preventative health care and poor habits that carry through the years such as poor diet and dental hygiene. In addition, as Figure 1 illustrates, overall oral health status and the percent of children in excellent or very good oral health in California is significantly lower than the national average.



Dental caries is the single most common chronic childhood disease, 5 times more common than asthma and 7 times more common than hay fever.

<sup>1</sup> Oral Health in America: A Report of the Surgeon General Available at: [www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/](http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/). Accessed 3/10/2014, 2014.

<sup>2</sup> Mayo Clinic Available at: [www.mayoclinic.com/](http://www.mayoclinic.com/). Accessed 3/10/2014, 2014.

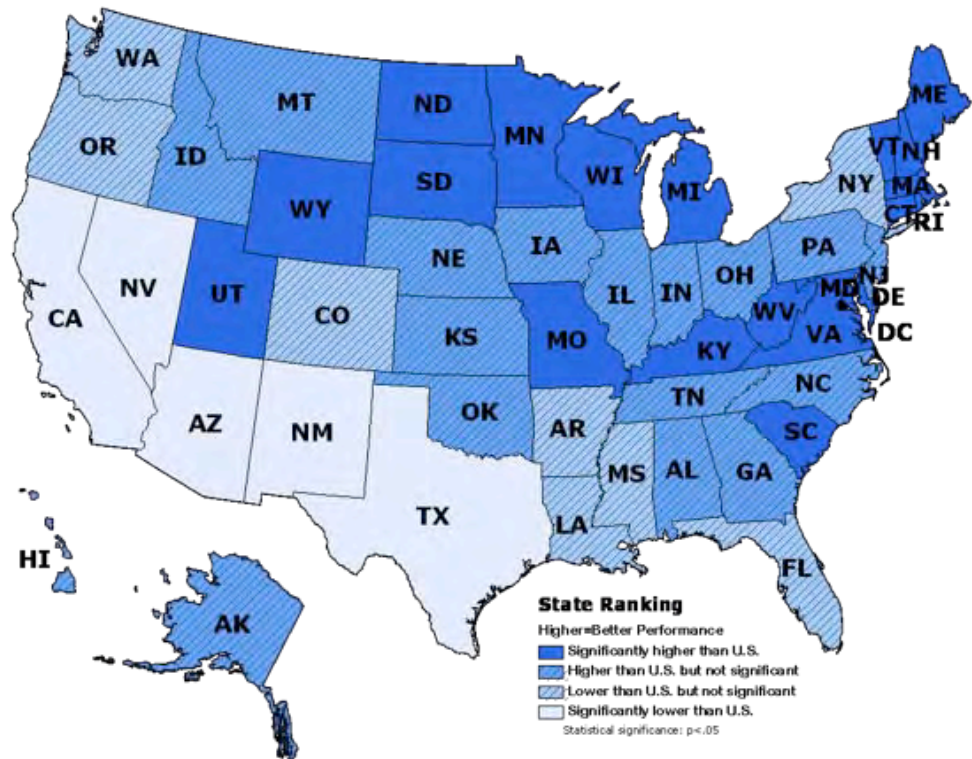
<sup>3</sup> Home – American Dental Association – ADA.org Available at: [www.ada.org/](http://www.ada.org/). Accessed 3/10/2014, 2014.

<sup>4</sup> Oral Health - Healthy People Available at: [www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=32](http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=32). Accessed 3/10/2014, 2014.

<sup>5</sup> Newacheck PW, Hughes DC, Hung YY, Wong S, Stoddard JJ. The unmet health needs of America’s children Pediatrics 2000 Apr;105(4 Pt 2):989-997.

<sup>6</sup> Advancing Oral Health in America Available at: [www.nap.edu/openbook.php?record\\_id=13086](http://www.nap.edu/openbook.php?record_id=13086). Accessed 3/10/2014, 2014.

Figure I. Overall Oral Health Status



Percent of children in excellent or very good oral health.

The National Survey of Children’s Health showed that nationwide, 22.1 percent of children ages 1-17 had 1 or more oral health problems (toothache, decay, broken teeth, bleeding gums) in the past 6 months in the HRSA Region IX (California, Hawaii, Arizona and Nevada), as opposed to 18.7 percent of children nationwide.<sup>7</sup> Among different race and ethnic groups California data shows that Black, non-Hispanic children and Hispanic children are at the highest risk with a rate of 37.9 and 25.4 percent respectively, as compared to 14.8 percent for non-Hispanic White and non-Hispanic Asian children.<sup>8</sup>

<sup>7</sup> 2011 NSCH National RUCA Profile Available at: [www.childhealthdata.org/browse/snapshots/nsch-profiles/ruca-national](http://www.childhealthdata.org/browse/snapshots/nsch-profiles/ruca-national). Accessed 11/27/2011, 2011.

<sup>8</sup> 2012 NSCH Disparities Snapshot Race Ethnicity Available at: [www.childhealthdata.org/browse/snapshots/nsch-profiles/raceethnicity?geo=1](http://www.childhealthdata.org/browse/snapshots/nsch-profiles/raceethnicity?geo=1). Accessed 3/10/2014, 2014.

Although everyone is in need of regular preventive dental care, many do not access care until there is pain or visible decay. About 17 million low-income children nationwide received no dental care in 2009. Low-income adults are almost twice as likely as higher-income adults to have gone without a dental check-up in the previous year. The barriers to care include lack of dental insurance coverage, lack of knowledge about the importance of preventive care, cultural and linguistic factors, transportation, and difficulty in navigating the healthcare system. Ultimately these barriers lead to poor oral health outcomes. Almost 60 percent of children ages 5 to 17 in the United States have dental caries. When dental problems are left untreated the condition worsens and can lead to severe problems with health, poor performance in school and chronic pain. There were over 830,000 visits to emergency rooms across the country in 2009 for preventable dental conditions – a 16 percent increase since 2006.

One promising solution to this crisis is to bring dental care services to people in their communities. Community based dental care provides preventive care and early treatment to people at schools, school-based health centers, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) centers, Head Start and Early Head Start preschools, residential facilities for dependent people and other potential community sites. By expanding services to reach people in the communities where they live, great strides can be made in improving oral health and is a patient-centered approach to the provision of oral health services. This guide has been developed as a resource for health centers that are developing these innovative oral health programs and those health centers interested in this type of care. The information provided is intended to assist health centers in navigating the existing regulations and policies in order to create sustainable oral health programs in underserved communities across the state.

## Health Centers are the Solution

Health centers are ideally situated to address the unique challenge of accessing oral health services. Federally Qualified Health Centers (FQHCs) were created to bring comprehensive health services to underserved populations and to develop services in response to community needs. Health centers are often the main healthcare provider of services in rural and low-income neighborhoods and are able to provide a myriad of primary medical care, behavioral health care, and dental services.

Many health centers are responding to the oral health needs in their communities by bringing dental services to schools and other community sites. These locations offer excellent venues for engaging families who might not otherwise seek out preventive dental services. By providing early care, health centers are able to prevent dental disease and the result is better health outcomes for those communities. There are a number of innovative models and methods for health centers to bring dental services into community sites. These include creating distributed teams connected via tele-health technology, having dental hygienists work in these sites, and having dentists work in these sites using mobile or portable equipment and even contracting with private community dentists.



Health Centers are ideally situated to address this challenge.



The need for oral health services in the underserved population is extreme and given existing capacity, it cannot be met through traditional means alone.

## Federal Expectations for Community Based Services

FQHCs are expected to provide community based services. Federal guidance makes clear that FQHC services must extend to off-site locations in order to ensure access to the communities they serve. The Bureau of Primary Health Care (BPHC) states that: "Health centers must provide services at locations and times that ensure services are accessible to the community being served... in locations ranging from homeless shelters to migrant farm worker camps to public housing communities to schools."<sup>9</sup>

BPHC also instructs that health centers "must collaborate appropriately with other health care and social service providers in their area...to ensure the effective use of limited health center resources, providing a comprehensive array of services for clients..."<sup>9</sup> Not all services can or should occur within the physical site of a health center. Therefore health centers are charged with coordinating care services in their communities. The BPHC expects health centers to provide services at locations that ensure their services are accessible to the community being served. As a result, many health centers offer services outside the traditional clinic setting, including homeless shelters, migrant farmworker camps, public housing, and schools. As described in Appendix B, Form 5a, preventive dental care is one of the required services; emergency and restorative dental services are considered optional for health centers to provide.

## Options for Serving Community Oral Health Needs

The need for oral health services in the underserved population is extreme and given existing capacity cannot be met through traditional means alone. Additionally, many health centers in rural and low-income areas are unable to hire enough dentists to meet the need of the community. Health centers have many options to choose from in expanding services including utilizing alternative provider types, providing care in non-traditional settings, and using new service delivery models.

### New Service Delivery Models

*Health centers can use new service delivery models such as the following:*

- Part-time Clinics or "intermittent clinic sites"
- Telehealth Tools (e.g. the Virtual Dental Home)
- Contracting with private dental offices (Appendix G provides links to additional resources on this topic)

### Non-Traditional Settings

*Health centers can also provide services in non-traditional settings such as the following:*

- Elementary school sites
- School-based health centers
- WIC programs
- Head Start or state preschool programs
- Residential facilities for dependent people

<sup>9</sup> Bureau of Primary Health Care. Program Requirements. Accessed on May 22, 2014 from < <http://bphc.hrsa.gov/about/requirements/>>.

## Alternative Provider Types

Health centers can utilize alternative dental provider staff such as the following:

- Registered Dental Assistants with Expanded Function (RDAEF-II)
- Dental Hygienists
- Registered Dental Hygienists in Alternative Practice (RDHAP)
- Dental and Dental Hygiene Students and Residents

## New Service Delivery Models

### Intermittent Clinic Sites

Many community based dental sites can be operated as part-time clinics or what California refers to as “intermittent clinics.” California Welfare and Institutional Code 14043.15 exempts intermittent and mobile clinics from separate enrollment in Medi-Cal. Additionally, if a health center is operating an intermittent clinic site, they are exempt from licensure and a license is not required to operate this type of clinic. An intermittent clinic site operates no more than 30 hours per week<sup>10</sup> and operates under a parent facility, which is licensed. Statutory regulation pertaining to intermittent clinic sites is found in the H&S Code Section 1206 (h), which states:

A clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 30 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.

According to the statute, an intermittent clinic site must be: (1) operated by a licensed primary care clinic; (2) only open for limited services of no more than 30 hours of services/week; and (3) meets the administrative regulations and requirements relevant to fire and life safety. These definitions are explained thoroughly below. Please see Appendix A for a checklist developed for implementing an intermittent clinic site.

### REQUIREMENTS FOR INTERMITTENT CLINIC SITES

#### I. Operated by A Licensed Primary Care Clinic

To qualify as an “intermittent clinic site,” the FQHC must “operate” the site. A Memorandum of Understand or MOU should be written between the FQHC and the intermittent clinic site.

*In order to verify that the intermittent clinic site is operated by a licensed primary care clinic, it is recommended that FQHCs have a lease or Memorandum of Understanding (MOU) in place which:*

- Identifies the clinic space and hours of operation;
- Includes a floor plan with clinic space highlighted;
- Identifies that the clinic has control of the operations of that space during the clinic hours; and
- Indicates the cost, start date and length of agreement.

<sup>10</sup> AB 1130 signed by the Governor on October 1, 2015 and effected January 1, 2016. In-between November 1, 2015 – December 31, 2015, allowable hours per week should not exceed 20. For additional information on the legislation please visit: [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160ABI130](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160ABI130)

## 2. Only Open for Limited Services of No More Than 30 hours Per Week

Patient access (a.k.a. open doors) to the clinic must not exceed 30 hours in any given week. Staff may be present at the site during additional hours to complete charting, administrative tasks, clean-up, etc.

*The requirement can be evidenced by:*

- Documentation including patient records;
- Photograph of posted hours; and
- Patient schedule

## 3. Meets the Administrative Regulations and Requirements Relevant to Fire and Life Safety

Site must have fire clearance on file. This clearance is based on the Code on fire safety notation in statute effective at time of licensure.

### NOTIFYING MEDI-CAL

In addition to meeting the statute mandates, FQHCs should ensure that Medi-Cal is informed of the intermittent clinic site. The Medi-Cal program requires notification of the operation of an intermittent clinic site. The Medi-Cal program also retains the right to inspect intermittent clinic sites relative to billing issues. For compliance purposes, to the extent possible, intermittent clinic sites should maintain a copy of the fire clearance, policies and procedures, and patient records at the intermittent clinic sites.

In order to notify Medi-Cal, a letter should be submitted to the Medi-Cal Provider Enrollment Division on the organization's letterhead which includes the intermittent clinic site address and hours of operation. There should also be a statement that the clinic is staffed and supplied by the parent site. It is also recommended that the local district office for Licensing, typically the California Department of Public Health is notified. A sample letter can be found in Appendix H.

Intermittent clinic sites retain the ability to bill for Medi-Cal services under their "parent" clinic's provider number, since they are technically operating as an extension of the licensed full-time site. For FQHCs, intermittent clinic sites retain the ability to bill for Medi-Cal services at the parent clinic's PPS rate.

While there is no formal licensing process outlined in the law for the initiation of an intermittent clinic site, and although not required, some health centers have chosen to notify their L&C District Office when opening an intermittent clinic site so that this information might be included in their file. Such notification has on a couple of occasions created confusion with District Office staff who subsequently sought to survey the intermittent clinic site. However, the Licensing and Certification (L&C) Division has no jurisdiction over intermittent clinic sites and has no authority to survey or inspect any exempt clinic for compliance with licensure standards. The only jurisdiction that L&C has concerning intermittent clinic sites is concerning their exempt status.

### NOTIFYING CMS – ENROLLING IN THE MEDICARE PROGRAM

Institutional providers must enroll in the Medicare Program to receive payment for covered services they furnish to Medicare beneficiaries. This requirement also applies to intermittent clinic sites. The process to complete this action is described below in the National Provider Identifier (NPI) section. In conclusion, health centers seeking to provide services at community based sites may operate these locations as intermittent clinic sites if they meet all of the standards and requirements outlined above pursuant to Section 1200 of the Health and Safety Code and Title 22 of the California Code of Regulations.

## SAME SERVICES AVAILABLE TO ALL FQHC PATIENTS

Services in a health center's federal scope of project are defined for the organization/entity and not for the individual site. Therefore, it is not required that all services within an approved scope of project be available at every service site. However, patients must have reasonable access to the full array of services offered by the health center. Moreover, all approved services must be made available equally to all patients regardless of their ability to pay and available through a sliding fee scale.

## MALPRACTICE COVERAGE

FQHCs are eligible to obtain free malpractice coverage through the Federal Tort Claims Act (FTCA), but they must apply for this and meet the requirements. In order for community-based dental services to be eligible for FTCA coverage they must be included in the health center's federal scope of project and included on the FTCA application. In general, health center employees are protected under FTCA even when they work outside of the clinic at community based sites. However, providers who are contracted by the health center and are not working full time (at least 32.5 hours per week) are not covered.<sup>2</sup> For example, if a contract dentist works less than full-time and provides approved services at an approved site, the dentist would not be covered under FTCA, but the health center would remain covered. Dentists who volunteer to provide services for the FQHC are also not covered under FTCA. It is important, therefore, to obtain additional liability coverage for volunteer and part-time providers.

FTCA coverage also requires a Quality Improvement program. Health centers must include the community based services in their Quality Improvement (QI) policies and activities, including documentation in the QI plan, QI committee minutes, and Board meeting minutes. The FTCA application (initial or renewal) must also include the providers from the community based site.

## Contracting with Private Dental Offices

In 2009, the CHIP Reauthorization Act authorized that federally qualified health centers (FQHCs) and look-alikes could contract with private dentists to provide dental services to health center patients in the dentists' private offices. There are many advantages to both the dentist and health center when they contract to provide care to FQHC patients. Most FQHCs have experience entering contractual agreements with private providers to increase their capacity to provide specific medical services to their patients. Contracting for dental services in a comparable way is a model that is not only permitted by federal and state regulators, but also endorsed and promoted in concept by the California Dental Association and the National Association of Community health Centers (NACHC). A variety of toolkits and guides exist for health centers interested in this model. For more information please refer to Appendix F.

## Virtual Dental Home

Another model of community based care that is being used effectively at schools and other sites is the Virtual Dental Home. The Virtual Dental Home (VDH) started as a pilot project created and managed by the University of the Pacific School of Dentistry in a variety of sites throughout California. The Virtual Dental Home is a community-based oral health delivery system in which people receive preventive and early intervention therapeutic services in community settings where they live or receive educational, social, or general health services. It utilizes the latest telehealth technology to link practitioners in the community with dentists at remote office sites. Registered dental hygienists in alternative practice (RDHAP), registered dental hygienists working in public health programs (RDH), and registered dental assistants provide care in the community based setting and collaborate with a dentist via telehealth who makes diagnostic and treatment decisions to provide care. This system is bringing much needed services to individuals who might otherwise receive no care.



Providers who are contracted by the health center and are not working full time (at least 32.5 hours per week) are not covered.

Legislation enacted in 2014, Assembly Bill 1174, effective January 1, 2015 means health centers are now allowed to bill for “store-and-forward” teledentistry services. This means that health centers can hire dental hygienists to collect records and perform procedures within their scope in community sites. The health center can subsequently bill for the telehealth enabled team’s community-based services. For example, if a health center dental hygienist collects records and these are reviewed by a health center dentist, the health center could bill for an encounter the same as if these procedures had taken place at the parent site. Additionally, if the dentists direct the hygienist to perform additional procedures (i.e. sealants, interim therapeutic restorations) those visits could also be billed as encounters, the same as if these procedures had taken place at the parent site.

## Non-Traditional Settings

### School-Based Settings

School-Based dental settings are typically designed to improve access to dental care by reducing barriers for all children. Children with the most needs are the ones that are best served in school-based settings, but all children can benefit from the services provided by their school’s program. School-based settings often benefit parents in addition to the children. For some parents, taking time during the work day to take a child to a dental appointment can be difficult – having dental services at school may mean that parents do not have to take time off from work for their child’s dental appointments. In addition, school-based oral health care may eliminate barriers such as transportation and most programs welcome parents in their child’s appointment. In all cases, school-based settings keep parents informed by providing clear notification of the child’s condition and the treatment he/she received. School-based dental sites can function as a safety net and as a gateway to a permanent dental home.



Each of these oral health programs may be staffed by a variety of licensed dental professionals.

#### TYPES OF SITES

*Dental care can be provided at school-based setting utilizing a variety of methods including:*

- 1. FIXED SITE** (ex. a school based health center clinic)  
A fixed clinic is one in which a full dental clinic is permanently installed within a school.
- 2. MOBILE SITE** (ex. dental clinic van)  
Mobile dental programs utilize a full set of dental equipment that is located on a van or other mobile vehicle.
- 3. PORTABLE SITE** (ex. utilizing regular school space temporarily for staff that bring their dental equipment in to the site)  
Portable dental programs use dental equipment that can be transported via a car and set up within a school.

## SCOPE OF SERVICES

Dental care can be provided in numerous ways at school-based settings. Table 1 explains the basic summary.

### 1. PREVENTATIVE

These services typically include dental education, oral screenings, fluoride applications, sealant placement, and referral for follow up dental treatment. They can also include “secondary prevention” procedures such as Interim Therapeutic Restorations.

### 2. COMPREHENSIVE

These services typically include all of the preventative services, radiographs, fillings, simple extractions, etc.

Table 1. Common Scope of Services at School-based Settings<sup>11</sup>

	PREVENTION ONLY	DIAGNOSTIC, PREVENTION AND LIMITED RESTORATIVE	COMPREHENSIVE / RESTORATIVE
<b>SERVICES PROVIDED</b>	Dental hygiene examination; screenings; fluoride; sealants; referrals for diagnosis/treatment; cleanings (not necessary for the placement of sealants)	Telehealth dental examination; x-rays; photographs and electronic records; diagnosis; fluoride; sealants; Interim Therapeutic Restorations by dental hygienist or EFDA (see Virtual Dental Home above)	Dental examinations; radiographs; diagnosis/treatment by a licensed dentist; cleanings; fluoride; sealants; fillings; simple extractions; crowns (on baby teeth); referrals as needed
<b>NECESSARY EQUIPMENT</b>	For sealants only: dental chair; light source; curing light; water, dental unit with water, suction and slow speed hand piece; compressor	Dental chair; X-Ray machine (portable); light source; curing light; dental unit with water, suction, slow speed hand piece; compressor	Dental chair; X-Ray machine (portable); light source; curing light; dental unit with water, suction, and hand pieces; compressor
<b>SERVICES COMMONLY REFERRED OUT</b>	X-Rays; dental diagnosis/treatment	Complex restorative and surgical services	Complex fillings or extractions; root canals; crowns; services for children with behavior management needs.

There are many types of services provided by school-based programs, ranging from programs providing screenings only to those providing comprehensive dental care, and each of them can use any of the aforementioned equipment. Since individual communities have unique needs and school-based programs vary greatly, it is important to match needs with services when selecting an appropriate program.

<sup>11</sup> Reaching New Height in Health with School-Based Oral Health Programs. (2011). Massachusetts Coalition for Oral Health. [http://www.bu.edu/mcoh/files/2009/06/9134\\_White-Paper\\_r5aPROOF.pdf](http://www.bu.edu/mcoh/files/2009/06/9134_White-Paper_r5aPROOF.pdf).

## CARE TEAM

School-based sites are supported in various ways through federal, state and local funding; corporate support; foundation grants; in-kind contributions; and reimbursements from Medi-Cal or CHIP. FQHCs, for profit entities, non-profits groups and universities with dental and dental hygiene programs have also established mobile or portable dental services to increase their outreach to communities and schools. Staffing for these sites can use various combinations of dentists, dental hygienists and dental assistance aided most commonly by program coordinators, drivers, or other support staff. School administrator, teachers and other school based personnel are important attributes to the care team and are directly involved with the school-based site in numerous ways.

## Regulatory Requirements for New Services and Locations

In order to provide community based dental services a health center must follow a few regulatory requirements. Explanations of these follow.

### Federal Change in Scope

Whenever a health center adds a new service or a new clinic site, they must apply to the federal Health Resources and Services Administration (HRSA) for a change in scope. HRSA must approve the services and activities undertaken by health centers as the health center's federal "scope of project." The scope of project is defined as "the approved service sites, services, providers, service area(s) and target population(s) which are supported (wholly or in part) under the total section 330 grant-related project budget."

*HRSA approval of activities as a health center's scope of project is very important because it:*

- Identifies the services and sites that are eligible for PPS reimbursement;
- Extends Federal Tort Claims Act (FTCA) coverage, the medical malpractice insurance for health centers and their employees;
- Provides the site information which enables health centers to purchase discounted drugs under the section 340B Drug Pricing Program;
- Defines the approved sites for State Medicaid Agencies to calculate reimbursement rates under the Prospective Payment System (PPS); and
- Defines the approved sites for the Centers for Medicare and Medicaid Services to determine a health center's FQHC Medicare rate.

### WHEN A FEDERAL CHANGE IN SCOPE IS REQUIRED

If the community service site is not already listed in the FQHC's approved scope of project, then the FQHC would be required to get prior approval to add a service site. Likewise, if the FQHC does not already have dental services listed as an approved service, then the FQHC would need to add dental services to its scope of project.

To determine whether a federal change in scope is required, the health center should review the information for their organization in the Electronic Handbook (EHB) on forms 5a, 5b and 5c (each are included in Appendix B).

- **FORM 5a** is the list of services provided by a health center, with each one identified as being:
  - **Column 1:** Provided directly by the health center (“grantee”)
  - **Column 2:** Provided via contract or referral agreement, where the health center pays
  - **Column 3:** Provided via contract or referral agreement, where the health center does NOT payWhenever a change is made for a service from one column to a different column, a federal change in scope is required.
- **FORM 5b** lists all the clinics that are operated by the health center (both state-licensed sites and sites that qualify as intermittent clinic sites under California’s definition). Whenever a health center wishes to add a new clinic site (licensed or intermittent), then a federal change in scope is required.
- **FORM 5c** lists a health center’s other locations and activities. This is where a health center would specify such things as dental care at multiple school sites on a rotational basis or contracting with private dental offices.

### APPLYING FOR A FEDERAL CHANGE IN SCOPE

The Board of Directors must approve the proposed new service or site and document such approval in the Board minutes. Health centers must consult first with their HRSA Project Officer and must submit any change in scope request at least 60 days in advance of the desired implementation date. The request is submitted via the HRSA Electronic Hand Book (EHB).

In the EHB application, HRSA will ask for the health center’s current status and the projected change that this new service or location will result in. This includes budget and staffing information as well as a narrative description. As with all requests for scope of project changes, the health center must demonstrate that the change can be accomplished without additional 330 funds. The health center must demonstrate, by submitting a revised project budget, the change in scope will result in either breaking even or generating new revenue. New revenue generated as a result of a new service or site must be invested in activities that further the mission of the health center.

Finally, if there is any potential for service area overlap by adding a new site or broadening its service area, the health center should attempt to secure letters of support from any health centers, or explain why such support could not be secured (see Service Area Overlap PIN 2007-09). Although the paperwork for a federal change in scope does require time and attention, it is not a competitive process. HRSA has made a commitment to make final decisions to change in scope requests within 60 days with the effective date of approval occurring no earlier than the date of receipt of a request for prior approval.

## State Level Change in Scope

Not all federal change in scope applications require a change of scope at the state level. A health center is required to file a state level change of scope only if their projected PPS rate decreases by at least 2.5% as a result of the change. If the PPS rate is projected to increase, then the state level change in scope application is optional (with the exception of billing for dental hygienist services – see below)

### New Location

A health center may operate in a new location in one of three ways, depending on the situation.

- Licensed community clinic
- Intermittent clinic site
- Off-site services (*not-billable*)

A new PPS rate must be set only for licensed new sites. Intermittent clinic site, that operate less than 30 hours per week, do not have their own PPS rate. Examples of intermittent clinic sites often include a school or long term care facility. These sites utilize the PPS rate of their parent clinic site. No application for intermittent clinic sites is required and no state-level change in scope is required. Likewise off-site services do not require a state-level change of scope unless the projected PPS rate will decrease by more than 2.5%. Because the rules regarding off-site services are ambiguous, health centers are advised to consult with their legal counsel regarding billing for off-site services.

### NATIONAL PROVIDER IDENTIFIER (NPI)

Every clinic site and provider must have their own National Provider Identifier (NPI). This number can be obtained online through the Centers for Medicare and Medicaid Services (CMS) and is provided immediately upon request. A new clinic site, either licensed or intermittent, must obtain an NPI prior to operating. Institutional providers must obtain an NPI prior to applying for enrollment in the Medicare Program. Enrolling in Medicare authorizes you to bill and receive payment for covered services you furnish to Medicare beneficiaries. If you do not already have an NPI, you may apply for one at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> on the CMS website, or by completing Form CMS-10114, "NPI Application/Update Form," and mailing it to the NPI Enumerator at the address listed on the form.<sup>12</sup>

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<sup>12</sup> Link to CMS-10114, as of March 2014. < <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.PDF>>.

## Billing Process for Community Based Services

The rules for Medi-Cal billing at community based sites is the same as the rules for billing at the dental clinic. The visit must be a medical necessary face-to-face encounter, with a billable provider (with the exception of telehealth encounters described below), for a Medi-Cal covered service, provided to a Medi-Cal beneficiary.

### Billing

The state of California defines under what circumstances those activities become billable under the FQHC payment system. They are complementary and both must be satisfied for a patient visit to be considered billable. In California, the State considers the following locations to be billable:

- A licensed FQHC clinic location;
- Registered Intermittent Clinic sites; and
- Licensed or intermittent mobile vans

### Special Considerations for Billing

1. If the services are performed at an intermittent clinic site, then the services will be billed at the parent site's PPS rate.
2. Dental visits at FQHCs are billed directly to Medi-Cal – not to Denti-Cal. A code 03 is used on the UB04 billing form and a health center receives the full PPS rate for the visit.
3. When a health center has a contract with a dental managed care plan for Medi-Cal beneficiaries, then the health center bills the health plan separately and bills a Code 18 wrap to the state. This code 18 wrap provides the difference between the health plan payment and their PPS rate for that visit.
4. If a dental managed care Medi-Cal patient is seen out-of-network, the FQHC can still bill for the visit. They should bill the managed care plan and then bill a code 18 wrap to the state. They must maintain documentation if the health plan denies the claim and will then be made whole to their full PPS rate during the annual reconciliation. In addition, the health center must refer the patient back to their assigned provider for future visits. However, the patient does have to option to request a change to their assigned provider from Medi-Cal.

### Billing for Telehealth

*There are two examples where telehealth can be considered a billable visit:*

1. Telehealth visits in dental are billable if the dentist is engaging with the patient in real-time (i.e. a "virtual" face-to-face encounter).
2. A FQHC/RHC can use store and forward telehealth technology (teledentistry) for dental care at an intermittent site. This means a non-billable provider can perform covered dental procedures and/or capture dental images and other dental records during a visit with a patient at the intermittent site. The non-billable provider electronically can send these images and records to a billable provider at the FQHC/RHC. The provider at the FQHC/RHC reads the images and records and electronically sends consultation notes and/or instructions back to the non-billable provider at the intermittent site.

The FQHC/RHC can bill a visit for these encounters because a covered service was performed by or under the supervision of the billable provider. As specified in Section 14132.725 of the Welfare and Institutions Code "face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward."



**REMEMBER:** Your HRSA defined services includes all your FQHC clinics activities.



The DHCS states that “under no circumstances should a provider begin billing dental hygienist services without first submitting a Change in Scope of Service Request or Alternate Payment Methodology election”.

It is suggested that the billable and non-billable providers carefully document the procedures performed in the community (including obtaining radiographic and/or photographic images and recording progress notes for each visit) and the billable provider who reviews these records document that review by recording progress notes.

### Billing Nuances of the Virtual Dental Home Model

The event that defines the VDH is an exam done remotely by a billable provider (most likely a dentist) back in the FQHC clinic. That dentist is in a licensed clinic when he/she does the VDH exam. Therefore, it is our understanding that the exam is a billable visit regardless of the location of the support staff collecting the information (sometimes not in an intermittent site or licensed van).

### Billing for Dental Hygienists

The option for FQHCs to elect to provide dental hygienist services as a billable visit became effective January 1, 2008. Election of this option requires the FQHC to submit certain PPS rate reconsideration documents to the State Department of Health Care Services (DHCS) prior to implementing billing for dental hygienist services. In correspondence addressed to the California Primary Care Association, the DHCS states that “under no circumstances should a provider begin billing dental hygienist services without first submitting a Change in Scope of Service Request or Alternate Payment Methodology election”.

For FQHCs that included the cost of dental hygienist services in their PPS rate as of December 31, 2007, the DHCS requires submission of Form DHCS 3078 (FQHC/RHC Dental Hygienist Services PPS Alternate Payment Methodology Worksheet). For other situations involving the addition of dental hygienist services after December 31, 2007, the DHCS requires submission of Form DHCS 3096 (Change in Scope of Service Request Form). Submission of the appropriate aforementioned form is necessary for the DHCS to rebase the FQHC’s PPS rate as a prelude to the FQHC implementing billing for dental hygienist services. In addition, it’s important to note that multiple encounters with a dentist and a dental hygienist that take place on the same day will constitute a single visit; accordingly, only dental hygiene services that occur on a day separate from when other dental services occur will qualify for separate billing.

*For situations involving the addition of dental hygienist services after December 31, 2007, consider the three following scenarios:*

1. FQHC has included the cost of dental hygienist services and dental hygienist visits in an earlier Change in Scope of Service Request submission – in this circumstance, notification to the DHCS of the health center’s intention to begin billing for dental hygienist services should be sufficient without a requirement to submit another Change in Scope of Service Request (please note that this communication may be submitted to the DHCS clinic email inbox at [clinics@dhcs.ca.gov](mailto:clinics@dhcs.ca.gov); in a situation of this nature, it is recommended that the FQHC request a written confirmation from the DHCS of permission to implement billing for dental hygienist services).
2. FQHC has included the cost of dental hygienist services in an earlier Change in Scope of Service Request submission but did not include dental hygienist visits – in this circumstance, another Change in Scope of Service Request must be submitted.
3. FQHC has initiated dental hygienist services but has not previously submitted a Change in Scope of Service Request – in this circumstance, a Change in Scope of Service Request must be submitted.

Given the complexity of these issues, FQHCs considering this election should have proactive communication with appropriate personnel at the DHCS to ensure that this process is navigated in a manner that is consistent with DHCS expectations and enforcement actions.

## Productivity Standards

In general, dental services are not subject to a productivity standard; both dentists and dental hygienists are exempt from productivity standards. The only exception to this is for those sites that had the costs of dental hygienists included in their PPS rate prior to January 2008 and are utilizing the APM method.

## Conclusion

Community based dental care is an important component of health center operations across California. It provides outreach and early intervention for the most vulnerable populations and focuses on preventive care. These non-traditional settings are an opportune place to engage with patients who would not otherwise access prevention and early treatment. Community based dental care is already making a big difference in the lives of many people and has the potential to expand much further. With additional populations gaining coverage under healthcare reform and with adult dental benefits being restored in California's Medi-Cal program, the time is right for health centers to respond and expand oral health services across the state.

Community based oral health programs are instrumental to improving the oral health of California's children by increasing access and removing barriers to care. For residents from communities where access to dental care is a problem children especially benefit from school-based sites. Community based oral health programs reduce these barriers to care by providing preventive and in some cases restorative dental services.



Community based oral health programs are instrumental to improving the oral health of California's children.

## Appendix A

### FQHC Checklist<sup>13</sup> for Implementing an Intermittent Clinic Site

REQUIRED STEPS	NOTES
<p><b>Call your HRSA Project Officer and discuss with them the steps needed specific to your organization</b></p>	
<p><b>Write a Memorandum of Understanding between the FQHC and the intermittent clinic site which describes:</b></p> <ul style="list-style-type: none"> <li>• Clinic space and hours of operation</li> <li>• Floor plan with clinic space highlighted</li> <li>• Clinic control of space operations during clinic hours</li> <li>• Cost, start date, and length of agreement</li> </ul>	
<p><b>Demonstrate evidence of 30-hour requirement through:</b></p> <ul style="list-style-type: none"> <li>• Documentation including patient records;</li> <li>• Photograph of posted hours; and</li> <li>• Patient schedule</li> </ul>	
<p><b>Meet administrative regulations and requirements</b></p> <ul style="list-style-type: none"> <li>• Maintain fire clearance, policies and procedures, and patient records at the intermittent clinic sites</li> </ul>	
<p><b>Notify Medi-Cal (see Appendix H for example letter)</b></p> <ul style="list-style-type: none"> <li>• Submit letter to the Medi-Cal Provider Enrollment Division on organization's letterhead <ul style="list-style-type: none"> <li>• Includes intermittent clinic site address and hours of operation</li> <li>• Make a statement that the clinic is staffed and supplied by the parent site</li> </ul> </li> <li>• Recommended to also notify local district office for licensing, typically the California Department of Public Health</li> </ul>	
<p><b>Notify CMS-Enrolling in the Medicare Program</b></p> <ul style="list-style-type: none"> <li>• Obtain National Provider Identifier (NPI) through CMS prior to operating and applying for enrollment in Medicare Program</li> <li>• If you do not have a NPI, apply for one at <a href="https://nppes.cms.hhs.gov/NPPES/Welcome.do">https://nppes.cms.hhs.gov/NPPES/Welcome.do</a> on the CMS website or by completing Form CMS-10114, "NPI Application/Update Form", and mailing it to the NPI Enumerator at the address listed on the form</li> </ul>	
<p><b>Obtain Malpractice Coverage</b></p> <ul style="list-style-type: none"> <li>• In order for community-based dental services to be eligible for FTCA coverage they must be included in the health center's federal scope of project and included on the FTCA application</li> <li>• Obtain additional liability coverage for volunteer and part-time providers</li> <li>• Include community based services in Quality Improvement policies and activities, including documentation in the QI plan, QI committee minutes, and Board meeting minutes. The FTCA application (initial or renewal) must also include the providers from the community based site.</li> </ul>	

<sup>13</sup> **NOTE:** This checklist may not represent all necessary steps for establishing an intermittent clinic site. It is the responsibility of each organization to consult with their HRSA Project Officer and review the state and federal regulations to verify compliance. CPCA has researched this process and feels it's comprehensive but recognizes there is a chance for updated regulations, policies and processes.

**FQHC Checklist for Implementing an Intermittent Clinic Site** *(continued)*

ADDITIONAL STEPS, IF APPLICABLE	NOTES
<p><b>Consult with Legal Counsel Regarding Billing Process for Community Based Services</b></p> <ul style="list-style-type: none"> <li>• Go through state-level rate change process prior to initiating billing of Dental Hygienist's services if clinic already had dental hygienists on staff prior to January 1, 2008 and has not gone through a state-level-rate change since that time</li> <li>• Add dental hygienists as billable providers in one of two ways:               <ul style="list-style-type: none"> <li>• When a site submits a change in scope for another service change, the addition of dental hygienists can be included as well. The FQHC would submit a normal change in scope request (form 3096)</li> </ul> </li> </ul> <p><i>If the clinic does not otherwise qualify for a change in scope they can utilize the Alternative Payment Methodology (APM) (form 3078)</i></p>	
<p><b>Apply to the Federal Health Resources and Services (HRSA) for a Change in Scope</b></p> <ul style="list-style-type: none"> <li>• Apply whenever a health center wishes to add a new clinic site (licensed or intermittent), the community service site is not already listed in the FQHC's approved scope of project, the FQHC does not already have dental services listed as an approved service, and whenever a change is made for a service in one column to a different column in form 5a</li> <li>• Review information of organization's services in Electronic Handbook on forms 5a, 5b, and 5c</li> <li>• Consult first with your HRSA Project Officer and submit change in scope request at least 60 days in advance of desired implementation date. The request is submitted via the HRSA Electronic Handbook.               <ul style="list-style-type: none"> <li>• Include budget and staffing information and narrative description</li> <li>• Submit a revised project budget to demonstrate that the change can be accomplished without additional 330 funds, and that the change in scope will result in either breaking even or generating revenue</li> </ul> </li> </ul> <p><i>If there is any potential for service area overlap by adding a new site or broadening its service area, you should attempt to secure letters of support from any health centers or explain why such support could not be secured</i></p>	
<p><b>Apply for State Level Change in Scope</b></p> <p><i>No application for intermittent clinic sites is required and no state-level change in scope is required</i></p>	

## Appendix B

### Form 5a – Services Provided

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i>  <b>FORM 5A: SERVICES PROVIDED</b> <b>(REQUIRED SERVICES)</b>		<b>FOR HRSA USE ONLY</b>	
		<b>Grant Number</b>	<b>Application Tracking Number</b>
<b>CLINICAL SERVICES:</b> Service Type	Service provided directly by applicant	Service provided by formal written contract/agreement (Applicant pays for service)	Service provided by formal written referral arrangement/agreement (Applicant DOES NOT pay)
General Primary Medical Care			
Diagnostic Laboratory			
Diagnostic X-Ray			
Screenings – Cancer			
Screenings – Communicable Diseases			
Screenings – Cholesterol			
Screenings – Blood Lead Test for Elevated Blood Lead Level			
Screenings – Pediatric Vision, Hearing, and Dental			
Emergency Medical Services			
Voluntary Family Planning			
Immunizations			
Well Child Services			
Gynecological Care			
Obstetrical Care			
Prenatal and Perinatal Services			
Preventive Dental			
Referral to Behavioral Health <sup>1</sup>			
Referral to Substance Abuse <sup>1</sup>			
Referral to Specialty Services			
Pharmacy			
<b>SUBSTANCE ABUSE SERVICES (Required for HCH Programs):</b>			
• Detoxification			
• Outpatient Treatment			
• Residential Treatment			
• Rehabilitation (Non-Hospital Settings)			

<sup>1</sup> Applicants are required to provide behavioral health and substance abuse services by referral arrangements. In addition, applicants may provide these services by applicant or formal agreement by indicating these services under additional services.

**Form 5a – Services Provided** *(continued)*

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i> <b>FORM 5A: SERVICES PROVIDED</b> <b>(REQUIRED SERVICES)</b>		<b>FOR HRSA USE ONLY</b>	
		<b>Grant Number</b>	<b>Application Tracking Number</b>
<b>NON-CLINICAL SERVICES: Service Type</b>	<b>Service provided directly by applicant</b>	<b>Service provided by formal written contract/agreement (Applicant pays for service)</b>	<b>Service provided by formal written referral arrangement/agreement (Applicant DOES NOT pay)</b>
Case Management – Counseling/Assessment			
Case Management – Referral			
Case Management – Follow-Up/Discharge Planning			
Case Management – Eligibility Assistance			
Health Education			
Outreach			
Transportation			
Translation			
Substance Abuse Services (Required for HCH Programs): – Harm/Risk Reduction (e.g., nicotine gum/patches, educational materials)			

Form 5a – Services Provided (continued)

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i> <b>FORM 5A: SERVICES PROVIDED</b> <b>(ADDITIONAL SERVICES)</b>		FOR HRSA USE ONLY	
		Grant Number	Application Tracking Number
CLINICAL SERVICES: Service Type	Service provided directly by applicant	Service provided by formal written contract/agreement (Applicant pays for service)	Service provided by formal written referral arrangement/agreement (Applicant DOES NOT pay)
Urgent Medical Care			
Dental Services – Restorative			
Dental Services – Emergency			
Behavioral Health – Treatment/Counseling			
Behavioral Health – Developmental Screening			
Behavioral Health – 24-Hour Crisis			
Substance Abuse Services			
Comprehensive Eye Exams and Vision Services			
Recuperative Care			
Environmental Health Services			
Occupational Health – Screening for Infectious Diseases <sup>2</sup>			
Occupational Health – Injury Prevention Programs <sup>2</sup>			
Occupational Therapy			
Physical Therapy			
TB Therapy			
Hepatitis C – Therapy/Treatment			
Podiatry			
Rehabilitation (Non-Hospital Settings)			

<sup>2</sup> Additional Services for Health Centers serving Migratory and Seasonal Agricultural Workers. Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average .5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

Form 5a – Services Provided (continued)

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i> <b>FORM 5A: SERVICES PROVIDED</b> <b>(ADDITIONAL SERVICES)</b>		<b>FOR HRSA USE ONLY</b>	
		<b>Grant Number</b>	<b>Application Tracking Number</b>
<b>NON-CLINICAL SERVICES: Service Type</b>	<b>Service provided directly by applicant</b>	<b>Service provided by formal written contract/agreement (Applicant pays for service)</b>	<b>Service provided by formal written referral arrangement/agreement (Applicant DOES NOT pay)</b>
WIC			
Nutrition (not WIC)			
Child Care			
Housing Assistance			
Employment and Education Counseling			
Food Bank/Meals			

Form 5b – Service Sites

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i> <b>FORM 5B: SERVICE SITES FOR HRSA USE ONLY</b>		<b>FOR HRSA USE ONLY</b>	
		<b>Grant Number</b>	<b>Application Tracking Number</b>
<b>SITE QUALIFICATION CRITERIA</b>			
<b>Is the site an “admin-only” site?</b> <i>(If Yes, the site is an ‘Admin-only’ site, select ‘Not Applicable’ for questions ‘a’ to ‘d’ below. If No, the site is a Service Delivery site, answer questions ‘a’ to ‘d’ Yes or No.)</i>		[ ] Yes [ ] No	
<b>a.</b> Are/will health center encounters generated by documenting in the patients’ records face-to-face contacts between patients and providers?		[ ] Yes [ ] No [ ] Not Applicable	
<b>b.</b> Do/will providers exercise independent judgment in the provision of services to the patient?		[ ] Yes [ ] No [ ] Not Applicable	
<b>c.</b> Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location?		[ ] Yes [ ] No [ ] Not Applicable	
<b>d.</b> Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?		[ ] Yes [ ] No [ ] Not Applicable	
<b>CHOOSE SITE LOCATION SETTING</b>			
Is the Site a Domestic Violence (Confidential)?		[ ] Yes [ ] No [ ] Not Applicable	
<b>SITE INFORMATION</b>			
Name of Service Site		Service Site Type	
Location Type		Location Setting	
Number of Contract Service Delivery Locations			
(Voucher Screening Only)		Number of Intermittent Sites (Intermittent Only)	
Web URL			
Site Operated by	[ ] Grantee/Applicant [ ] Sub-Recipient [ ] Contractor		
<b>ORGANIZATION: If site is operated by sub-recipient or contractor, please provide the organization information below</b>			
Organization Name			
Address (Physical)			
Address (Mailing)			
EIN			
Comments			
Date Site was Opened		Date Site was Added to Scope	
Site Operational By		Medicare Billing Number	

Form 5b – Service Sites (continued)

DEPARTMENT OF HEALTH AND HUMAN SERVICES <i>Health Resources and Services Administration</i> <b>FORM 5B: SERVICE SITES FOR HRSA USE ONLY</b>		FOR HRSA USE ONLY	
		Grant Number	Application Tracking Number
<b>ORGANIZATION (continued):</b> If site is operated by sub-recipient or contractor, please provide the organization information below			
Medicaid Billing Number		Medicaid Pharmacy Billing Number	
Site Phone Number		Site Fax Number	
Site Physical Address			
Administration Phone Number		Service Area Population Type	<input type="checkbox"/> Urban <input type="checkbox"/> Rural <input type="checkbox"/> Sparsely Populated
Service Area Zip Codes <i>(include only those from which the majority of the patient population will come)</i>		Service Area Census Tracts <i>(include only those from which the majority of the patient population will come)</i>	
<b>SITE INFORMATION</b>			
Operational Schedule	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Calendar Schedule	<input type="checkbox"/> Year-Round <input type="checkbox"/> Seasonal
Total Hours of Operation when Patients will be Served per Week (include extended hours)		Months of Operation (required for Permanent and Seasonal Locations)	Total Hours of Operation when

**PUBLIC BURDEN STATEMENT:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

Form 5c – Other Activities / Locations

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <i>Health Resources and Services Administration</i> <b>FORM 5C: OTHER ACTIVITIES / LOCATIONS</b>	<b>FOR HRSA USE ONLY</b>	
	<b>Grant Number</b>	<b>Application Tracking Number</b>
<b>ACTIVITY/LOCATION</b>		
Type of Activity		
Frequency of Activity		
Description of Activity		
Type of Location(s) where Activity is Conducted		
<b>ACTIVITY/LOCATION</b>		
Type of Activity		
Frequency of Activity		
Description of Activity		
Type of Location(s) where Activity is Conducted		
<b>ACTIVITY/LOCATION</b>		
Type of Activity		
Frequency of Activity		
Description of Activity		
Type of Location(s) where Activity is Conducted		

## Appendix C

### Department of Health Care Services' Memo on Intermittent Clinic Sites



State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

September 7, 2012

Mr. David Quackenbush  
Vice President, Programs & Member Services  
California Primary Care Association  
1231 I Street, Suite 400  
Sacramento, CA 95814

Subject: Intermittent Sites

Thank you for your letter dated August 21, 2012, which in part, addresses the issue of intermittent sites, also known as satellite clinics. In response to the information you provided, we offer the following responses.

DHCS concurs that (1) FQHCs that operate intermittent clinics are eligible to receive PPS rate reimbursements for those visits under the Medi-Cal Program, and (2) intermittent clinic services are reimbursable as FQHC services provided the following requirements are met.

1. "The services rendered are of the type that would be covered if provided at the parent site of the FQHC."

***A&I concurs with this point.***

2. "The health center provides services to patients at the site for 20 hours or less every week."

***A&I would like to clarify that the application of the 20-hour rule stated in Health and Safety Code Section 1206(h) means "hours of operation," not 20 hours of service provided to patients. Hours of operation means the clinic is open for business (the doors are unlocked) for 20 hours or less per week. During our meeting yesterday with Ginger Smith and Petra Stanton, consensus was obtained on the definition of "hours of operation" as described.***

---

Audits and Investigations  
PO Box 997413, MS 2000, Sacramento, CA 95899-7413  
Telephone Number (916) 440-7552 – FAX Number (916) 440-7555  
Internet Address: [www.dhcs.ca.gov](http://www.dhcs.ca.gov)

## Department of Health Care Services' Memo on Intermittent Clinic Sites

Mr. David Quackenbush  
September 7, 2012, Page 2

3. "The site is included in the health center's federal HRSA scope of project."

***A&I concurs with this point.***

4. "There is a billable provider providing the service."

***A&I concurs with this point.***

5. "The clinic space is operated by the health center during the intermittent clinic hours of operation."

***A&I concurs with this point.***

6. "The health center owns or leases the space or has a Memorandum of Understanding with the host site. The lease or MOU should clearly identify the space within the building which constitutes the intermittent clinic and specify the clinic hours of operation."

***A&I concurs with this point.***

Because the Healthy Families program has not yet fully transitioned to DHCS, we can only provide our position on the matter for the Medi-Cal program only.

We appreciate our continued collaboration with CPCA to clarify and resolve outstanding issues, which will aid CPCA with its intent to provide appropriate guidance to its members. Feel free to contact me if you have any questions.

Sincerely,



Bruce Lim, CPA  
Deputy Director

cc:

Karen Johnson, Chief Deputy Director, DHCS  
Bill Alameda, Assistant Deputy Director, DHCS A&I  
Jeff Sandman, Chief, Financial Audits Branch, DHCS A&I  
Deborah Ortiz, Vice President of Governmental Affairs, CPCA  
Ginger Smith, Director of Healthcare Operations, CPCA  
Petra Stanton, Associate Director of Health Center Policy and Services, CPCA

## Appendix D

### Department of Health Care Services' Memo on Dental Services



State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

September 7, 2012

Mr. David Quackenbush  
Vice President, Programs & Member Services  
California Primary Care Association  
1231 I Street, Suite 400  
Sacramento, CA 95814

Subject: Contracting with Private Dentists

In response to your letter dated August 21, 2012, this letter confirms the Department of Health Services' (DHCS) position regarding federally qualified health centers (FQHCs) contracting services with private dentists.

We recognize that the Children's Health Program Act of 2009 (CHIPRA) Section 501(d) added a new section 1902(a)(72) to the Social Security Act and also amended section 2107(e)(1) (B) of Title XXI, to permit health centers to contract with private dentists for services to their FQHC patients. In addition, on March 21, 2011, the Centers for Medicare and Medicaid Services (CMS) issued guidance that payment to FQHCs for such services be paid in accordance with the State plan.

DHCS concurs that FQHCs may contract with an off-site private dental provider to render dental services that would be of the type that would be covered if provided on-site at the FQHC. In these cases, the FQHC will be eligible to bill the Medi-Cal Program at the PPS rate. Because the Healthy Families program has not yet fully transitioned to DHCS, we can only provide our position on the matter for the Medi-Cal program only.

DHCS is also in agreement with the California Primary Care Association (CPCA) and the California Dental Association's proposal that FQHCs must ensure:

- There is a contract with the private dentist that includes a provision that the dentist's office will not bill Medi-Cal directly for the same services.
- Dental services are included in the FQHC's federal scope of project.

---

Audits and Investigations  
PO Box 997413, MS 2000, Sacramento, CA 95899-7413  
Telephone Number (916) 440-7552 – FAX Number (916) 440-7555  
Internet Address: [www.dhcs.ca.gov](http://www.dhcs.ca.gov)

Department of Health Care Services' Memo on Dental Services

Mr. David Quackenbush  
September 7, 2012, Page 2

- The patient is an established patient of the FQHC and the FQHC refers the patient to the dentist.

We appreciate our continued collaboration with CPCA to clarify and resolve outstanding issues, which will aid CPCA with its intent to provide appropriate guidance to its members. Feel free to contact me if you have any questions.

Sincerely,



Bruce Lim, CPA  
Deputy Director

cc:

Karen Johnson, Chief Deputy Director, DHCS  
Bill Alameda, Assistant Deputy Director, DHCS A&I  
Jeff Sandman, Chief, Financial Audits Branch, DHCS A&I  
Deborah Ortiz, Vice President of Governmental Affairs, CPCA  
Ginger Smith, Director of Healthcare Operations, CPCA  
Petra Stanton, Associate Director of Health Center Policy and Services, CPCA

## Appendix E

### Department of Health Care Services' Memo on Out-of-Network



State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

June 3, 2013

Ginger Smith, Director  
Health Center Operations  
California Primary Care Association  
1231 I Street, Suite 400  
Sacramento, CA 95814

Dear Ms. Smith:

During recent meetings with the California Primary Care Association (CPCA), the issue of "out of network" Medi-Cal managed care beneficiaries receiving services at Federally Qualified Health Centers (FQHCs) was discussed. The discussion centered on the increasing frequency of "out of network" visits at FQHCs relating to Medi-Cal beneficiaries. In these instances, CPCA wants assurance that the visits will be fully reimbursed by the Department of Health Care Services (DHCS) as part of the Code 18, Code 19, and Code 20 reconciliation process.

Our current process is, Audits and Investigations (A&I) counts "out of network" visits as reimbursable at the Prospective Payment Systems (PPS) rate established for each clinic, subject to offset of managed care payments (paid at the managed care plan's out of network rates) received by the clinics. Proof of payment from the managed care plans showing that "out of network" services were billed to and subsequently paid or denied by the managed care plans shall be maintained by the clinics. Further, proof of payment from the managed care plans is subject to review by A&I during the Code 18, Code 19, and Code 20 reconciliation process.

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Audits and Investigations  
PO Box 997413, MS 2000, Sacramento, CA 95899-7413  
Telephone Number (916) 440-7552 – FAX Number (916) 440-7555  
Internet Address: [www.dhcs.ca.gov](http://www.dhcs.ca.gov)

Department of Health Care Services' Memo on Out-of-Network

Ginger Smith, Director  
Page 2  
June 3, 2013

In addition to the above documentation, since Medi-cal beneficiaries in managed care plans are required to be seen by "in network providers" except in emergency or other isolated instances (e.g. on vacation), we ask that clinics document that they reminded the Medi-Cal beneficiary of this situation, and redirect the beneficiary back to an "in network provider" to receive services or have the beneficiary request to change networks.

Sincerely,



Bruce Lim  
Deputy Director

cc: Karen Johnson  
Chief Deputy Director  
Department of Health Care Services  
P.O. Box 997413-MS 0000  
Sacramento, CA 95899-7413

William L. Alameda  
Assistant Deputy Director  
Audits and Investigations  
P.O. Box 997413-MS 2000  
Sacramento, CA 95899-7413

Jeff Sandman, Chief  
Financial Audits Branch  
P.O. Box 997413  
Sacramento, CA 95899-7413

Deborah Ortiz, Vice President  
Governmental Affairs  
California Primary Care Association  
1231 I Street, Suite 400  
Sacramento, CA 95814

# Appendix F

## Template I MOU for Intermittent Clinic Site

### MEMORANDUM OF UNDERSTANDING

#### Health Center and Community Setting

##### PURPOSE

The purpose of this memorandum of understanding is to establish working guidelines for the provision of dental services by **CCHC** program (hereafter **CCHC**) to students of the School (here after School). Specific goals include:

- Documentation of the working relationship between the parties.
- Establishment of a coordination and referral process that best meets the needs of the students served.
- Clarification of the rights and responsibilities of the participating agencies, their employees and agents.

##### TERM

The term of this Memorandum of Understanding shall be from April 19, 2011 till June 13th, 2011 or sooner depending on how many students take advantage of the dental program. If we do not complete the students by the end of the school year 2011 we will return in the fall to complete treatment plans on students signed up for the program at the beginning of the school year 2011/12.

##### RESPONSIBILITIES OF PARTIES

**CCHC** agrees to:

- Employ licensed dental practitioners to provide general dental services to residents of school
- Share information pertinent to the delivery of services to students with the designated School liaison.

**School** agrees to:

- Designate a staff member to provide coordination and liaison services, including, but not limited to: scheduling of appointments, completion of required consents and other paperwork, and follow-up for services rendered.
- Provide a suitable physical location for the provision of services.
- Provide mutually-agreed upon infrastructure, including, but not limited to: access to electricity, hand washing facilities, use of telephone or fax as needed, etc.
- Provide School staff to assist in the event that a patient needs to be lifted or transported. **CCHC** staff may not perform this function.

##### INSURANCE

**Worker's Compensation:** **CCHC** and School agree that **CCHC** employees are not employees of School and that School employees are not employees of **CCHC**. **CCHC** and School shall each maintain workers compensation insurance in accordance with applicable sections of the California Labor Code for their own employees.

**Medical Liability:** CCHC shall indemnify, hold harmless and defend School and its Board of Trustees, officers, agents and employees from and against all claims, damages, losses and expenses arising out of or resulting from CCHC's performance of the work covered in this contract. Such indemnification shall extend to claims, demands or liabilities occurring after contract completion.

**GENERAL PROVISIONS**

- CCHC and School shall each comply with all applicable county, state and federal regulations.
- CCHC's Mobile Dental program operates as an extension of its licensed community health centers and is subject to the same legal and regulatory requirements.
- CCHC will provide the following services:
  - Dental screening exams
  - Dental education
  - Full treatment services (cleanings, fillings, etc) on a case-by-case basis.
- Services will be provided at the school site during regular school hours, some students in after school programs can be seen with consent after hours.
- All documentation of services provided will be housed at \_\_\_\_\_, and all existing CCHC policies and procedures for maintenance of clinical records will apply.

**AMENDMENT**

Amendments to this agreement shall be in writing and signed by an authorized representative of each party.

---

BY	BY
CCHC	School

---

DATE	DATE
------	------

## Template 2 MOU for Intermittent Clinic Site

### MEMORANDUM OF UNDERSTANDING BETWEEN

#### School District and Clinic

This Memorandum of Understanding (hereinafter referred to as the "Memorandum") is made and entered into on \_\_\_\_\_ ("Effective Date") by and between the SCHOOL DISTRICT, located at (address) (hereinafter referred to as the "District"), and Clinic, Located at (address) (hereinafter referred to as "Clinic"), (each a "Party" and collectively the "Parties"), with regard to the following:

**WHEREAS**, the District recognizes the importance of students' physical, dental and emotional health and its relationship to learning; and

**WHEREAS**, the District believes in the value of maintaining the quality of school health services offered to students and their families; and

**WHEREAS**, CLINIC is a non-profit community clinic organized under the laws of the State of California, engaged in providing medical services within the County of San Diego; and

**WHEREAS**, CLINIC's mission is to improve the availability and cost-effectiveness of primary care services;

**WHEREAS**, it is the Parties intention that the purpose of this program is to provided need preventive dental care, oral health education, and access to a dental home for the students of the District.

**NOW, THEREFORE**, the Parties to this Memorandum do hereby mutually covenant and agree as follows:

- I. SERVICE LOCATIONS:** CLINIC shall provide those Services set forth in Section II below to those Day Care, Preschools, Elementary and Middle Schools found within the District.
- II. SERVICES.** CLINIC shall provide the following Services to those schools identified in Section I above:
  - 1.** CLINIC shall provide, through a licensed dentist, school-based preventive dental services including dental screenings, topical fluoride varnish applications, oral health education, dental report cards, and dental referrals for procedures needing to be completed off-site (hereinafter collectively referred to as the "Services"). CLINIC shall provide all equipment and supplies that are necessary and proper to deliver the services being provided under this Memorandum.
  - 2.** In addition to those Services being provided in Section I above, if CLINIC can secure sufficient funding from third party sources, CLINIC shall also provide additional preventive dental services including, but not limited to, dental sealants on subsequent visits.
  - 3.** Upon execution of this Memorandum, CLINIC shall begin coordinating with representatives from each of the schools to establish protocols for consent forms. CLINIC needs written consent forms from parents or guardians prior to providing services and dental care to all students. The forms will explicitly inform parents about all potential preventative services being offered by CLINIC. CLINIC will provide the District with the requisite screening consent forms and other pre-registration forms. The District will provide students the forms through the school's pre-existing registration procedures. CLINIC will provide services to all students who provide the written consent form.

4. All students who provide a written consent form will have the opportunity to receive needed dental services provided under this Memorandum regardless of insurance status or ability to pay. Services provided to insured students will be billed to their dental insurance company. Donated Services will be available to uninsured children. In the event that additional dental care is required, students shall be referred to CLINIC's nearest dental facilities for further or follow-up dental care.
5. For students receiving services under this Memorandum, they may receive follow-up and /or emergency care when CLINIC is not on the school site. CLINIC will provide follow-up and/or emergency care services to students at their (clinic locations) facility, located at (address).

**III. TIME OF SERVICE.** CLINIC shall coordinate with School Representatives to implement a schedule for the Services to be provided. The Parties may mutually agree to extend hours and days of operation as deemed warranted and feasible by the Parties.

#### **IV. TERM & TERMINATION OF MEMORANDUM.**

1. **Term.** The term of this Memorandum shall commence as of the Effective Date set forth above and shall continue in full force and effect for until June 30, 2014 (the "Initial Term"). Upon expiration of the Initial Term, this Memorandum shall automatically renew for consecutive one (1) school year periods each, July 1st to June 30th (each a "Renewal Term"), unless otherwise terminated by either Party. Notwithstanding the foregoing, the dental screening Services set forth in Section II above shall commence on the Effective Date set forth above.
2. **Termination.** Either Party may terminate this Memorandum at any time, for any reason, with or without cause, upon providing thirty (30) days written notice to the other Party. No termination under the Section shall affect any then-existing rights, obligations or defenses of either Party with respect to (i) continuing obligations, or (ii) any breach of any obligation hereunder.

#### **V. INSURANCE.**

1. Prior to commencement of the Services, CLINIC shall present to the District evidence of insurance with respect to general liability, worker's compensation, and professional liability. CLINIC general liability coverage (covering all dental services providers as well as the agency) shall, at a minimum, provide limits of \$1,000,000/3,000,000 per claim/occurrence. CLINIC agrees to provide at least thirty (30) days' written notice prior to cancellation, non-renewal, or material change of such insurance.
2. Prior to commencement of CLINIC's services, the District shall provide evidence of insurance with respect to general liability. The District's general liability coverage shall, at a minimum, provide limits of \$1,000,000/\$3,000,000 per claim/occurrence. District agrees to provide at least thirty (30) days written notice prior to cancellation, non-renewal, or material change of said insurance.

#### **VI. HOLD HARMLESS.**

1. The District shall defend, indemnify and hold CLINIC, its officers, employees, and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages arising out of the District's performance of this Memorandum but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the District, its officers, agents, and employees.
2. CLINIC shall defend, indemnify and hold the District, its officers, employees and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages arising out of CLINIC's performance of this Memorandum but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of CLINIC, its officers, employees, students and agents.

**VII. REPORTING/EVALUATION.** CLINIC shall cooperate, subject to applicable statutory provisions of confidentiality, in such evaluations or assessments of the school-based dental screening program as the District may reasonably require. CLINIC may utilize evaluation data and/or collect additional data for research studies, publication, scholarly pursuits, and related activities subject to the District's established procedures of research and evaluation. The District shall be provided with an annual report providing statistical data regarding the service provided during the previous 12 months.

**VIII. RECORDS.** Dental records developed and maintained shall be the property of CLINIC. CLINIC shall be the custodian of records for purposes of legal process relative to such records. CLINIC shall maintain on file or in its control for a period extending to at least four (4) years after the expiration of this Memorandum. Patient records will be released only if patient/guardian gives written consent. The Parties understand the records are protected under both HIPAA and FERPA.

**IX. FINGERPRINTING.** All CLINIC personnel providing services on a District site must pass a background / fingerprint check before he/she is allowed to enter a District site.

**X. COMPLIANCE WITH GOVERNMENTAL REQUIREMENTS.**

1. CLINIC and District shall comply with all codes, ordinances, rules, regulations, and requirements of all municipal, state, and federal authorities now in force, or which may hereinafter be in force pertaining to the operation of the school-based screening program. The Parties agree that in the event new governmental requirements are imposed which effect the parties' obligations and performance under this Memorandum, the Parties shall negotiate mutually acceptable additional terms to conform this Memorandum to such new requirements.
2. CLINIC and District shall comply with all codes, ordinances, rules, regulations, and requirements of all municipal, state, and federal authorities now in force, or which may hereinafter be in force which affect the Services being provided under this Memorandum.

**XI. ASSURANCE OF NON-DISCRIMINATION.** CLINIC and District both assure that it shall not discriminate on the basis of race, religion, sex, sexual orientation, national origin, age, or handicap in employment or in the operation of its program.

**XII. MISCELLANEOUS PROVISIONS.**

1. **Governing Law.** This Memorandum shall be construed and enforced in all respects according to the laws of the State of California. Both Parties agree that any action brought under this Memorandum shall be exclusively in the County of San Diego.
2. **Severability.** If any provision of this Memorandum is found to be invalid or unenforceable by any court, such provision shall be ineffective only to the extent that it is in contravention of such applicable laws without invalidating the remaining provisions herein, unless such an invalidity or unenforceability would defeat an essential business purpose of this Memorandum.
3. **Modification/Amendments.** Both Parties acknowledge and agree that this Memorandum may be only amended in writing as mutually agreed upon by both Parties.
4. **Assignment and Delegation.** Neither Party may assign rights and delegate duties under this Memorandum to any other person without the prior written consent of the other Party, which consent shall not be unreasonably withheld.
5. **Entire Agreement.** This Memorandum contains the entire understanding between Parties with respect to the subject matter of this Memorandum and incorporates all of the covenants, conditions, promises, and agreements exchanged by the Parties hereto. This Memorandum supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between the Parties with respect to the subject matter of this Memorandum.

6. **Waiver.** No waiver of or failure by any Party to enforce any of the provisions, terms, conditions or obligations herein shall be construed as a waiver of any subsequent breach of such provision, term, condition or obligations or acts shall be deemed an extension of the time for performance of any other obligations or acts.

7. **Notices.** All notices required or permitted by this Memorandum shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

**If to CLINIC:**

XXXXX, CEO  
XXXXX  
XXXXXXXXXXXXXXXXX  
(XXX) XXXXXXX

**If to District:**

XXXXX  
XXXXX  
XXXXX  
(XXX) XXXXXXX

8. **Final Approval.** This Agreement is of no force or effect until approved by the Governing Board of the District and executed by a District official delegated the responsibility by the Governing Board.

**IN WITNESS WHEREOF,** The Parties hereto have agreed to and executed this Memorandum by their respective officers thereunto duly authorized as of the Effective Date set forth above. The respective signatories warrant, and represents that said individual(s) have the authority and proper authorization to execute this Memorandum.

CLINIC

SCHOOL DISTRICT

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

## Appendix G

### Contracting with Private Dental Offices

#### Existing Toolkits

**NOTE:** These toolkit hyperlinks were active at the date of publication. If the hyperlinks are no longer active, please search for the document using the title and author.

- 1. TITLE:** *Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers. An FQHC Handbook.*

**AUTHOR:** Children's Dental Health Project

**ACCESSED AT:** [www.ada.org/~/media/ADA/Public%20Programs/Files/access-to-dental-care\\_fqhc-handbook.ashx](http://www.ada.org/~/media/ADA/Public%20Programs/Files/access-to-dental-care_fqhc-handbook.ashx)
- 2. TITLE:** *Partnering California's Health Centers with Private Dentists: Why and How? A Care Delivery Innovation for California FQHCs. A Companion to the FQHC Handbook.*

**AUTHOR:** Children's Dental Health Project with the support of the California HealthCare Foundation

**ACCESSED AT:** [https://cdhp.s3.amazonaws.com/resource/199/attachment\\_1/original.pdf?1382979187](https://cdhp.s3.amazonaws.com/resource/199/attachment_1/original.pdf?1382979187)

## Appendix H

### Sample Notification Letter to Medi-Cal for Intermittent Clinic Site

[Date]

Department of Health Care Services  
Provider Enrollment Division  
RE: Intermittent Site notification  
MS 4704  
P.O. Box 997412  
Sacramento, CA 95899-7412

Re: Welfare & Institutions Code § 14043.15(e) Notice of Intermittent Clinic Site

Dear [Salutation/Current Chief]:

This letter is intended to fulfill the requirements of Welfare & Institutions Code § 14043.15(e), and to serve as notice by [intermittent clinic name], a nonprofit community clinic, that it is operating a clinic exempt from licensing by the Department of Health Services under subdivision (h) of Section 1206 of the Health & Safety Code. [parent clinic name] is a Federally Qualified Health Center that operates the following intermittent site:

[intermittent clinic name and address]

This site is operated by a licensed primary care clinic, and the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services for the intermittent site. For your reference, [parent clinic name's] Medi-Cal NPI number is [#####].

Should you have any questions or if you require any additional information from us please contact me at [#####].

Sincerely,

#### DISCLAIMER

The information in this Technical Assistance Guide is intended only to provide a general overview of the topics addressed. This publication is not intended to provide legal advice or to substitute for the guidance, counsel, or advice of a legal counsel on any matters particular to a specific primary care clinic.



**California  
Primary Care**  
ASSOCIATION

[www.cPCA.org](http://www.cPCA.org)

1231 I Street, Suite 400

Sacramento, CA 95814

(916) 440-8170

Complete Packet 210 of 342

**CPCA**  
**Increasing Access to Oral Health**  
**A Technical Assistance Guide for California Health Centers**  
**Supplement and Suggested Edits**  
**DRAFT - May 22, 2017**

The California Primary Care Association (CPCA) has produced a Guide for health centers for increasing access to oral health.<sup>1</sup> One section of that document is being revised, the section on the billing process for community-based services. This document contains suggestions for edits to that section which are being reviewed at the time of this writing.

### **Billing Process for Community-Based Services**

The rules for Medi-Cal billing at community based sites is the same as the rules for billing at the dental clinic. The visit must be

- a medically necessary face-to-face encounter,
- with a billable provider,
- for at least one service covered, and
- provided to a Medi-Cal beneficiary.

However, there is an exception to this rule when using telehealth connected teams as explained below.

#### Billing Circumstances

The state of California defines under what circumstances these activities become billable under the FQHC payment system. The State considers the following locations to be locations or circumstances where dental services are billable:

- In a licensed FQHC clinic location;
- In a registered Intermittent Clinic sites; and
- In a licensed mobile van
- In a site where services are delivered through a contract between a health center and contracted a dentist or dental service organization,
- In various sites using telehealth technologies (as described below).

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1. California Primary Care Association (CPCA). Increasing Access to Oral Health. A Technical Assistance Guide for California Health Centers. [http://www.cPCA.org/cPCA2013/assets/File/CPCA\\_OralHealth\\_vf-1.pdf](http://www.cPCA.org/cPCA2013/assets/File/CPCA_OralHealth_vf-1.pdf)

### Considerations for Billing in Special Circumstances:

1. If the services are performed at an intermittent clinic site, then the services will be billed at the parent site's PPS rate.
2. Dental visits at FQHCs are billed directly to Medi-Cal – not to Denti-Cal. A code 03 is used on the UB04 billing form and a health center receives the full PPS rate for the visit.
3. When a health center has a contract with a dental managed care plan for Medi-Cal beneficiaries, then the health center bills the health plan separately and bills a Code 18 wrap to the state. This code 18 wrap provides the difference between the health plan payment and their PPS rate for that visit.
4. If a dental managed care Medi-Cal patient is seen out-of-network, the FQHC can still bill for the visit. They should bill the managed care plan and then bill a code 18 wrap to the state. They must maintain documentation if the health plan denies the claim and will then be made whole to their full PPS rate during the annual reconciliation. In addition, the health center must refer the patient back to their assigned provider for future visits. However, the patient does have to option to request a change to their assigned provider from Medi-Cal.

### Billing in a Community Environments – General Principles

*There are several mechanisms where dental services can be delivered in a community site, which have been registered as intermittent clinic, and the visit is considered a billable visit:*

1. A dentist, employed by the health center, is in the community site and delivers the services.
2. A dental hygienist, employed by a health center that has added dental hygiene services performed by dental hygienists to their HRSA Scope of Project, is in the community site and delivers the services. (See below)
3. A dentist, who is not in the community site, reviews records collected by a dental hygienist (or in some circumstances a dental assistant licensed in extended functions – RDAEF) and completes an examination and treatment plan. (see details below)
4. A dental hygienist (or in some circumstances a dental assistant licensed in extended functions – RDAEF) delivers dental services in a community setting and is “supervised by a dentist using telehealth technologies. (See details below).
5. Visits where dental care is delivered using Telehealth technologies are billable if the dentist is engaging with the patient in real-time (i.e. a “virtual” face-to-face encounter).

### Billing in a Telehealth Environment for Services Performed Using Store-and-Forward Telehealth Technologies

A FQHC/RHC can use store and forward telehealth technology (teledentistry) for dental care at an intermittent site or licensed FQHC location where a dentist is not present. This means a non-billable provider can perform covered dental procedures and/or capture dental images and other dental records during a visit with a patient at the intermittent site or licensed FQHC location. The non-billable provider electronically can send or make these images and records available to a billable provider at the FQHC/RHC. The billable provider at the FQHC/RHC reviews

the images and records and electronically sends consultation notes and/or instructions back to the non-billable provider at the intermittent site or licensed FQHC location.

The ability of the dentist to perform an examination using telehealth technologies is supported by the American Dental Association's Code on Dental Procedures and Nomenclature (CDT Code), which is considered the standard coding set in the dental industry. It explains the process of performing a dental examination as a "thorough evaluation and recording of the extra oral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures." "These codes recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist." In summary, records can be collected by non-billable providers and the dentist can review the records and complete the examination and treatment plan.

The non-billable provider can also perform dental services under the supervision of dentist (the billable provider). In this case the dentist reviews records of the services performed and documents the review in the same manner that this would be done in an in-person environment.

The FQHC/RHC can bill a visit for these encounters because a covered service was performed by or under the supervision of the billable provider. As specified in Section 14132.725 of the Welfare and Institutions Code "face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward."<sup>2</sup>

It is suggested that the billable and non-billable providers carefully document the procedures performed in the community (including obtaining radiographic and/or photographic images and recording progress notes for each procedure and visit) and the billable provider who reviews these records document that review by recording progress notes. Only one encounter should be billed for covered services even if the covered procedures are started on one date and completed on a subsequent date.

The March 2016 Denti-Cal Bulletin, that describes the fee-for-service billing process for services performed using store-and-forward teledentistry, suggests that teledentistry records be reviewed within 48 hours after they are available to the reviewing dentist.<sup>3</sup>

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2. California Welfare and Institutions Code. Section 14132.725.  
[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC).
  3. California Department of Health Care Services. Denti-Cal Bulletin. Volume 32, Number 4. March 2016.  
[http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume\\_32\\_Number\\_04.pdf](http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_32_Number_04.pdf).

## Considerations for Using Dental Hygienist and Dental Assistants in Telehealth Connected teams

In 2014, AB 1174 and subsequent regulations, added 2 new procedures to the scope of practice of dental assistants licensed in extended function (RDAEF)<sup>4</sup>, dental hygienists (RDH) and registered dental hygienists in alternative practice (RDHAP) which facilitate the delivery of dental care using telehealth-connected teams.<sup>5</sup> These duties, which can be performed after specified training and certification are:

- RDAEFs, RDHs, and RDHAPs can make the decision about which radiographs to take, if any, to facilitate an initial oral evaluation by a dentist.
- RDAEFs, RDHs, and RDHAPs can place “Interim Therapeutic Restorations” (ITR)

The allowable scope of practice for dental assistants and dental hygienists can influence which allied dental personnel are best utilized in telehealth-connected teams in which circumstances. The following table is a general description of these considerations:

Duty	RDAEF	RDH	RDHAP
Collect electronic dental records (with the exception of radiographs) prior a patient being seen by a dentist	I	I	I
Take radiographs prior a patient being seen by a dentist	T	T	T
Place topical fluoride	G	G or P	I
Perform prophylaxis	N	G or P	I
Perform scaling and root planning	N	G or P	I
Place sealants	G	G or P	I
Place interim therapeutic restorations	T and G	T and G	T and G

T = After training and supervision in this procedure

G = General supervision - after instructions by a dentist to perform the procedure)

I = Prior to instructions by a dentist to perform the procedure

P = “In a public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity” (CA B&P Code 1911)

N = Not allowed

4.. As used in this document, RDAEF refers to a dental assistant in expended functions licensed under CA B&P Code Section 1753.4 and sometimes referred to as an RDAEF II.

5. Assembly Bill 1174, 2014.

[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB1174](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1174).

Another consideration is dental hygienists with the RDHAP license, have specific training in the required curriculum for this license, on working with people with complex medical and other conditions.

## **Section on Dental Hygienists as Billable Providers**

CPCA has published a separate document that describes the process and implications of adding dental hygienists as billable providers to a health center's HRSA Scope of Project.<sup>6</sup>

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6. NEED REFERENCE



## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		David B. Vliet	A
II. Approval of Agenda	<ul style="list-style-type: none"> <li>Executive Summary</li> </ul>	David B. Vliet	A
III. Approval of Minutes	<ul style="list-style-type: none"> <li>July 13 Meeting Minutes</li> <li>August 11 Meeting Minutes</li> </ul>	David B. Vliet	A
IV. Federal Politics & Advocacy	<p><b>Verbal Update -</b></p> <ul style="list-style-type: none"> <li>✓ Political Landscape in DC</li> <li>✓ Health Center Funding Cliff Update</li> <li>✓ Federal Budget Update</li> <li>✓ ACA Repeal Update</li> <li>• Immigration Legislation – <b>Please see memo in Government Programs</b></li> </ul>	<p>Angie Melton</p> <p>Liz Oseguera</p>	<p>D</p> <p>A</p>
V. State Politics, Legislation & Advocacy	<p><b>Verbal Update -</b></p> <ul style="list-style-type: none"> <li>✓ State Political Landscape and 2018 Elections</li> <li>• CPCA Bill Tracking Report – <a href="#">click here</a> to view and/or print</li> <li>• 2017 Legislative Review: CPCA Sponsored Legislation and Bills of Importance</li> </ul>	<p>Christy Bouma</p> <p>Beth Malinowski</p>	<p>I/D</p> <p>I/D</p>
VI. FY17-18 State Budget	<ul style="list-style-type: none"> <li>State Budget Implementation</li> </ul>	Beth Malinowski	I
VII. Policy Prioritization	<ul style="list-style-type: none"> <li>Policy Prioritization One Pager</li> <li>Policy Prioritization Action Grid</li> </ul>	Andie Patterson	A
VIII. Advocacy and Communication	<ul style="list-style-type: none"> <li>Communications Strategy</li> <li>✓ Imprenta Statewide Communications Plan – <b>Verbal Update</b></li> <li>• Advocacy Strategy</li> </ul>	<p>Andrea Chavez</p> <p>Andie Patterson</p> <p>Janalynn Castillo</p>	<p>D</p> <p>D</p> <p>D</p>
IX. Adjourn		David B. Vliet	A



## ***Executive Summary***

Date: September 28, 2017

To: Legislative Committee

LEGISLATIVE COMMITTEE / EXECUTIVE SUMMARY

### **Federal Politics, Budget & Advocacy**

- Funding Cliff: For the first time, on September 30, 2017, S-CHIP, Community Health Center, National Health Service Corps, and Teaching Health Center GME program funding has expired. As a result of aggressive advocacy, at time of writing, Senate and House bills are being marked-up, and partners are hopeful that meaningful action will occur in October.
- ACA Repeal: The Graham-Cassidy-Heller-Johnson ACA repeal bill, the third attempted ACA repeal this year, is not currently moving. Future ACA repeal and destabilization attempts are expected, with FY 2019 Budget reconciliation a likely target for this next effort. With the recent resignation of HHS Secretary Tom Price, much attention on his replacement will focus on what this selection signals for ACA repeal and Medicaid stability.
- Tax Reform: Between now and December, we expect much Congressional attention to be focused on Tax Reform
- Immigration Policy: As CPCA's immigration work advances, staff recommend members take action today to formalize positions on a number of pieces of federal legislation, including the Dream Act.

### **State Politics, Legislation & Advocacy**

- This year, at CPCA's bequest, CaliforniaHealth+Advocates sponsored or cosponsored, three bills – SB 323 (Mitchell); SB 456 (Pan); and AB 1003 (Bloom).
- CPCA, through CaliforniaHealth+ Advocates, broadened its legislative work in 2017 to include support of many pieces of state legislation that were in response to federal policy shifts and threats; including legislation and resolutions that address immigration, Planned Parenthood and family planning services, and coverage stabilization.
- CPCA, through CaliforniaHealth+ Advocates, in partnership with regional associations and health centers, participated in a robust AB 1250 (Jones-Sawyer) opposition campaign.

### **Enacted FY17-18 State Budget Summary**

- The Song-Brown Healthcare Workforce Training Program received a \$33M installment of new funds. Awards will be determined during the November 29-30, 2017 Song Brown Commission meeting in Southern California.
- California Health Facilities Financing Authority (CHFFA) staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application process.
- DHCS has outlined payment methodologies and begun submitting the State Plan Amendment (SPA) for the use of California Healthcare, Research and Prevention Tobacco Tax Act (Prop. 56) funds for supplemental payments.

- CPCA continues to work with DHCS on State Plan Amendments, one of which is the MFT implementation to become billable providers by July 2018.

### **Policy Prioritization**

- This year's policy prioritization process started in August with a call for members to provide feedback on what CPCA's policy priorities should be in 2018.
- The Consortia gathered feedback directly then CPCA along with the consortia synthesized it all in a mid-September meeting.
- This year's policy priorities echo last years, but there are fewer so that CPCA and its affiliate, CaliforniaHealth+ Advocates can be more targeted, and hopefully more successful on very challenging issues.

### **Advocacy and Communications**

#### Communications Strategy

- CaliforniaHealth+ Advocates staff recommends a focused external communications strategy for 2018.
- Advocates will work closely with the consortia and health centers to proactively engage media and stakeholders on priority issues.

#### Advocacy Strategy

- Member-focused grassroots advocacy efforts preserved CA's \$100 million for primary care workforce, successfully pushed CPCA's sponsored legislation to the governor's desk, and helped defeat three ACA repeal attacks.
- CaliforniaHealth+ Advocates is committed to providing CPCA membership new ways to improve advocacy infrastructure at all levels of an organization.
- At this year's CPCA annual conference, CaliforniaHealth+ Advocates will provide members with advocacy opportunities to partake in.

## CALIFORNIA PRIMARY CARE ASSOCIATION

### Legislative Committee

July 13, 2017

10:10 am – 12:00 pm

**Members:** David B. Vliet – Chair, Antonio Alatorre, Tanir Ami, Dolores Alvarado, Lucinda Bazile, Doreen Bradshaw, Cynthia Carmona, Lynn Dorroh-Watson, Rachel Farrell, Ben Flores, Cathy Frey, Jane Garcia, Larry Garcia Greg Garrett, Franklin, Britta Guerrero, Alicia Hardy, Steve Health, Sherry Hirota, Cathryn Hyde, Erica Jacquez, Deena Lahn, David Lavine, Becky Lee, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Scott McFarland, Leslie McGowan, Danielle Myers, Joanne Preece, Tim Pusateri, David Quackenbush, Mary-Michal Rawling, Tracy Ream, Lucresha Renteria, Tim Rine, Jacqueline Ritacco, Melinda Rivera, Gary Rotto, Sendy Sanchez, Laura Sheckler, Suzie Shupe, Paulo Soares, Graciela Soto-Perez, Terri Lee Stratton, Mary Szecsey, Sabine Talaugon, Vernita Todd, Henry Tuttle, Jason Vega, Christina Velasco, Tony Weber, Paula Wilson

**Guests:** Christy Bouma, Meagan Subers, Tiffany Robertson, Irma Cota, Anitha Mullangi, Michael Schaub, Wanna Mine

**Staff:** Carmela Castellano-Garcia, Beth Malinowski, Kelley Aldrich, Victor Christy, Andie Patterson, Meaghan McCamman, Liz Oseguera, Andrea Chavez, Mike Witte, Allie Budenz, Meghan Nousaine

### Call to Order

The meeting was called to order by the chair at 10:16 am.

### Approval of Agenda

A motion was made and seconded to approve the agenda as written. **The motion carried.**

### Federal Politics, Budget & Advocacy

Andie Patterson summarized the memo written by Angie Melton of the Margolin Group, noting the following; the year continues to be active and unpredictable on the federal front.

- It was anticipated that a budget reconciliation bill that included ACA Repeal would be signed into law in January. Now it is July and the Republican Congress is still trying to find a path forward on their “repeal and replace” strategy. Congress would like to complete action on the ACA Repeal bill one way or the other before the August recess, which now starts on August 14 for the Senate and July 28 for the House.
- A package of health care financing programs, including CHIP, the Health Center fund, the National Health Service Corps, and Teaching Health Centers, must be completed by September 30 when the current fiscal year ends, and in addition the annual discretionary appropriations process that provides a portion of the Health Center fund has gotten off to a

slow start. While there is bi-partisan support for this legislation, it is in no way guaranteed to pass.

- Advocacy works! Keep up the amazing work, participate in coalition events, continue to collect patient stories, call, and tweet and e-mail your Members of Congress. Use NHCW to thank supportive Members of Congress and make sure they continue advocating for health center funding.

Beth Malinowski gave members an update from her meetings with NACHC, which echo, advocacy is working, but we need to make sure we continue to push for health center funding.

Andie urged members to participate in the survey coming out from the AG's office in regards to reproductive health. What will happen if the ACA is taken away, think about services provided, especially for women, timely access to prenatal and cervical cancer screenings? It's a loose, loose situation.

### **State Politics, Legislation & Advocacy**

Meagan Subers (Capitol Connection) highlighted what's currently going on in the Capitol; noting the upcoming deadlines for both fiscal and non-fiscal bills including our sponsored bills SB 323 and SB 456. The legislature will be out on recess 7/21 – 8/21, then they'll have two weeks to wrap things up for the 2 year bill process.

SB 562 – Arambula held the bill for both policy and political reasons which drew extremely unruly protests. Capitol staff is very unhappy.

Christy Bouma (Capitol Connection) gave an update of the other issues sucking the life out of the dome, mainly the Cap and Trade program. There's lots of negotiating going on, the new deadline is now Monday.

Beth informed members that with the Budget Act of 2017 signed, the legislature is now focused on moving policy bills through the legislative process. Sept. 15<sup>th</sup> is the last day for each house to pass bills. At this time our sponsored legislation – SB 323 (Mitchell) and SB 456 (Pan) are moving nicely through the process.

Beth discussed staff recommended positions on the following bills and the chair called for a motion:

- **AB 1250** (Jones-Sawyer D) - Counties: contracts for personal services – ***Recommend OPPOSE, UNLESS AMENDED***
- **AB 1340** (Maienschein R) - Continuing medical education: mental and physical health care integration – ***Recommend moving from WATCH to SUPPORT***

#### **Motion Summary:**

*A motion was made and seconded to take an OPPOSE UNLESS AMENDED position on AB 1250 (Jones-Sawyer D) - Counties: contracts for personal services. (Rine/McCarthy) The motion carried.*

**Motion Summary:**

*A motion was made and seconded to take the staff's recommendation of moving from WATCH to SUPPORT on AB 1340 (Maienschein R) - Continuing medical education: mental and physical health care integration. (Rine/McFarland) The motion carried.*

Beth continued with updates on SB 387 and SB 562:

- SB 387 (Thurmond), a bill of considerable interest to the membership, which, if passed, would create minimum wage requirements for trainees has been held by the author – this bill will no longer be moving in 2017.
- SB 562 (Lara/Atkins), The Healthy California Act, has been held in the Assembly. It is uncertain as to whether or not the authors and sponsors, working with leadership, will decide to move the bill next year. In conversation going forward, we want to make sure we're in a good place and we want to be the people that inform the authors on the bill.

**Enacted FY17-18 State Budget Summary**

Beth was proud to announce that the recently signed FY17-18 budget reflects strong support for health centers and the patients we serve. Through successful lobbying and advocacy, we are excited to note the following:

- \$100 Million Workforce Funding Reinstated: The signed budget includes \$100 million to support primary care residency, including teaching health center, and loan repayment.
- 340B Drug Discount Program Untouched: The passed budget includes no changes to contract pharmacies or other provisions relating to the 340B Program...though it's still a battle.
- New \$20 Million Lifeline Grant Program: Establishes the Community Clinic Lifeline Grant Program for small and rural health clinics suffering financial losses, and appropriates \$20 million from the Health Expansion Loan Program (HELP II) fund one-time for this purpose.

**Advocacy and Communications**

Andie explained that CaliforniaHealth+ Advocates has prioritized advocacy efforts on the Federal attempts to repeal and replace the Affordable Care Act and since November 2016, Advocates has sent 27 advocacy alerts to members that include Federal updates and advocacy asks. Advocates has also provided members with analyses, talking points and summaries on the all ACA repeal and replace policies.

**CALIFORNIA PRIMARY CARE ASSOCIATION**  
**Legislative Committee On-line Meeting**  
August 8, 2017  
10:0 am – 11:00 pm

**Attendee Report:**       **David B. Vliet – Chair**, Javier Alvarado, Doreen Bradshaw, Merrill Buice, Gregory Cramer, Nick Cutler, Lisa Eisenberg, Gilbert Fimbres, Timothy Fraser, Naomi Fuchs, Claudio Galvez, Greg Garrett, Dean Germano, Nik Gupta, Haleh, Hatami, Steve Heath, Tina Jagtiani, Barbara Kidder Garcia, Neil Kozuma, David Lavine, Sandra Lopez, Alejandro Medina, Amy Moy, Luella Penserga, Joanne Preece, Craig Pulsipher, David Quackenbush, Tim Rine, Melinda Rivera, Sendy Sanchez, Steve Schilling, Suzie Shupe, Matthew Stevens, Deanna Stover, Terri Stratton, Dong Suh, Mary Szecsey, Sabine Talaugon, Vernita Todd, Marcela Vargas, David Vliet, Becky Lee

**Staff:**                   Beth Malinowski, Kelley Aldrich, Victor Christy, Andrea Chavez, Michael Helmick, Andie Patterson, Liz Oseguera, Daisy Po’oi, Vaughn Villaverde

**Call to Order**

The meeting was called to order by the chair at 10:02 am.

**Approval of Agenda**

A motion was made and seconded to approve the agenda as written. **The motion carried.**

Beth Malinowski gave members an update on CPCA’s two sponsored bills, SB 323 and SB 456.

Beth updated members on AB 1250 and explained the recommended change in position. **AB 1250** (Jones-Sawyer D) - Counties: contracts for personal services – staff recommends moving from OPPOSE UNLESS AMENDED to an OPPOSE position. The chair called for a motion.

**Motion Summary:**

*A motion was made and seconded to move to an OPPOSE position on AB 1250 (Jones-Sawyer D) - Counties: contracts for personal services. (Schilling/Fraser) The motion carried.*

Beth went to discuss next steps, including the joint coalition letter being headed up by CalNonprofits and the template letter of support that CaliforniaHealth+ Advocates will be creating and sending out.

The meeting was adjourned at 10:47 am

Submitted by Kelley Aldrich



Date: September 25, 2017  
To: Legislative Committee  
From: Beth Malinowski, Deputy Director of Government Affairs  
Re: 2017 Legislative Review: CPCA Sponsored Legislation and Bills of Interest

**MEMORANDUM**

**I. Overview**

This year, building on our success from the 2015-2016 session, at CPCA's bequest, CaliforniaHealth+ Advocates sponsored or cosponsored, three bills. At time of writing one of these bills, **SB 323 (Mitchell)** is awaiting action by the Governor. With two additional bills, **SB 456 (Pan)** and **AB 1003 (Bloom)** well positioned for debate in the second year of this session. These bills, and our broader legislative review, must also be considered in the context of a very robust, and successful, FY 17-18 state budget strategy (see [Enacted Budget memo](#), presented July 2017).

In addition to these sponsored bill and budget efforts, CaliforniaHealth+ Advocates influenced dozens of bills and participated in robust partnerships to achieve legislative success to forward CPCA's policy priorities. This year, Advocates, also had the challenging task of maneuvering difficult political and policy waters as it participated in an oppose campaign (AB 1250) and expressed strong concerns on a number of bills early in session. For both legislative and budget success, partnerships continued to be key to our capitol strategy.

Advocate's tracked over 200 bills of interest, submitted letters of support on over 50 measures, and provided oral testimony on dozens of bills. We also educated and informed legislators and committee staff on bill impacts to health centers and, when needed, advocated for amendments to reflect health center interests. Through CaliforniaHealth+ Advocates, our work on the budget, sponsored bills and other bills of interest, California health centers and community clinics continue to increase their presence in the building. Our increased strength in the capitol, was evidenced by increased opportunities for Advocate's, and its members, to not only inject the health center perspective, but be a key witness in a variety of legislative hearing and briefings held since November 2016 to defend the ACA and protect California's diverse communities from federal policy threats.

With a few exceptions (for bills substantially amended late in session), this year also highlighted the value of increased contact with the Legislative Committee when the state legislature is in session. By holding monthly calls, CPCA was able to be more nimble and responsive to changing policy debates, legislative amendments, and political dynamics thereby enabling the advocacy affiliate, CaliforniaHealth+ Advocates to be more nimble and responsive.

## II. 2017 Sponsored Legislation

**SB 323 by Senator Holly Mitchell (D-Los Angeles)** seeks to improve Californians' access to behavioral health services by eliminating a barrier which prevents community health centers from participating in the Drug Medi-Cal and Specialty Mental Health programs. Due to a veto-threat by Governor Brown, in 2016, an earlier version of this bill (SB 1335) was held in the Senate. This year, the bills co-sponsor, the Community Clinic Association of Los Angeles County (CCALAC), and Advocates worked closely with DHCS to bring to the legislature and Governor a bill that better reflects advocates' interests and DHCS needs. At time of writing, this bill is awaiting action by the Governor.

**SB 456 by Senator Richard Pan (D-Sacramento)** will improve the health of California's most vulnerable people by allowing FQHCs to be directly reimbursed for services that promote continuity of care and wellness in ways not covered by PPS, including services associated with innovative projects like the Whole Person Care pilots. While we expect that this bill will reduce overall costs to the health care system through better care coordination, addressing social determinants of health, and incentivizing wellness services that keep patients healthy and out of the emergency room, DHCS has significant concerns about this bill. With this in mind, and working closely with the author, it was determined that this bill would become a two-year bill effort to allow for greater discussion with DHCS and other partners.

**AB 1003 by Senator Richard Bloom (D-Santa Monica)** sought to address Type 2 diabetes, dental disease, heart disease, stroke – debilitating epidemics in California - by creating a dedicated revenue source for prevention and care. Due to continued opposition by the soda industry, as well as the introduction of competing legislation to create a snack tax (**AB 274**), there was much debate as to whether or not this bill should be introduced in the first year. The author, strongly committed to introduction, worked with Assembly leadership to commit this bill for assignment to the proper committee for study. The Coalition for a Healthy California, to which CaliforniaHealth+ Advocates was a leading member, is working on intersession strategies to support this effort.

## III. Bills of Interest

Our work on bills of interest highlights well how community clinic and health center perspectives are being heard in the legislature. As we consider the impact of this work on our overall strength as an association, two elements are particularly important to note. First, other associations are increasingly coming to us for partnership and content expertise. Secondly, legislative staffers and committee staff are also increasingly seeking our perspective on legislation too.

In the wake of the November 2016 election, and the swearing in of the U.S. president and cabinet hostile to many of California's core values, this year also highlighted how state legislation can be used to counter these efforts. CPCA, through CaliforniaHealth+ Advocates, broadened its legislative work in 2017 to include support of many pieces of this legislative response. This can be seen in the introduction of legislation and resolutions that address immigration, Planned Parenthood and family planning services, and coverage stabilization.

Immigration: Advocates stood with California Immigrant Policy Center (CIPC) and other members of the Latino Health Alliance in support a wide variety of bills that protect immigrant patients and communities and guarantee them access to important services and opportunities. Element of this immigration bill package that Advocates supported included **AB 21 (Kalra), SB 29 (Lara), SB 30 (Lara), SB 31 (Lara), SB 54 (De Leon)**. Collectively, these bills range from access to higher education (**AB 21**) to city, county and state engagement and disclosures of information to federal immigration agents (**SB 29; SB 31; SB 54**)

Stabilizing Coverage and Family Planning Services: With leadership from the Assembly and Senate Health Committee Chairs – Assemblymember Wood and Senator Hernandez, a number of bills were introduced to directly counter federal ACA destabilization efforts and support a strong state exchange. Two bills of particular note, and that targeted Covered California, were **AB 156 (Wood)** – a bill to maintain current annual open enrollment periods – and **SB 133 (Hernandez)** – a bill to address rising continuity of care concerns as plans leave the marketplace. In support of family planning service, **SB 743 (Hernandez)** prohibits a Medi-Cal managed care plan from restricting choice in family planning service providers.

Restarting Universal Coverage Conversations: Senator Lara, with a track record of expanding coverage, and buoyed by activists committed to finding a California solution to federal coverage challenges, introduced **SB 562**. While some controversy and debate surround the timing of this bill’s introduction, and many health industry experts felt the initial language was unworkable, many organizations, including Advocates, stood up to welcome conversation. While Advocates continues to have no formal position on this bill, staff have participated in stakeholder meetings and anticipate continuing to be part of dialog related to this effort in the coming months.

Like 2016, legislative efforts on workforce, oral health, behavioral health, and other clinical matters continue to highlight well the significant expansion seen in how the legislature engages CaliforniaHealth+ Advocates as subject matter experts. Regardless if a bill moves through the process, if a bill gets signed or vetoed, our ability to be an accessible expert to legislators and their staff will bring long-term positive impacts to our relationships in the Capitol. Of note, in some cases, Advocates, on behalf of CPCA, found meaningful ways to share concerns without taking a formal position that could have been oppositional to a key legislative partner. Here are some examples of our impact:

Workforce: Our work on the FY16-17 budget continued to secure our place as an expert on primary care workforce. Even before the 2017 session had begun, the Republican Caucus leadership were engaging Advocates as content matter experts on primary care training. Our expertise could be seen in the inclusion of health care workforce in **AB 316 (Waldron)**. Advocates, on behalf of Advocates, also met with Assemblymember Friedman and California Association of Nurse Practitioners on **AB 1560**, a bill to modify the ratio of advance practice

clinicians to physicians to discuss health center impact. While staying neutral on two workforce bills – **AB 148 (Mathis)** - a loan repayment bill and **AB 387 (Thurmond)** – minimum wage for trainees, we were able to effectively share our concerns with the bills’ respective authors early in the legislative process. Both bills, for different reasons, failed to move through the legislative process in 2017 (**AB 148** was held on Senate suspense and **AB 387** failed deadline in the 1<sup>st</sup> house). Important to note, **AB 387** can resurface in 2018.

While not legislation, in 2017, Advocates, was successful in advocating for health center candidates for two Governor appointed openings on the California Healthcare Workforce Policy Commission (Song-Brown Commission). We are excited to share that the two commissioners have just started their new terms – Jasmeet K. Bains, MD (representing family medicine residents) and Deanna Stover, PhD., RN (representing practicing registered nurses).

Behavioral Health: With behavior health sponsored bills in back to back legislative sessions, and CPCA and CaliforniaHealth+ Advocates’ staff continuing to use regulatory, policy, and programmatic spaces to raise the profile of health center behavioral health expertise, this year Advocates was well positioned to influence behavioral health legislation. This year, the California Association of Licensed Professional Clinical Counselors (CALPCC), used CPCA’s 2016 Marriage and Family Therapist legislation (AB 1863) as a guide to replicate similar success for the Licensed Professional Clinical Counselors (LPCC). On multiple occasions, staff of the legislature came to Advocates to seek expertise on behavioral health workforce, the AB 1863 model, and how it could be used to advance **AB 1591 (Berman)** – the LPCC as FQHC as billable providers bill. In addition to our work on the bill, staff also prioritized work on **AB 1315 (Mullin)**. Signed on 10/2, the chaptered bill establishes a new advisory committee to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the purposes of creating an early psychosis and mood disorder detection and intervention competitive selection process that will expand the provision of high-quality, evidence-based services in this state by providing funding to counties for this purpose. While this does not change the Proposition 63 (MHSA) structures that drive funding to counties, this is a significant step in the right direction. The new advisory committee will be required to have a health center representative. The inclusion of this in the chaptered bill is a result of Advocate’s work with the Steinberg Institute (the bill’s sponsor) and recognizes the critical role of health centers in the delivery of behavioral health services.

Oral Health: Impact of the Little Hoover Commission’s scathing report on Denti-Cal could still be felt in the capitol this year. Additionally, the death of a young dental patient in Alameda, set off quick legislative action. In particular, Assemblymember Thurmond introduced **AB 224 – Dentistry anesthesia and sedation**. This bill, specifically related to pediatric anesthesia, would create new standards for the administration of minimal and moderate sedation included new staffing requirements and other changes that were of significant concern to members of CPCA’s Dental Directors Peer Network. At the request of these members, meeting were held with the bill’s author, sponsors, and other advocates close to the effort.

The bill, in its amended form, did alleviate member concerns. This bill failed deadline and could resurface in 2018.

Clinical Affairs: Coordinating closely with CPCA's CMO, clinical expertise was provided on numerous occasions. In addition to some of the bills referenced above, and similar to last session, Advocates, continued to educate Senator Hill on antimicrobial stewardship in the health center setting. This year, the Senator introduced a far trimmer antimicrobial stewardship bill that would solely impact laboratory settings (**SB 43**). The amended bill no longer targets a certain setting and, instead, aims to require the Antimicrobial Stewardship and Resistance Subcommittee of the Healthcare Associated Infections Advisory Committee of the department, on or before January 1, 2019. This bill failed deadline and could resurface in 2018. Early in session, we also consulted sponsors of **SB 528 (Stone)**, a bill regarding utilization of automated drug delivery system, on pharmacy infrastructure at health center.

Cannabis: With the passage of Proposition 64, The Adult Use of Marijuana Act of 2016, the California legislature went to work creating laws to guide the budding industry. Advocates is tracking this industries development and paying particularly close attention to bills that may impact how new revenues generated by this industry are spent. For example, Advocates met with Assemblymember Wood's staff on **AB 1135**, a bill that would require the State Department of Public Health and the State Department of Education to establish an inclusive public stakeholder process to seek input from stakeholders to determine a disbursement formula for the funds provided to the State Department of Health Care Services from the California Marijuana Tax Fund.

Lastly, in 2017, for the first time in some years, health centers were at the center of an opposition campaign (**AB 1250**) – Counties and Contracts for Personal Services. **AB 1250** was held in the Senate Rules Committee and was not brought to the floor. In the final weeks of session, health center advocates had a strong presence in the capitol and in local conversations regarding this bill. This is a significant short-term victory that could not have happened without the close coordination of health centers, consortia and partners across the state. Additionally, this effort provided an important opportunity to educate the legislature on the role of county and health center contracts in providing for the needs of our underserved communities. As this bill could move again in 2018, we cannot drop our guard and will be strategizing on how to proceed next session.

This fall, as the Capitol's staff prepare for the second year of session, the impact of our 2017 work can already be seen. In particular, other associations and interests are already coming to CaliforniaHealth+ Advocates with legislative concepts for 2018 and coalition partners are already meeting with Advocates staff to continue momentum on bill work that will continue into the second year.

#### IV. Resources

- 9/13/17\_Important Updates from the State Capitol: Changes, Fights & Opportunities in the Home Stretch –

[https://d3n8a8pro7vhm.cloudfront.net/capca/pages/2108/attachments/original/1507153884/2017.10.04\\_Resource\\_Email\\_Update.pdf?1507153884](https://d3n8a8pro7vhm.cloudfront.net/capca/pages/2108/attachments/original/1507153884/2017.10.04_Resource_Email_Update.pdf?1507153884)

- 2017-18 Enacted Budget Summary -

[https://d3n8a8pro7vhm.cloudfront.net/capca/pages/60/attachments/original/1498609423/Enacted\\_Budget\\_Summary\\_06.27.17.pdf?1498609423](https://d3n8a8pro7vhm.cloudfront.net/capca/pages/60/attachments/original/1498609423/Enacted_Budget_Summary_06.27.17.pdf?1498609423)

Date: October 3, 2017  
To: Legislative Committee  
From: Beth Malinowski, Deputy Director of Government Affairs  
Re: California 2017-18 Budget Implementation

**MEMORANDUM**

Since the enactment of the Budget Act of 2017, state agencies have moved forward with swift action to implement elements of the budget that are critical to advancing the health care delivery system. In the paragraphs below please find brief updates on some of these key efforts:

- **Primary Care Residency Funding Reinstated**

The Song-Brown Healthcare Workforce Training Program received a \$33M installment of new funds. In August, OSHPD moved forward with launching the new Song Brown Family Medicine and Primary Care Residency application, the revised application now utilized to access these new funds. The application period for existing and new programs opened mid-August and closed mid-September. Seventy-seven applications were received, which included ten applications for new programs. With 48 family medicine and 29 PCR (Internal Medicine, OB/GYN, and Pediatric) applications received this year, OSHPD staff have confirmed that this is the largest number of applications the program has ever received. Awards will be determined during the November 29-30, 2017 Song Brown meeting in Southern California. Staff monitored the application process, providing technical assistance as needed, and will be tracking application decisions closely.

- **Community Clinic Lifeline Grant Program**

California Health Facilities Financing Authority (CHFFA) staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. In August CHFFA began outreach to key stakeholders. CHFFA has also hosted two stakeholder webinars.

CPCA is working with CHFFA staff, and monitoring the implementation closely. This includes meeting with CHFFA staff regularly, including Ron Washington, Interim Director of CHFFA. CPCA intends to help CHFFA staff gather feedback and create a program that is most responsive to the needs of community clinics and health centers. In that spirit, CPCA is hosting a Lifeline Grant Program Webinar on Tuesday, October 17 at 11:00 a.m. Please [click here](#) to register. Feedback gathered on the 10/17 webinar will be turned into formal comments and submitted to CHFFA in advance of their October 26 board meeting. *Please see Government Programs Committee for an additional memo.*

If you have additional questions or feedback on program implementation, please email Michael Helmick - [mhelmick@cpc.org](mailto:mhelmick@cpc.org).

- **Proposition 56 Supplemental Payments**

As part of the spending plan agreement, DHCS had until July 31, 2017 to determine the rules for allocating these supplemental payments. Honoring this deadline, DHCS has outlined payment methodologies and begun submitting state plan amendments for the use of California Healthcare, Research and Prevention Tobacco Tax Act funds for supplemental payments. Pending SPA approval (SPA 17-029), FQHCs will be eligible for supplemental payments for FPACT services, but will not be eligible for any other Prop. 56 supplemental payments. These payments will be retroactive to July 1, 2017. *Please see 330 Committee for an additional memo.*

- **AB 1863**

CPCA continues to work with DHCS on the state plan amendments, one of which will be MFT implementation to be billable providers by July 2018. This element of the SPA has not yet commenced but DHCS intends to include it in the SPA that will be submitted to CMS in December.

CPCA will continue to update members on implementation of these and other budget items as the fiscal year progresses.

# California Primary Care Association Public Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

## Coverage and Access for All

- Protect Californians' right to comprehensive health care **coverage**.
- Ensure Californians' in rural and urban areas have **access** to vital health care services that meet the comprehensive healthcare needs of individual patients and communities.

## Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services

- Continue to refine and develop an **innovative financial model** for health center reimbursement that leverages the unique strengths of health centers and positions them to meet patients where the patient is at.
- Empower patients to access and utilize healthcare services appropriately by advancing policy which allows and incentivizes the seamless **integration of primary, oral, and behavioral health care** services.
- Help rural and urban communities strengthen the **behavioral health delivery system** through coordination of mental health and substance use disorder service in the primary care setting.
- Support patients by strengthening **culturally competent care, case management, preventative care, and coordination of care with social services and community resources**.
- Improve the quality and delivery of care to patients by promoting healthcare innovation and quality improvement through systemic **Pay-for-Performance** and **shared savings** programs.

## Strong Workforce and Core Business Infrastructure

- Counter the nation's shortage of healthcare providers, especially in underserved communities, by maintaining funding for innovative **residency programs**, improving **loan repayment programs**, reforming **provider licensing**, and championing novel workforce development strategies.
- Advocate for **equitable and transparent reimbursement policies** and the application of those policies in a standardized and timely fashion.

## Building Healthy Communities

- Address the **social determinants of health** that affect families we serve. By looking at "upstream" non-clinical factors, we aim to disrupt the trajectory of poor health and instead, help people build a core foundation of health in their communities.

**California Primary Care Association - Policy Platform 2018**

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

Objective	ACTION - IMPLEMENTATION		
	Legislative	Administrative	Educational
<b><u>Coverage and Access for All</u></b>			
Protect Californians' right to comprehensive health care coverage.	<ul style="list-style-type: none"> <li>-Working with NACHC, continue aggressive federal advocacy for solutions that promote long-term 330 program funding stability.</li> <li>- Advocate for federal and state protections to the ACA and Medicaid to ensure as broad and inclusive a benefit package as possible, including primary/behavioral/oral health care.</li> <li>- Engage in the universal coverage/single payer efforts in a robust and thoughtful manner using member-informed, board approved principles.</li> <li>- Continue to fight for an inclusive country that welcomes and protects all persons regardless of immigration status.</li> </ul>		
Ensure Californians' in rural and urban areas have access to vital health care services that meet the comprehensive healthcare needs of individual patients and communities.	<ul style="list-style-type: none"> <li>- Continue to advocate for a robust and comprehensive health care delivery system where patients have choice of providers, including Planned Parenthood.</li> <li>- Continue to fight for an inclusive country that welcomes and protects all persons regardless of immigration status.</li> <li>- Continue to lay the necessary ground work that will lead to the elimination of unnecessary barriers to care, including licensing and building code rules that prevent the creation and operation of safe new health centers.</li> <li>- Add the necessary provisions to AB 2053 - the consolidated licensing bill- to allow an intermittent site that moves to full time to continue to use the parent site's PPS rate</li> </ul>	<ul style="list-style-type: none"> <li>- Work with DHCS to develop educational tools for dental providers to help ensure that when audits are done the rules and expectations are understood well in advance.</li> <li>- Build strong working relationships with OSHPD and DPH to further our licensing and building code interests.</li> <li>- Engage with OSHPD to build a better process for flex requests and reform OSHPD 3 regulations.</li> </ul>	<ul style="list-style-type: none"> <li>-Educate policy makers on the challenges with OSHPD3</li> <li>-Provide training opportunities related to licensing and OSHPD 3 standards.</li> </ul>
<b><u>Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services</u></b>			
Continue to refine and develop an innovative financial model for health center reimbursement that leverages the unique strengths of health centers and positions them to meet patients where the patient is at.		<ul style="list-style-type: none"> <li>- Work to ensure a value based APM is implemented in CA in a manner that is supportive of FQHCs</li> </ul>	<ul style="list-style-type: none"> <li>- Continue to position health centers for the APM through the CP3 (Capitation Payment Preparedness Program)</li> <li>- Disseminate best practices to non APM sites</li> <li>- Work towards risk stratification for SDOH. Build data gathering into APM pilot and work with NACHC on a national strategy.</li> </ul>
Empower patients to access and utilize healthcare services appropriately by advancing policy which allows and incentivizes the seamless integration of primary, oral, and behavioral health care services.	<ul style="list-style-type: none"> <li>- Determine whether or not there are legislative approaches to enhance health center capacity to meet the behavioral health need of patients. Could include same day billing legislation.</li> </ul>	<ul style="list-style-type: none"> <li>- Implement AB1863 MFT to ensure billing for MFTs is as easy as doing a scope change</li> <li>- Ensure that CCHCs are recognized for the important role that they play in the BH delivery system, and ensure that MSHA funding is available to support their BH work.</li> </ul>	<ul style="list-style-type: none"> <li>- Engage with county BH directors and others to showcase the ways in which CCHCs can partner with county-based BH delivery systems</li> <li>- Support clinic and health center participation in the Dental Transformation Initiative.</li> </ul>
Help rural and urban communities strengthen the behavioral health delivery system through coordination of mental health and substance use disorder service in the primary care setting.		<ul style="list-style-type: none"> <li>Implement SB 323- Drug Medi-Cal and Specialty Mental Health contract services and FQHCs</li> </ul>	<ul style="list-style-type: none"> <li>- Provide technical assistance on behavioral health contracting and billing processes to ensure that CCHCs are fully able to participate in the BH delivery system.</li> </ul>

**California Primary Care Association - Policy Platform 2018**

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Objective	ACTION - IMPLEMENTATION		
	Legislative	Administrative	Educational
Support patients by strengthening culturally competent care, case management, preventative care, and coordination of care with social services and community resources.	- Ensure that "services that follow the patient" are left out of reconciliation	- Work with the state to develop robust and appropriate 340B claims processes to ensure health centers are protecting the state from duplicate discounts.	- Help health centers better understand the rules of 340B and how to best track the savings to ensure program integrity. - Working with the health plans, facilitate a coordinated implementation of the Health Home Program with the goal of ensuring the plans and providers implementing the benefit save the state money and the benefit remains in perpetuity
Improve the quality and delivery of care to patients by promoting healthcare innovation and quality improvement through systemic Pay-for-Performance and shared savings programs.	- explore opportunities to mitigate the challenges posed by assigned but unseen Medi-Cal beneficiaries		- Rebrand and enhance the CP3 program to focus and tailor to the P4P programs and to be for all health centers regardless of APM interest

**Strong Workforce and Core Business Infrastructure**

Counter the nation's shortage of healthcare providers, especially in underserved communities, by maintaining funding for innovative residency programs, improving loan repayment programs, reforming provider licensing, and championing novel workforce development strategies.	<p>- At the Federal Level, work with NACHC, AATHC, and Clinicians for the Underserved to stabilize Federal funding solutions and HRSA policies that strengthen investments in Teaching Health Centers and National Health Service Corp.</p> <p>- At the state level, work to develop a comprehensive workforce policy platform through a policy convening to centralize our work into one coalition, to create and foster the ability to influence graduate medical education reform, expansion of the primary care team, and continue to support policy that grows the workforce pipeline.</p> <p>- State advocacy to ensure the the Brown Administration remains committed to the \$100 M workforce investment.</p>	<p>- Working with NACHC and OSHPD inform conversations on HPSA rescoring and methodology</p> <p>-- Participate in stakeholder groups at multiple state agencies, aim to inform and influence a statewide health workforce agenda that centers on the needs of health center patients. Included, but not limited to, expanded funding of loan repayment, reintroduction of state GME funding, and supporting pipeline and educational programs/partnerships that diversify our provider workforce</p> <p>- Work with OSHPD, on implementation of provision of AB 2048 (Gray) - State Loan Repayment Program.</p> <p>- Work with OSHPD and partners on implementation of \$100 million investment in primary care residency and loan repayment.</p> <p>- Develop stronger relationships with Kaiser, ACU, AHEC, and other organizations to influence provider recruitment and retention.</p> <p>-Work with academic and foundation partners (including UCSF, Kaiser, CHCF) to advance research that will support our workforce strategy.</p> <p>- Strengthen relationships with licensing boards to guarantee timely licesnure for providers in rural and underserved communities</p>	<p>- Work with health centers to maximize their utilization of state and federal opportunities related to healthcare workforce (this includes increasing use of OSHPD programs like SLRP).</p> <p>- Provide statewide learning opportunities around innovative workforce models, and partner with higher learning institutions to influence positive change in primary care degree/certificate programs.</p> <p>- Support teaching health center and hospital/health center residency partnerships by connecting health center to training and experts on residency development.</p> <p>-Educate health centers on how to expedite processing of provider licenses.</p>
Advocate for equitable and transparent reimbursement policies and the application of those policies in a standardized and timely fashion.  Complete Packet 233 of 342		<p>- Work with A&amp;I to ensure that auditors are working with health centers in a transparent and fair manner and that rules are understood and agreed upon by both health centers and state auditors</p> <p>- Continue working with A&amp;I and health centers on an FQHC SPA that protects and strengthens FQHC interests and ensures clear, transparent, and standardized rules.</p>	

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Objective	ACTION - IMPLEMENTATION		
	Legislative	Administrative	Educational
<b><u>Building Healthy Communities</u></b>			
Address the social determinants of health that affect families we serve. By looking at "upstream" non-clinical factors, we aim to disrupt the trajectory of poor health and instead, help people build a core foundation of health in their communities.	<ul style="list-style-type: none"> <li>- Continue to support legislative solutions to address healthy communities (for example, Sugar Sweetened Beverage Tax, Housing, Medi-Cal rates for electric breast pumps).</li> <li>- Support critical partners in the social safety net like WIC, CalFresh</li> </ul>		- Help spread use of a tool to capture SDOH

Date: September 19, 2017

To: Legislative Committee

From: Andrea Chavez, Senior Program Coordinator of Public Affairs

Re: External Communication Priorities

MEMORANDUM

### **Recommendation for Proactive External Communications Strategy**

Over the past year, CaliforniaHealth+ Advocates has strived to have a more robust external communication strategy. We have created timelines and processes to ensure the health center perspective is a part of all major health policy debates taking place. We have externally communicated to the media and stakeholders on a variety of different issues including: ACA repeal, workforce, Planned Parenthood, immigration, and protecting Medicaid. While all of the issues are central to CPCA's legislative and policy priorities, we have primarily been reactive to the policy debates of the day and the issues have not been framed around a common theme, thus diluting the potential for our external communications efforts to be a tool that advances our policy objectives.

To deliver greater impact on key priorities, and to build and deepen CaliforniaHealth+ Advocates brand recognition, staff recommend for 2018 that we focus external communications to a core message and a few select policy objectives. Working deliberately with the consortia and health centers, Advocates' will have a yearlong plan that proactively engages media and stakeholders.

The recommended approach has the advantages of resonance (one unified health center voice), brand recognition (clarity and trust), and impact (policy victories). The consequence, however, is that Advocates will not engage in every issue. We must first have brand recognition and trust before we can begin to weigh in on any and all issues related to health.

### **2018 Recommended Policy Priorities**

Staff has created a core message framework for Advocates:

#### ***Overarching Message***

CaliforniaHealth+ Advocates aims to advance policies that ensure all Californians, regardless of race, gender, sexual orientation, or immigration status have affordable health care coverage, and access to comprehensive and culturally-appropriate services so that health and prosperity can be realized by all.

The three themes in the core message are Coverage/ Access/ Social Justice

Staff recommends focusing external communications on the following three policy priorities that members identified as high priority during the policy prioritization process as viewed through the core message lens:

- Access: Workforce
- Coverage: Protecting Medicaid

- Social Justice: Immigration – health for all

All three issues meet one, or all, of the below factors that constitute “newsworthiness,” some of course better than others:

- **Timely:** The issue is current and relevant.
- **Significant:** The number of people affected.
- **Local Impact (Proximity):** local significance and resonance.
- **Prominent:** High profile issues or well-known players receive more coverage.
- **Human Interest:** Pulls at the heart.

Issue Analysis : Newsworthy					
Issue	Timely	Significant	Local Impact	Prominent	Human Interest
Coverage: Protecting Medicaid	Currently under attack by President and GOP	If ACA is repealed, millions of people will lose coverage	Impacts local economies and California as a state	President Trump & well-known GOP representatives are prominent voices in these discussions	There are people with stories of how Medicaid has helped them or how repealing ACA would impact them
Access: Workforce	There is a real and documented health workforce shortfall	California is short thousands of primary care providers	Impacts towns/cities throughout CA		Find stories about how a workforce shortage is impacting peoples’ ability to access care
Social Justice: Immigration (Example: DACA)	Currently under attack by President and Administration	Impacts nearly 800,000 young people across the nation	California is home to nearly 223,000 DACA recipients - the highest in the nation.	President Trump and his Administration are prominent voices in these discussions	Dreamers have come forward with personal stories about how scared they are about being deported to a country they’ve never known

**Media Relations Components**

Advocates would like to work with members and consortia to proactively engage media and stakeholders on these three priority policy issues, to help establish health centers as a prominent voice and as an expert resource for media. The following strategies are recommended:

**1. Earned Media**

- **Editorial Board Meetings:** Schedule editorial board meetings with targeted publications to discuss policy priorities. These meetings will include representatives from Advocates, as well as selected members in the region.

- **Develop & Place Op-eds/LTEs:** Identify and place Letter-to-the-Editors (LTE) on behalf of members or op-eds on behalf of Advocates’ CEO in key regional and local media (i.e. The Sacramento Bee, San Francisco Chronicle). Op-eds give us the opportunity to provide a more in-depth point of view on subjects and LTE’s help give the community health clinics a voice in their region.
- **Develop WTAS:** Develop “What they are saying” documents twice a month to send to reporters and legislators. Sending WTAS helps highlight the opinion of health leaders who support Advocates’ mission, including health center leaders.
- **Develop ICYMI:** Format “In Case You Missed It” for all relevant news hits to send to target media list and legislators, subsequently helping to keep health centers at the top of mind.
- **Develop Health Center Contact List:** This will be a master spreadsheet that has contact name numbers for health center leaders throughout the state that have already agreed to speak to reporters on each of these issues. This will help Advocates’ facilitate last-minute media requests, ensuring we take advantage of all media opportunities.
- **Media Training:** Hire a firm to conduct a media training for media key to help them successfully convey key messages
- **Statements/Press releases:** Develop statements or press releases to send statewide.
- **Reporter Outreach:** Continue to follow up with reporters who expressed interest to provide additional information and determine coverage opportunities.
- **Media Monitoring:** Monitor media and personally follow up with reporters writing about relevant topics letting them know that Carmela is available for future interviews.

2. Proactive Digital/Social Media

- **Social Media Content Calendars:** Develop social media content that further communicates key messages and objectives and advocacy priorities.
- **Paid Digital:** Recommend only utilizing paid digital for high profile campaigns on hot button topics.
- **Develop Infographics & Videos:** Utilize infographics and videos to tell the California Community Health Center Story as it relates to each of the issues.

Sample: 2018 First Quarter Timeline*	
Month	Activities
January (Preparation)	<ul style="list-style-type: none"> <li>• Develop Editorial Calendar</li> <li>• Schedule editorial board meetings with target publications &amp; with members for February &amp; March</li> <li>• Develop materials for editorial board meetings on priority issues</li> <li>• Develop Health Center Media Contact List</li> <li>• Hold media training for media contacts</li> <li>• Develop social calendars, infographics and videos</li> </ul>
February (Execution)	<ul style="list-style-type: none"> <li>• Attend editorial board meetings</li> <li>• Identify pitch opportunities for priority communications</li> <li>• Reporter outreach</li> <li>• Develop WTAS and ICYMI following media hits and send to target</li> </ul>

	reporters and legislators <ul style="list-style-type: none"> <li>• Develop and place at least one op-ed per issue</li> <li>• Media monitoring</li> <li>• Execute social calendars</li> </ul>
<b>March (Execution)</b>	<ul style="list-style-type: none"> <li>• Attend editorial board meetings</li> <li>• Identify pitch opportunities for priority communications</li> <li>• Reporter outreach</li> <li>• Develop WTAS and ICYMI following media hits and send to target reporters and legislators</li> <li>• Develop and place at least one op-ed per issue</li> <li>• Media monitoring</li> <li>• Execute social calendars</li> </ul>

*\*The execution will largely depend on the media cycle and unexpected events that happen at the Federal and State level. While our messaging will be the same, Advocates' will closely monitor media coverage to find opportunities to capitalize on media trends.*

###

Date: September 27, 2017  
To: Legislative Committee  
From: Janalynn Castillo, Advocacy Coordinator  
Re: Grassroots Advocacy

**MEMORANDUM**

**I. Background**

***Insights from 3rd Quarter Advocacy: July - September 2017***

Last November, we knew that the effort to repeal and replace the Affordable Care Act (ACA) was a top priority for President Trump and the GOP. Eleven months later, we continue to fight for access and coverage for our patients. In this quarter alone, we activated our grassroots network to fight three ACA repeal legislation attacks. But we didn't stop there. Even with all of these threats, our collective advocacy preserved California's \$100 million for primary care workforce and successfully pushed CPCA's sponsored state legislation through the legislative process. This quarter, members asked CaliforniaHealth+ Advocates (Advocates) to provide more CA-specific messaging and advocacy activities, and we listened by launching a #ProtectMedicaid advocacy tool kit for ACA repeal attacks and innovative National Health Center Week (NHCW) engagement activities such as, a statewide health center photo contest and a two-week NHCW health center recognition banner displayed at the entrance of the Governor's office. ACA repeal efforts will continue, Medicaid attacks will arise in new ways, and we are no closer to fixing the health center funding cliff. Work will need to continue into the fourth quarter -we must continue to fight back.

Our member's strength and commitment to enact an advocacy infrastructure at all levels of the organization is more important than ever. CPCA's state legislative agenda and federal advocacy will only be successful through our continued partnership with the RAC, CPG and all of you. This is an opportunity for membership to revisit and identify areas of improvement to CPCA's advocacy infrastructure.

Please review the opportunities listed below and commit to at least one by signing our advocacy pledge card by October 18. Your participation is needed to help strengthen our unified advocacy infrastructure and presence throughout the state. In January, Advocates will report on what opportunities worked well and areas we can revisit in the fourth quarter.

**II. Advocacy Opportunities**

***Opt-in Advocacy: 10k Campaign***

At CPCA's Annual Conference in October, Advocates will launch a 10k in 100 days campaign to increase the current statewide grassroots network count from 8,500 to 10,000 by the end of January. With recent feedback from a member-wide advocacy survey, we created an online California-specific action center for people to sign up and become a health center advocate. Our goal is 1,500 new sign-

ups in 100 days. In September, we launched a mini version of the 10k campaign and 200 new advocates opted in to participate in local, state, and federal advocacy campaigns within a 7 day period. Imagine the impact to our statewide grassroots network with a 100 day sign-up period! Please join the 10k Campaign webinar in mid-October for member participation details and resources to continue the growth and effectiveness of the advocacy network as a whole.

***State Advocacy: Letters of Support for the 2018 Legislative Cycle***

CPCA's sponsored legislation successfully made it to the Governor's desk for signature. We would like to thank you for your engagement and response to submit letters of support (LOS). CPCA's advocacy approach for the final stage included outreach to all members and targeted outreach to partner organizations. LOS continue to be an effective tool in our advocacy because they establish an official record and show our statewide strength. It is important to recognize that LOS must be updated as the bills move through the legislative process. In the third quarter, the return rate on LOS declined during the legislative process and up until the Governor's desk. As we prepare for the 2018 legislative cycle, we would like your help to identify ways to maintain a high rate of LOS during the legislative process. Please provide your feedback to [jana@healthplusadvocates.org](mailto:jana@healthplusadvocates.org).

***Public Affairs Peer Network***

CPCA's Public Affairs Peer Network (PAPN), which convenes a monthly call, provides a forum for health center and consortia staff who engage in public affairs work (government, community, media, advocacy, etc.) to share best practices and learn from one another. Going forward, it is the intent of the PAPN to continue dialogue on ways to strengthen advocacy and in turn provide feedback to Advocates' staff on how to best support health centers in state and federal legislative engagement. If you would like to be included in future PAPN calls, please contact Kelley Aldrich at [kaldrich@cpca.org](mailto:kaldrich@cpca.org)

***NACHC - Advocacy Centers of Excellence (ACE)***

An Advocacy Center of Excellence, or ACE, is a Health Center that has achieved certain measures of advocacy success and demonstrated ongoing commitment to advocacy by making it an organizational priority. ACEs are actively engaged and involved with NACHC and federal policy issues, as well as their state Primary Care Association. Today there are three California health centers currently participating in ACE. With the influx of federal policy issues, Advocates will host a call in mid-November to revisit California's ACE participation and interest amongst members.

**III. Discussion**

- What else can we be doing to support your organization's advocacy infrastructure?
- How can we help increase your social media and/or online presence?



**Board of Directors**  
 Wednesday, October 11, 2017  
 12:15 – 2:30p  
 Hilton Anaheim, Laguna A/B

**Naomi Fuchs, Chair**

**Agenda**

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Naomi Fuchs, Chair	A
II. Approval of Agenda		Naomi Fuchs, Chair	A
III. Consent Calendar • Approval of Minutes	• July 14, 2017, Minutes	Naomi Fuchs, Chair	I/D/A
IV. CEO Report	• Final 2018 Board Calendar • <i>Memo: "CPCA Training Program and TA Update"</i>	Carmela Castellano-Garcia	I/D
V. Approval of Financial Audit for FY 2016-17	• 2017 Audit and Findings Report	Matt Krehe, CPA, Sr. Manager, Gilbert & Associates	I/D/A
VI. Financial Presentation	• Board Financial Presentation • Financial Reports ending August 31, 2017	Carmela Castellano-Garcia and Sandy Birkman	I/D/A
VII. Speaker: Mr. James Luisi, new NACHC Board Chair and CEO of North End Waterfront Health in Boston, MA	• Bio	James Luisi, NACHC Board Chair	I/D
VIII. Epic Partnership Update	• <i>Memo: Corporate Structure &amp; Governance Model for CPCA-led Epic Program (w/ 3 attachments)</i> • Epic Business Plan • TAG Workgroup Summary • Board Workgroup Summary	Carmela Castellano-Garcia with Andy Principe and Robert Beaudry	I/D/A
IX. Approval of Committee Action Items and Brief Informational Reports	• AG Worker Health • Audit • Clinicians  • Executive • Finance/Ventures Finance • 330 • Governance • Government Programs • Legislative	• Leslie McGowan • Tony Weber • Anitha Mullangi & Ellen Piernot • Naomi Fuchs • Kevin Mattson • Corinne Sanchez • Mary Szecsey • Isabel Becerra • David Vliet	I/D/A

	<ul style="list-style-type: none"> <li>Rural Health</li> <li>Workforce</li> </ul>	<ul style="list-style-type: none"> <li>Lucresha Renteria</li> <li>Dean Germano</li> </ul>	
X. California Health+ Advocates Board seats	<ul style="list-style-type: none"> <li>Memo: <i>“Designation of CaliforniaHealth+ Advocates Board Members for 2018”</i></li> </ul>	Carmela Castellano-Garcia	I/D/A
XI. NACHC Update (recurring)		David Vliet, new NACHC Region IX rep	I
XII. RAC Update (recurring)		Ralph Silber, CEO, Alameda Health Consortium	I
XIII. Outgoing Chair Report		Naomi Fuchs	I
<b>NEW BUSINESS</b> XIV. Seating of FY 2017-18 Board of Directors	(Chair Elect from 2016-17 Immediately Assumes Chair role)	Naomi Fuchs; Outgoing Chair & Scott McFarland, Incoming Chair	A
XV. Election of FY 2017-18 Board Officers * A. Chair-Elect B. Secretary C. Treasurer D. Speaker E. Vice-Speaker F. Members-at-Large (3)  * Officers elected one at a time in the order noted above		Scott McFarland, Chair	A
XVI. Adjourn Board (Scott); convene Ventures Board (Naomi)		Scott McFarland, Chair & Naomi Fuchs, Chair	A
<i>Additional Attachments:</i>	<ul style="list-style-type: none"> <li>CPCA Code of Conduct</li> <li>Board Attendance Policy</li> </ul>		I

## Board of Directors Meeting

July 14, 2017

### Meeting Minutes

**Board Members Present :** *Chair-Elect:* Scott McFarland, Robin Affrime, Isabel Becerra, Doreen Bradshaw, Ben Flores, Cathy Frey, Jane Garcia, Britta Guerrero, Nik Gupta, Kerry Hydash, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, Tim Rine, Jackie Ritacco, Ralph Silber, Paulo Soares, Graciela Soto-Perez, Mary Szecsey, David Vliet, Paula Wilson

**Members Absent:** Deb Farmer, Naomi Fuchs, Sherry Hirota, Richard Veloz

**Guests:** No guests signed in.

**Staff:** Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Sandy Birkman, Andie Patterson, Ginger Smith, Robert Beaudry, Val Sheehan, Erin Perry, Jodi Samuels

#### **1. Call to Order**

Chair-elect Scott McFarland called the meeting to order at 10:15a.

#### **2. Closed Session**

The Board convened a Closed Session from 10:15 – 10:35a for the purpose of discussing the CEO's evaluation. The Board meeting was reconvened at 10:35a.

#### **3. Approval of Agenda**

A revised agenda was distributed prior to the start of the meeting, adding the Committee Action reports.

##### **Motion**

A motion was made and seconded to approve the agenda as presented (McCarthy/Frey). **The motion carried.**

#### **4. Consent Calendar**

##### **Motion**

A motion was made and seconded to approve the Consent Calendar (Lynch/Myers). **The motion carried.**

#### **5. CEO Report**

Carmela Castellano-Garcia, President and CEO, provided a brief report and thanked members who attended the summer membership appreciation event at her home the prior evening. She thanked the Government Affairs staff for their hard work and success around the budget, noting that CPCA and CaliforniaHealth+ Advocates are gaining more clout in the Capitol. Carmela introduced the newest staff members and summer interns.

## **6. Approval of Committee Action Items**

**AG Worker Health** – no report.

**Audit** – N/A

**Clinicians** – no report.

**Executive** – no report.

**Finance/Ventures Finance** –

### **Motion**

A motion was made and seconded to approve the allowable and unallowable cost policy. (Mattson/Gupta). **The motion carried.**

### **Motion**

A motion was made and seconded to approve the financials as presented. (Mattson/Frey). **The motion carried.**

**330** –

### **Motion**

A motion was made and seconded to move the proposed P4P draft position for approval (Lynch/Szecsey). **The motion carried.**

### **Motion**

A motion was made and seconded to authorize CPCA staff to support DHCS' proposed language with the State Plan Amendment on productivity standards and 90-day requirement upon approval from the members participating on the SPA webinars and legal review by Kathryn Doi, Attorney at Hanson Bridgett, LLP (Lynch/Ritacco). **The motion carried.**

**Governance** –

### **Motion**

A motion was made and seconded to approve the suggested Bylaws changes to go to membership vote. (Szecsey/Myers). **The motion carried.**

### **Motion**

A motion was made and seconded to accept staff's recommendation for the non-member Associate fee structure and benefits. (Szecsey/Frey). **The motion carried.**

**Government Programs** – no report.

**Legislative** –

### **Motion**

A motion was made and seconded to take an "Oppose unless Amended" position on AB 1250 (Jones-Sawyer) re: Counties – contracts for personal services. (Vliet/Rine). **The motion carried.**

### **Motion**

A motion was made and seconded to take the staff's recommendation of moving from "Watch" to "Support" on AB 1350 (Maienschein) re: Continuing medical education: mental and physical health care integration. (Vliet/McCarthy). **The motion carried.**

**Rural Health** – no report.

**Workforce** – no report.

### **7. Strategic Plan Work plans**

Carmela Castellano-Garcia provided a brief report regarding the Strategic Plan 2017-2020 High Level Work plans, noting that a high level status report and any relevant work plan updates will be provided at the January and July Board meetings. Feedback included the need for the plans to address specific state and federal issues such as OSHPD3. Updates will be made accordingly.

### **8. Epic Partnership**

Consultant Andrew Principe, Starling Advisers, was in attendance to present information related to the proposed CPCA/Epic partnership for an HIT platform for CCHCs. Members were directed to PowerPoint slides in the Board packet for this discussion. Additional handouts included a pro forma and roles and responsibilities document. All related Epic documents are currently considered drafts.

Today is meant to be a discussion rather than a decision-making session. The CPCA Executive Committee is specifically charged with reviewing any counter-proposal before submission, and the Board will also have the opportunity to review the counter proposal. Staff envisions a Board call in late August/early September to review a counter-proposal. There is also a Technical Advisory Group (TAG) that is comprised of the nine (9) health centers who have currently expressed interest in exploring an Epic partnership and who accompanied staff on a recent visit to Epic headquarters in Madison, WI. The TAG will also be reviewing the pro forma and counter-proposal before it goes to the Board and Executive Committee who will have final approval.

#### **Motion**

A motion was made and seconded to: 1) allow CPCA to continue with the budgeted funds to explore the partnership further; 2) slow down the timing; 3) form a subcommittee of other interested Board members along with the Executive Committee; and 4) explore organizational models and related questions. (Hydash/Becerra) **The motion carried.**

Regarding approaching Foundations for potential funding, the general consensus is that while this is something staff will explore, the timing is not yet right due to the infancy of the project. Members were urged to send additional strategic questions, and/or to express interest in participating, to COO Robert Beaudry.

### **9. NACHC Board Report**

Ben Flores, current Region IX NACHC representative, was unable to attend NACHC's most recent Board. He noted that Dr. George Sigounas is new HRSA Administrator; Jim Macrae goes back to the Bureau and Tonya Bowers moves back to Deputy Administrator.

### **10. RAC Update**

RAC Chair Suzie Shupe gave a brief update. She noted the California Wellness advocacy/communications grant and that Imprenta was the communications firm selected. A kick-off meeting with the Consortia will be planned for August, or the group may use their scheduled Staff Day if need be.

### **11. Adjourn**

There being no further business, the Board meeting was adjourned at 12:35p.

## CPCA 2018 BOARD MEETING CALENDAR

\*\* Dates will be based on event space availability, even after Board approval.

### Board & Committee Meetings

Thursday - Friday, January 18-19, 2018

Sacramento – TBD

**(NACHC Winter Strategy Mtg. – January 25-27, 2018 in Delray Beach, FL)**

### Day at the Capitol / Board & Committee Meetings

Wednesday, April 25 2018

Day at the Capitol & Reception

Sacramento – TBD

Thursday-Friday, April 26-27, 2018

Committee & Board meetings

Sacramento – TBD

**(NACHC P&I – March 14-18, 2018 in Washington, D.C.)**

**(NACHC Conf. for Agricultural Worker Health – May 5-7, 2018 in San Antonio, TX)**

*Mar. 31-Apr. 7, 2018*

*(Passover Week)*

*April 1, 2018*

*(Easter Sunday)*

### Board & Committee Meetings

Thursday-Friday, July 12-13, 2018

Sacramento – TBD

**(NACHC CHI – August 24-28, 2018 in Orlando, FL)**

### **\*\* Annual Conference / Board & Committee Meetings**

Tuesday-Wednesday, October 2-3, 2018

Board & Committee meetings

Sacramento – TBD

Thursday-Friday, October 4-5, 2018

Annual Conference

Sacramento Conv. Ctr.

**(NACHC PCA/HCCN Conference – Nov. 14-16, 2018 in New Orleans, LA)**

**(NACHC FOM/IT Conference – Oct. 16-18, 2018 in Las Vegas, NV)**

*Sept. 10, 2018*

*(Rosh Hashanah)*

*Sept. 19, 2018*

*(Yom Kippur)*

*Sept. 24-30, 2018*

*(Sukkot)*



## CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATE

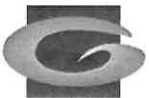
### Communications With Those Charged With Governance

*Submitted by*

**Gilbert Associates, Inc.**

We have audited the financial statements of the California Primary Care Association and Affiliates (the Association) for the year ended March 31, 2017. Professional standards require that we provide you with information related to our audit. We are providing the Association's Audit Committee with information regarding the scope and results of the audit to assist the Audit Committee in overseeing management's financial reporting and disclosure process. This information is intended solely for the use of Audit Committee, and management of the Association and is not intended to be, and should not be, used by anyone other than these specified parties. The following pages summarize these required communications.

September 18, 2017



**Gilbert Associates, Inc.**  
CPAs and Advisors

*Relax. We got this.™*

Complete Packet 247 of 342

## MANAGEMENT AND AUDITOR RESPONSIBILITIES

**Auditors' Responsibilities under Generally Accepted Auditing Standards (GAAS), *Government Auditing Standards*, issued by the Comptroller General of the United States, Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance)*.**

The financial statements are the responsibility of management. As stated in our engagement contract, our responsibility is to express opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles (GAAP). Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we considered the Association's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinions on the financial statements and not to provide assurance on the internal control over financial reporting. We also considered internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with Uniform Guidance.

As part of obtaining reasonable assurance about whether the Association's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit.

Also in accordance with Uniform Guidance, we examined, on a test basis, evidence about the Association's compliance with the types of compliance requirements described in the "U.S. Office of Management and Budget (OMB) Compliance Supplement" applicable to its major federal program for the purpose of expressing an opinion on the Association's compliance with those requirements. While our audit provides a reasonable basis for our opinion, it does not provide a legal determination on the Association's compliance with those requirements.

We issued an unmodified opinion on the consolidated financial statements of the Association for the year ended March 31, 2017.

## QUALITATIVE ASPECTS OF ACCOUNTING PRACTICES

### Significant Accounting Policies

Management is responsible for the selection and use of appropriate accounting policies. In accordance with the terms of our engagement letter, we will advise management about the appropriateness of accounting policies and their application.

The significant accounting policies used by Association are described in notes to the financial statements.

The Association consolidated the accounts of CaliforniaHealth Plus Advocates for the year ended March 31, 2017 in accordance with GAAP. No new accounting policies were adopted and no other application of existing policies was changed during 2017. No new accounting policies were adopted and the application of existing policies was not changed during 2017.

We noted no transactions entered into by the Association during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

### Management Judgments and Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users.

We considered the methodologies and judgments used in assessing the collectability of loans and other receivables, the selection of useful lives of property and equipment, and the allocation of functional expenses. We evaluated the key factors and assumptions used to develop these estimates in determining that they are reasonable in relation to the financial statements taken as a whole. In addition, the related financial statement disclosures are neutral, consistent and clear.

## INTERACTIONS WITH MANAGEMENT

<b>Planned Scope and Timing of the Audit</b>	We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter.
<b>Management Consultations with Other Independent Accountants</b>  In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a “second opinion” on certain situations. If a consultation involves application of an accounting principle to the Association’s financial statements or a determination of the type of auditor’s opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.	To our knowledge, there were no such consultations with other accountants.
<b>Disagreements with Management</b>  For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor’s report.	We are pleased to report that no such disagreements arose during the course of our audit.
<b>Management Representations</b>	We have requested certain representations from management that are included in their letter to us.
<b>Difficulties Encountered in Performing the Audit</b>	We encountered no significant difficulties in dealing with management in performing and completing our audit. Management and staff were well prepared and cooperative.

## OTHER MATTERS

<p><b>Other Audit Findings or Issues</b></p>	<p>We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Association's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.</p>
<p><b>Corrected and Uncorrected Misstatements</b></p> <p>Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management.</p>	<p>No significant adjustments or omitted disclosures were identified during our audit.</p>
<p><b>Supplementary Information</b></p> <p>With respect to the supplementary information accompanying the financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with accounting principles generally accepted in the United States of America, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.</p>	<p>The supplemental consolidating financial statements, as listed in the table of contents, are presented for the purpose of additional information to financial statement users, and in our opinion are fairly stated in all material respects to the financial statements as a whole.</p> <p>The schedule of expenditures of federal awards is required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, <i>Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards</i> (Uniform Guidance) and in our opinion is fairly stated in all material respects to the financial statements as a whole.</p> <p>The other supplementary information section as listed in the table of contents is presented for the purpose of additional analysis as required by the Uniform Guidance, and in our opinion is fairly stated in all material respects to the financial statements as a whole.</p>

**CALIFORNIA PRIMARY CARE  
ASSOCIATION AND  
AFFILIATES**

**CONSOLIDATED FINANCIAL  
STATEMENTS WITH INDEPENDENT  
AUDITOR'S REPORT**

**YEARS ENDED  
MARCH 31, 2017 AND 2016**

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

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## INDEPENDENT AUDITOR'S REPORT

**Board of Directors**  
**California Primary Care Association**  
**Sacramento, California**

### **Report on the Financial Statements**

We have audited the accompanying consolidated financial statements of California Primary Care Association and Affiliates (Association), which comprise the consolidated statements of financial position as of March 31, 2017 and 2016, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

### *Management's Responsibility for the Financial Statements*

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

### *Auditor's Responsibility*

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

***Opinion***

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of California Primary Care Association and Affiliates as of March 31, 2017 and 2016, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

***Other Matters***

***Other Information***

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplemental consolidating financial statements are presented for the purpose of additional analysis and are not a required part of the basic consolidated financial statements. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. Code of Federal Regulation (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

***Other Reporting Required by Government Auditing Standards***

In accordance with *Government Auditing Standards*, we have also issued our report dated September 18, 2017, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Association's internal control over financial reporting and compliance.



GILBERT ASSOCIATES, INC.  
Sacramento, California

September 18, 2017

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATED STATEMENTS OF FINANCIAL POSITION MARCH 31, 2017 AND 2016

	<u>2017</u>	<u>2016</u>
<b>ASSETS</b>		
<b>CURRENT ASSETS:</b>		
Cash and cash equivalents	\$ 7,259,561	\$ 5,279,519
Grants receivable	510,692	1,630,376
Dues and accounts receivable	324,242	186,641
Current portion of loans receivable	2,278,220	2,665,074
Prepaid expenses	<u>187,495</u>	<u>95,948</u>
Total current assets	10,560,210	9,857,558
<b>NONCURRENT ASSETS:</b>		
Certificates of deposit	806,713	808,401
Loans receivable, Net	4,099,372	5,175,261
Property and equipment, Net	<u>4,871,647</u>	<u>5,104,835</u>
<b>TOTAL ASSETS</b>	<u>\$ 20,337,942</u>	<u>\$ 20,946,055</u>
<b>LIABILITIES AND NET ASSETS</b>		
<b>CURRENT LIABILITIES:</b>		
Accounts payable	\$ 215,905	\$ 142,098
Accrued expenses	275,029	248,593
Deferred revenues	427,794	94,290
Current portion of loans payable	<u>176,879</u>	<u>657,852</u>
Total current liabilities	1,095,607	1,142,833
<b>LOANS PAYABLE, Net</b>	<u>3,635,667</u>	<u>3,810,971</u>
Total liabilities	<u>4,731,274</u>	<u>4,953,804</u>
<b>NET ASSETS:</b>		
Unrestricted	13,465,732	13,356,938
Temporarily restricted	<u>2,140,936</u>	<u>2,635,313</u>
Total net assets	<u>15,606,668</u>	<u>15,992,251</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<u>\$ 20,337,942</u>	<u>\$ 20,946,055</u>

The accompanying notes are an integral part of these consolidated financial statements.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATED STATEMENTS OF ACTIVITIES YEARS ENDED MARCH 31, 2017 AND 2016

	<u>2017</u>	<u>2016</u>
<b>UNRESTRICTED NET ASSETS:</b>		
<b>REVENUES:</b>		
Grants and contributions	\$ 3,930,754	\$ 3,417,671
Membership dues	1,966,044	1,374,218
Clinic support services	1,270,863	642,572
Conferences	906,360	722,293
Training and workshops	811,780	826,673
Interest income from loans	195,509	216,033
Interest and investment income	15,762	24,037
Other income	175,023	273,800
Net assets released from restrictions	<u>1,614,377</u>	<u>945,327</u>
Total revenues	<u>10,886,472</u>	<u>8,442,624</u>
<b>EXPENSES:</b>		
Program services:		
Clinic operations support	7,829,363	6,094,785
Legislative	852,503	657,551
Information systems and loan program	<u>210,642</u>	<u>186,846</u>
Total program services	8,892,508	6,939,182
Management and general	<u>1,885,170</u>	<u>1,645,809</u>
Total expenses	<u>10,777,678</u>	<u>8,584,991</u>
<b>INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS</b>	<u>108,794</u>	<u>(142,367)</u>
<b>TEMPORARILY RESTRICTED NET ASSETS:</b>		
Grants and contributions	1,120,000	3,248,931
Net assets released from restrictions	<u>(1,614,377)</u>	<u>(945,327)</u>
<b>INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS</b>	<u>(494,377)</u>	<u>2,303,604</u>
<b>INCREASE (DECREASE) IN NET ASSETS</b>	(385,583)	2,161,237
<b>NET ASSETS, Beginning of Year</b>	<u>15,992,251</u>	<u>13,831,014</u>
<b>NET ASSETS, End of Year</b>	<u>\$ 15,606,668</u>	<u>\$ 15,992,251</u>

The accompanying notes are an integral part of these consolidated financial statements.

**CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES**

**CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES  
YEAR ENDED MARCH 31, 2017**

	Program Services		Info. Sys. & Loan Program	Supporting Services	Total
	Clinic Operations Support	Legislative		Management & General	
Salaries and wages	\$ 3,034,308	\$ 204,096	\$ 140,036	\$ 758,577	\$ 4,137,017
Consultants	969,684	375,134	5,613	251,171	1,601,602
Conferences, meetings, and trainings	1,143,119	3,095	1,629	285,780	1,433,623
Contracted member support	952,206				952,206
Employee benefits	687,166	53,017	31,842	171,791	943,816
Travel	220,315	11,287		94,420	326,022
Depreciation	196,569	21,841		54,602	273,012
Occupancy	174,299	14,058	7,424	34,853	230,634
Interest expense	132,571	10,918	14,889	41,864	200,242
Marketing and outreach	12,811	126,412		26,267	165,490
Supplies	93,362	2,868	2,868	22,850	121,948
Board of Directors expenses				88,354	88,354
Dues, publications, and subscriptions	50,471	343	374	14,232	65,420
Printing and reproduction	36,082	15,654		9,020	60,756
Telecommunications	38,326	2,915	1,713	9,582	52,536
Professional services	30,446	7,232	1,870	7,611	47,159
Facilities and equipment rental	16,825	1,284	772	4,206	23,087
Provision for bad debts	4,587			1,147	5,734
Postage and delivery	1,296			324	1,620
Other expenses	34,920	2,349	1,612	8,519	47,400
<b>Total</b>	<b>\$ 7,829,363</b>	<b>\$ 852,503</b>	<b>\$ 210,642</b>	<b>\$ 1,885,170</b>	<b>\$ 10,777,678</b>

The accompanying notes are an integral part of these consolidated financial statements.

**CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES**

**CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES  
YEAR ENDED MARCH 31, 2016**

	Program Services		Info. Sys. & Loan Program	Supporting Services	Total
	Clinic Operations Support	Legislative		Management & General	
Salaries and wages	\$ 2,463,502	\$ 273,722	\$ 112,238	\$ 684,306	\$ 3,533,768
Consultants	866,915	102,224	4,459	252,422	1,226,020
Conferences, meetings, and trainings	778,874	87,217	777	216,354	1,083,222
Contracted member support	380,289				380,289
Employee benefits	586,695	65,188	27,294	162,971	842,148
Travel	141,258	15,695		39,238	196,191
Depreciation	210,317	23,369		58,421	292,107
Occupancy	156,032	18,937	6,399	43,342	224,710
Interest expense	143,221	15,913	27,916	39,783	226,833
Marketing and outreach	75,413	12,979		20,948	109,340
Supplies	92,768	11,186	2,119	25,769	131,842
Board of Directors expenses				48,137	48,137
Dues, publications, and subscriptions	51,236	5,693	111	14,232	71,272
Printing and reproduction	37,661	4,637		10,461	52,759
Telecommunications	31,483	3,498	1,324	8,745	45,050
Professional services	38,165	13,261	2,274	10,601	64,301
Facilities and equipment rental	18,053	2,006	818	5,015	25,892
Provision for bad debts	4,675				4,675
Postage and delivery	4,515	502		1,254	6,271
Other expenses	<u>13,713</u>	<u>1,524</u>	<u>1,117</u>	<u>3,810</u>	<u>20,164</u>
<b>Total</b>	<b>\$ 6,094,785</b>	<b>\$ 657,551</b>	<b>\$ 186,846</b>	<b>\$ 1,645,809</b>	<b>\$ 8,584,991</b>

The accompanying notes are an integral part of these consolidated financial statements.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATED STATEMENTS OF CASH FLOWS YEARS ENDED MARCH 31, 2017 AND 2016

	<u>2017</u>	<u>2016</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
Increase (decrease) in net assets	\$ (385,583)	\$ 2,161,237
Reconciliation to net cash provided by operating activities:		
Depreciation	273,012	292,107
Decrease in fair value of certificates of deposit	5,008	31,015
Loan loss reserve	(57,044)	(67,429)
Changes in:		
Grants receivable	1,119,684	(1,313,681)
Dues and accounts receivable	(137,601)	(870)
Prepaid expenses	(91,547)	(14,448)
Accounts payable	73,807	(68,876)
Accrued expenses	26,436	47,854
Deferred revenues	333,504	23,214
Net cash provided by operating activities	<u>1,159,676</u>	<u>1,090,123</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES:</b>		
Purchases of certificates of deposit	(103,320)	
Maturities of certificates of deposit	100,000	
Funding of loans receivable	(1,950,000)	(3,335,000)
Principal payments received on loans	3,469,787	3,187,206
Purchases of property and equipment	(39,824)	(35,300)
Net cash provided (used) by investing activities	<u>1,476,643</u>	<u>(183,094)</u>
<b>CASH FLOWS FROM FINANCING ACTIVITIES:</b>		
Principal payments on loans payable	(656,277)	(656,099)
<b>INCREASE IN CASH AND CASH EQUIVALENTS</b>	1,980,042	250,930
<b>CASH AND CASH EQUIVALENTS, Beginning of year</b>	<u>5,279,519</u>	<u>5,028,589</u>
<b>CASH AND CASH EQUIVALENTS, End of year</b>	<u>\$ 7,259,561</u>	<u>\$ 5,279,519</u>
<b>OTHER CASH FLOW INFORMATION:</b>		
Interest paid	<u>\$ 200,242</u>	<u>\$ 226,833</u>

The accompanying notes are an integral part of these consolidated financial statements.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2017 AND 2016

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### 1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

California Primary Care Association (CPCA) is a nonprofit public benefit corporation whose purpose is to promote and facilitate equal access to quality healthcare for individuals and families. CPCA accomplishes its mission through organized primary care clinics and clinic networks that seek to maintain cost-effective, affordable medical services as well as meet the linguistic and cultural needs of California's diverse population.

CPCA Ventures (Ventures) is a nonprofit public benefit corporation that raises funds to enhance the capacity of California community clinics and health centers. Ventures provides a healthcare safety net in a competitive, managed-care environment through increased utilization of information systems. Ventures also provides access to low-interest financing for information systems and short-term emergency loans.

CaliforniaHealth Plus Advocates (Advocates) is a nonprofit public benefit corporation established in February 2016 to advance the mission of community health centers through state and federal advocacy.

**Principles of consolidation** – The accompanying financial statements reflect the consolidation of CPCA, Ventures and Advocates (collectively, the Association) who share common facilities and management. CPCA and Ventures are commonly controlled by the same Board of Directors and the Board of Directors of Advocates is selected by CPCA. Material transactions between the entities have been eliminated in the consolidated financial statements.

**Basis of presentation** – The consolidated financial statements are presented in conformity with professional standards for not-for-profit entities. The Association reports information regarding its financial position and activities according to three classes of net assets: unrestricted, temporarily restricted, and permanently restricted. The Association has no permanently restricted net assets.

**Revenue recognition** – Revenues from government grants are recognized when qualifying expenses are incurred. Grants from private foundations are treated as contributions and recognized in full when received or unconditionally promised. Such contributions are initially reported as an increase in temporarily restricted net assets. When a restriction expires (generally as payments are made to fulfill the grantor-imposed purpose of the contribution), temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of activities as net assets released from restrictions.

Membership dues are recognized as revenues in the applicable membership period. Revenue from training, conferences, and clinic support services is recognized when the related events occur. Dues and fees collected in advance are recorded as deferred revenues until earned.

**Cash and cash equivalents** – For financial statement purposes, the Association considers all investments with a maturity at purchase of three months or less to be cash equivalents.

The Association maintains its cash in bank deposit accounts that, at times, may exceed federally insured limits. The Association has not experienced any losses in such accounts. Management believes the Association is not exposed to any significant credit risk related to cash.

**Certificates of deposit** are stated at fair value.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS MARCH 31, 2017 AND 2016

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**Accounts receivable** are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a provision for bad debt expense and an adjustment to a valuation allowance based on its assessment of the current status of individual accounts. Management believes that all accounts are collectible and no allowance is necessary.

**Property and equipment** are stated at cost and depreciated using the straight-line method over estimated useful lives of three to thirty years. The Association's policy is to capitalize such items with a cost of \$5,000 or more.

**Income taxes** – CPCA and Ventures are publicly supported and exempt from income taxes under Internal Revenue Code Section (IRC §) 501(c)(3) and by the California Franchise Tax Board under Section 23701(d). Advocates is exempt from income taxes under Internal Revenue Code Section (IRC §) 501(c)(4) and by the California Franchise Tax Board under Section 23701(f). The Association has applied the accounting principles related to accounting for uncertainty in income taxes and has determined that there is no material impact on the consolidated financial statements. With some exceptions, the Association is no longer subject to U.S. federal and state income tax examinations by tax authorities for years prior to 2013.

**Functional allocation of expenses** – The costs of providing the program services have been summarized on a functional basis in the consolidated statements of activities and of functional expenses. Accordingly, certain costs have been allocated among the program services based on employees' time incurred and management's estimates of the usage of resources.

**Use of estimates** – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Significant estimates included in these financial statements are management's estimate of the loan loss reserve and selection of useful lives of property and equipment. Accordingly, actual results could differ from those estimates.

**Restatement and reclassifications** – Advocates' accounts were excluded from the previously issued March 31, 2016 consolidated financial statements as they were not considered material by Management. The March 31, 2016 consolidated financial statements have been restated to include the accounts of Advocates resulting in an increase in unrestricted net assets and the change in net assets of \$31,517, as of and for the year ended March 31, 2016.

Certain other 2016 amounts have been reclassified to conform to the 2017 financial statement presentation.

**Subsequent events** have been reviewed through September 18, 2017, the date the financial statements were issued. Management concluded that no material subsequent events have occurred since March 31, 2017 that require recognition or disclosure in the financial statements.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS MARCH 31, 2017 AND 2016

### 2. LOANS RECEIVABLE

The Association manages a revolving loan program for its community health centers. A third-party administrator, in a manner similar to a lending institution, approves the loans, manages the loan portfolio, and establishes the reserve for loan loss. The allowance for loan loss is calculated using a transaction risk rating as outlined in the third-party administrator's credit policies. A reasonable possibility exists that amounts ultimately uncollectible may differ materially from the amounts estimated. However, the amount of the difference cannot be determined. All loan payments are due on the first day of each month. If payment is not received by the first day of the subsequent month, the loan becomes past due. When the payment is 90 days past due the loan is placed on non-accrual and when any portion of a loan is deemed uncollectible, a full or partial charge off against the loan loss is made.

Interest income on the loans is recognized when payments are received. Servicing fees are deducted from interest income by the third-party administrator, before remittance to the Association.

Loans receivable are as follows:

	<u>2017</u>	<u>2016</u>
Capital loans, with interest at 3.175%, secured by equipment or receivables financed and a covenant not to encumber, if applicable. Maximum amount of each loan is \$1,000,000, interest-only due for the first six months followed by 5-year, fully amortizing payments.	\$ 6,867,711	\$ 7,795,525
Information system loans, with interest at 3.175%, secured by a first lien position on equipment financed with loan proceeds. Maximum amount of each loan is \$1,000,000, and the maximum term is five years.	_____	591,973
Total	6,867,711	8,387,498
Less loan loss reserve	(490,119)	(547,163)
Loans receivable – net of loan loss reserve	6,377,592	7,840,335
Less current portion	(2,278,220)	(2,665,074)
Total long-term loans receivable	\$ 4,099,372	\$ 5,175,261

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2017 AND 2016

### 3. PROPERTY AND EQUIPMENT

Property and equipment consist of the following:

	<u>2017</u>	<u>2016</u>
Building	\$ 6,476,678	\$ 6,476,678
Equipment	406,260	366,436
Furniture	<u>329,157</u>	<u>329,157</u>
Total	7,212,095	7,172,271
Less accumulated depreciation	<u>(2,340,448)</u>	<u>(2,067,436)</u>
Property and equipment, net	<u>\$ 4,871,647</u>	<u>\$ 5,104,835</u>

### 4. LOANS PAYABLE

Loans payable are as follows:

	<u>2017</u>	<u>2016</u>
Loan payable to First Citizens Bank for the purchase of a suite in a commercial building in Sacramento, California. The terms of the loan were modified on September 26, 2012 to fix the interest rate at 4.95%. Under the loan agreement, as modified, the balance of the loan is payable in monthly payments of \$26,330 with one final payment of the entire balance due February 1, 2020.	\$ 3,767,592	\$ 3,891,581
Loan payable to Dignity Health for the purpose of providing capital for financing loans to community clinics and health centers. Monthly payments of \$45,047 are due beginning June 1, 2012, including principal and interest of 2.475% per annum. The loan matures on April 30, 2017.	<u>44,954</u>	<u>577,242</u>
Total	3,812,546	4,468,823
Less current portion	<u>(176,879)</u>	<u>(657,852)</u>
Total long-term loans payable	<u>\$ 3,635,667</u>	<u>\$ 3,810,971</u>

Principal payments of loans payable as of March 31, 2017 are as follows:

2018	\$	176,879
2019		138,606
2019		<u>3,497,061</u>
Total	\$	<u>3,812,546</u>

Interest expense totaled \$200,242 and \$226,833 for the years ended March 31, 2017 and 2016, respectively.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2017 AND 2016

### 5. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets represent unexpended funds restricted by grantors for the following programs:

	<u>2017</u>	<u>2016</u>
The California Endowment – Capitated Payment Preparedness	\$ 670,475	\$ 796,000
Kaiser Foundation – Capitated Payment Preparedness	344,289	472,012
The California Endowment – Policy & Advocacy	222,322	182,761
CA Wellness Foundation – Capitated Payment Preparedness	221,079	290,867
Blue Shield – Capitated Payment Preparedness	140,307	173,139
Blue Shield – Strengthening SafetyNet	131,929	131,929
CA Healthcare Foundation – Capitated Payment Preparedness	128,986	341,029
Blue Shield – Act Now Fund	100,000	
DentaQuest Foundation – Strengthening SafetyNet	78,160	102,677
DentaQuest Foundation – National Oral Health Innovation and Integration Network	62,139	
National Association of Community Health Centers/Blue Shield of California Foundation - PRAPARE	30,000	
Kaiser Foundation - ECHO	11,250	24,500
Blue Shield – Behavioral Health		92,906
CA Healthcare Foundation – Data Security		27,493
Total	<u>\$ 2,140,936</u>	<u>\$ 2,635,313</u>

### 6. RETIREMENT PLANS

The Association sponsors a retirement plan under IRC §403(b). All regular employees of the Association are eligible to participate at the start of employment. The Association contributes up to 5% of gross salary, and such contributions vest with completion of one year of service. The Association incurred plan expenses of \$196,398 for 2017 and \$167,459 for 2016.

The Association also sponsors a retirement plan under IRC §457 for employees at the Director level. The plan allows for additional Association contributions and salary deferrals subject to limitations for eligible employees. The Association incurred plan expenses of \$7,009 and \$8,042 for 2017 and 2016, respectively.

### 7. CONCENTRATIONS OF CREDIT RISK

Loans receivable and related interest income are primarily concentrated among the Association's members in the primary care industry.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATING STATEMENT OF FINANCIAL POSITION MARCH 31, 2017

	<u>CPCA</u>	<u>Ventures</u>	<u>Advocates</u>	<u>Consolidated</u>
<b>ASSETS</b>				
<b>CURRENT ASSETS:</b>				
Cash and cash equivalents	\$ 3,090,327	\$ 4,168,171	\$ 1,063	\$ 7,259,561
Grants receivable	510,692			510,692
Dues and accounts receivable	324,242			324,242
Current portion of loans receivable		2,278,220		2,278,220
Prepaid expenses	186,649		846	187,495
Due from (to) affiliate	99,241	(128,849)	29,608	
Total current assets	4,211,151	6,317,542	31,517	10,560,210
<b>NONCURRENT ASSETS:</b>				
Certificates of deposit	806,713			806,713
Loans receivable, Net		4,099,372		4,099,372
Property and equipment, Net	4,871,647			4,871,647
<b>TOTAL ASSETS</b>	<b>\$ 9,889,511</b>	<b>\$ 10,416,914</b>	<b>\$ 31,517</b>	<b>\$ 20,337,942</b>
<b>LIABILITIES AND NET ASSETS</b>				
<b>CURRENT LIABILITIES:</b>				
Accounts payable	\$ 215,905			\$ 215,905
Accrued expenses	275,029			275,029
Deferred revenues	427,794			427,794
Current portion of loans payable	131,925	\$ 44,954		176,879
Total current liabilities	1,050,653	44,954		1,095,607
<b>LOANS PAYABLE, Net</b>	3,635,667			3,635,667
Total liabilities	4,686,320	44,954		4,731,274
<b>NET ASSETS:</b>				
Unrestricted	3,062,255	10,371,960	\$ 31,517	13,465,732
Temporarily restricted	2,140,936			2,140,936
Total net assets	5,203,191	10,371,960	31,517	15,606,668
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b>\$ 9,889,511</b>	<b>\$ 10,416,914</b>	<b>\$ 31,517</b>	<b>\$ 20,337,942</b>

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATING STATEMENT OF FINANCIAL POSITION MARCH 31, 2016

	<u>CPCA</u>	<u>Ventures</u>	<u>Advocates</u>	<u>Consolidated</u>
<b>ASSETS</b>				
<b>CURRENT ASSETS:</b>				
Cash and cash equivalents	\$ 1,900,709	\$ 3,328,810	\$ 50,000	\$ 5,279,519
Grants receivable	1,630,376			1,630,376
Dues and accounts receivable	186,641			186,641
Current portion of loans receivable		2,665,074		2,665,074
Prepaid expenses	95,948			95,948
Due from (to) affiliate	<u>283,422</u>	<u>(268,539)</u>	<u>(14,883)</u>	
Total current assets	4,097,096	5,725,345	35,117	9,857,558
<b>NONCURRENT ASSETS:</b>				
Certificates of deposit	808,401			808,401
Loans receivable, Net		5,175,261		5,175,261
Property and equipment, Net	<u>5,104,835</u>			<u>5,104,835</u>
<b>TOTAL ASSETS</b>	<u>\$ 10,010,332</u>	<u>\$ 10,900,606</u>	<u>\$ 35,117</u>	<u>\$ 20,946,055</u>
<b>LIABILITIES AND NET ASSETS</b>				
<b>CURRENT LIABILITIES:</b>				
Accounts payable	\$ 138,498		\$ 3,600	\$ 142,098
Accrued expenses	248,593			248,593
Deferred revenues	94,290			94,290
Current portion of loans payable	<u>125,567</u>	<u>\$ 532,285</u>		<u>657,852</u>
Total current liabilities	606,948	532,285	3,600	1,142,833
<b>LOANS PAYABLE, Net</b>	<u>3,766,014</u>	<u>44,957</u>		<u>3,810,971</u>
Total liabilities	<u>4,372,962</u>	<u>577,242</u>	<u>3,600</u>	<u>4,953,804</u>
<b>NET ASSETS:</b>				
Unrestricted	3,002,057	\$ 10,323,364	31,517	13,356,938
Temporarily restricted	<u>2,635,313</u>			<u>2,635,313</u>
Total net assets	<u>5,637,370</u>	<u>10,323,364</u>	<u>31,517</u>	<u>15,992,251</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<u>\$ 10,010,332</u>	<u>\$ 10,900,606</u>	<u>\$ 35,117</u>	<u>\$ 20,946,055</u>

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATING STATEMENT OF ACTIVITIES YEAR ENDED MARCH 31, 2017

	<u>CPCA</u>	<u>Ventures</u>	<u>Advocates</u>	<u>Consolidated</u>
<b>UNRESTRICTED NET ASSETS:</b>				
<b>REVENUES:</b>				
Grants and contributions	\$ 3,930,754			\$ 3,930,754
Membership dues	1,525,527		\$ 440,517	1,966,044
Clinic support services	1,270,863			1,270,863
Conferences	906,360			906,360
Training and workshops	811,780			811,780
Interest income from loans		\$ 195,509		195,509
Interest and investment income	10,689	5,073		15,762
Other income	117,979	57,044		175,023
Net assets released from restrictions	1,614,377			1,614,377
Intercompany revenue (expense)	(262,500)		262,500	
Total revenues	<u>9,925,829</u>	<u>257,626</u>	<u>703,017</u>	<u>10,886,472</u>
<b>EXPENSES:</b>				
Program services:				
Clinic operations support	7,829,363			7,829,363
Legislative	149,486		703,017	852,503
Information systems and loan program		210,642		210,642
Total program services	7,978,849	210,642	703,017	8,892,508
Management and general	1,886,782	(1,612)		1,885,170
Total expenses	<u>9,865,631</u>	<u>209,030</u>	<u>703,017</u>	<u>10,777,678</u>
<b>INCREASE IN UNRESTRICTED NET ASSETS</b>	<u>60,198</u>	<u>48,596</u>		<u>108,794</u>
<b>TEMPORARILY RESTRICTED NET ASSETS:</b>				
Grants and contributions	1,120,000			1,120,000
Net assets released from restrictions	(1,614,377)			(1,614,377)
<b>DECREASE IN TEMPORARILY RESTRICTED NET ASSETS</b>	<u>(494,377)</u>			<u>(494,377)</u>
<b>INCREASE (DECREASE) IN NET ASSETS</b>	<u>(434,179)</u>	<u>48,596</u>		<u>(385,583)</u>
<b>NET ASSETS, Beginning of Year</b>	<u>5,637,370</u>	<u>10,323,364</u>	<u>31,517</u>	<u>15,992,251</u>
<b>NET ASSETS, End of Year</b>	<u>\$ 5,203,191</u>	<u>\$ 10,371,960</u>	<u>\$ 31,517</u>	<u>\$ 15,606,668</u>

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## CONSOLIDATING STATEMENT OF ACTIVITIES YEAR ENDED MARCH 31, 2016

	<u>CPCA</u>	<u>Ventures</u>	<u>Advocates</u>	<u>Consolidated</u>
<b>UNRESTRICTED NET ASSETS:</b>				
<b>REVENUES:</b>				
Grants and contributions	\$ 3,417,671			\$ 3,417,671
Membership dues	1,374,218			1,374,218
Clinic support services	642,572			642,572
Conferences	722,293			722,293
Training and workshops	826,673			826,673
Interest income from loans		\$ 216,033		216,033
Interest and investment income (loss)	17,858	6,179		24,037
Other income	206,371	67,429		273,800
Net assets released from restrictions	945,327			945,327
Intercompany revenue (expense)	(50,000)		\$ 50,000	
Total revenues	<u>8,102,983</u>	<u>289,641</u>	<u>50,000</u>	<u>8,442,624</u>
<b>EXPENSES:</b>				
<b>Program services:</b>				
Clinic operations support	6,094,785			6,094,785
Legislative	639,068		18,483	657,551
Information systems and loan program		186,846		186,846
Total program services	6,733,853	186,846	18,483	6,939,182
Management and general	1,645,809			1,645,809
Total expenses	<u>8,379,662</u>	<u>186,846</u>	<u>18,483</u>	<u>8,584,991</u>
<b>INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS</b>				
	<u>(276,679)</u>	<u>102,795</u>	<u>31,517</u>	<u>(142,367)</u>
<b>TEMPORARILY RESTRICTED NET ASSETS:</b>				
Grants and contributions	3,248,931			3,248,931
Net assets released from restrictions	(945,327)			(945,327)
<b>INCREASE IN TEMPORARILY RESTRICTED NET ASSETS</b>				
	<u>2,303,604</u>			<u>2,303,604</u>
<b>INCREASE IN NET ASSETS</b>				
	2,026,925	102,795	31,517	2,161,237
<b>NET ASSETS, Beginning of Year</b>				
	<u>3,610,445</u>	<u>10,220,569</u>		<u>13,831,014</u>
<b>NET ASSETS, End of Year</b>				
	<u>\$ 5,637,370</u>	<u>\$ 10,323,364</u>	<u>\$ 31,517</u>	<u>\$ 15,992,251</u>

**CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES**

**SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS  
YEAR ENDED MARCH 31, 2017**

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	<u>CFDA Number</u>	<u>Federal Expenditures</u>
<b>U.S. Department of Health and Human Services:</b>		
Direct programs:		
State and Regional Primary Care Associations	93.129	\$ <u>2,889,496</u>

The accompanying notes to the schedule of federal awards is an integral part of this statement.

# CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES

## NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS MARCH 31, 2017

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### 1. BASIS OF PRESENTATION

The accompanying schedule of expenditures of federal awards of California Primary Care Association (CPCA) is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic consolidated financial statements.

### 2. INDIRECT COST RATE

CPCA has elected not to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

**REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING  
AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT  
OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH  
GOVERNMENT AUDITING STANDARDS**

**Board of Directors  
California Primary Care Association  
Sacramento, California**

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of California Primary Care Association and Affiliates (Association), which comprise the consolidated statements of financial position as of March 31, 2017, and the related statements of activities, functional expenses and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated September 18, 2017.

**Internal Control Over Financial Reporting**

In planning and performing our audit of the consolidated financial statements, we considered the Association's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Association's internal control. Accordingly, we do not express an opinion on the effectiveness of the Association's internal control.

*A deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

### **Compliance and Other Matters**

As part of obtaining reasonable assurance about whether the Association's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

### **Purpose of this Report**

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



**GILBERT ASSOCIATES, INC.**  
Sacramento, California

September 18, 2017

**REPORT ON COMPLIANCE FOR EACH MAJOR PROGRAM AND ON  
INTERNAL CONTROL OVER COMPLIANCE  
REQUIRED BY THE UNIFORM GUIDANCE**

**Independent Auditor's Report**

**Board of Directors  
California Primary Care Association  
Sacramento, California**

**Report on Compliance for Each Major Federal Program**

We have audited California Primary Care Association and Affiliates' (Association) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on the Association's major federal program for the year ended March 31, 2017. The Association's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

***Management's Responsibility***

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal program.

***Auditor's Responsibility***

Our responsibility is to express an opinion on compliance for the Association's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Association's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the Association's major federal program. However, our audit does not provide a legal determination of the Association's compliance.

***Opinion on Major Federal Program***

In our opinion, the Association complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended March 31, 2017.

**Report on Internal Control Over Compliance**

Management of the Association is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Association's internal control over compliance with the types of requirements that could have a direct and material effect on its major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Association's internal control over compliance.

*A deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.



**GILBERT ASSOCIATES, INC.**  
Sacramento, California

**September 18, 2017**

**CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES**

**SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
YEAR ENDED MARCH 31, 2017**

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**SECTION I - SUMMARY OF AUDITOR'S RESULTS**

**Financial Statements**

Type of auditor's report issued on whether the financial statements were prepared in accordance with GAAP: Unmodified

Internal control over financial reporting:

• Material weakness(es) identified? \_\_\_\_\_ Yes  No

• Significant deficiency(ies) identified? \_\_\_\_\_ Yes  No

Noncompliance material to financial statements noted? \_\_\_\_\_ Yes  No

**Federal Awards**

Internal control over major programs:

• Material weakness(es) identified? \_\_\_\_\_ Yes  No

• Significant deficiency(ies) identified? \_\_\_\_\_ Yes  None reported

Type of auditor's report issued: Unmodified

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? \_\_\_\_\_ Yes  No

Identification of major programs:

Name of Federal Program or Cluster CFDA Number

State and Regional Primary Care Associations 93.129

Dollar threshold used to distinguish between Type A and Type B programs: \$750,000

Auditee qualified as low-risk auditee?  Yes \_\_\_\_\_ No

**CALIFORNIA PRIMARY CARE ASSOCIATION AND AFFILIATES**

**SCHEDULE OF FINDINGS AND QUESTIONED COSTS  
YEAR ENDED MARCH 31, 2017**

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**SECTION II – FINANCIAL STATEMENT FINDINGS**

None noted.

**SECTION III – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS**

None noted.

**SECTION IV – STATUS OF PRIOR YEAR AUDIT FINDINGS**

None noted.

Board Financial Presentation

March 31, 2017

August 31, 2017

	CPCA	Ventures	Advocates	Combined	CPCA	Ventures	Advocates	Combined
<b>Statement of Financial Position</b>								
<b>ASSETS:</b>								
<b>Current Assets</b>								
Cash & Equivalents	\$ 3,090,327	\$ 4,168,171	\$ 1,063	\$ 7,259,561	\$ 2,638,654	\$ 3,743,848	\$ 312,634	\$ 6,695,136
Grants Receivable	\$ 510,692			\$ 510,692	\$ 359,686		\$ -	\$ 359,686
Dues and Accounts Receivable	\$ 324,242			\$ 324,242	\$ 415,758		\$ -	\$ 415,758
Current Portion of Loan Receivable		\$ 2,278,200		\$ 2,278,200		\$ 2,278,220		\$ 2,278,220
Prepaid Expenses/Undeposited Funds	\$ 186,649		\$ 846	\$ 187,495	\$ 7,666		\$ -	\$ 7,666
Due from (to) affiliate	\$ 99,241	\$ (128,849)	\$ 29,608	\$ -	\$ 196,589	\$ (196,520)	\$ (69)	\$ -
Noncurrent Assets								\$ -
Certificates of Deposit	\$ 806,713			\$ 806,713	\$ 872,449		\$ -	\$ 872,449
Loan Receivable, Net		\$ 4,099,373		\$ 4,099,373		\$ 4,580,822	\$ -	\$ 4,580,822
Property and Equipment, Net	\$ 4,871,647			\$ 4,871,647	\$ 4,871,647		\$ -	\$ 4,871,647
<b>TOTAL ASSETS</b>	<b>\$ 9,889,511</b>	<b>\$ 10,416,895</b>	<b>\$ 31,517</b>	<b>\$ 20,337,923</b>	<b>\$ 9,362,449</b>	<b>\$ 10,406,370</b>	<b>\$ 312,565</b>	<b>\$ 20,081,384</b>
<b>LIABILITIES &amp; NET ASSETS</b>								
<b>Current Liabilities</b>								
Accounts Payable	\$ 215,905			\$ 215,905	\$ 2,520	\$ -	\$ 1,750	\$ 4,270
Accrued Expenses	\$ 275,029			\$ 275,029	\$ 285,181	\$ -	\$ -	\$ 285,181
Deferred Revenue	\$ 427,794			\$ 427,794	\$ 539,820	\$ -	\$ -	\$ 539,820
Current Portion of Loan Payable	\$ 131,925	\$ 44,954		\$ 176,879				
Loan Payable (net)	\$ 3,635,667			\$ 3,635,667	\$ 3,715,326	\$ -	\$ -	\$ 3,715,326
<b>TOTAL LIABILITIES</b>	<b>\$ 4,686,320</b>	<b>\$ 44,954</b>		<b>\$ 4,731,274</b>	<b>\$ 4,542,847</b>	<b>\$ -</b>	<b>\$ 1,750</b>	<b>\$ 4,544,597</b>
<b>TOTAL NET ASSETS</b>	<b>\$ 5,203,191</b>	<b>\$ 10,371,941</b>	<b>\$ 31,517</b>	<b>\$ 15,606,649</b>	<b>\$ 4,819,602</b>	<b>\$ 10,406,370</b>	<b>\$ 310,815</b>	<b>\$ 15,536,787</b>
Unrestricted	\$ 3,062,255	\$ 10,371,941	\$ 31,517	\$ 13,465,713	\$ 2,904,173	\$ 10,406,370	\$ 310,815	\$ 13,621,358
Temporarily Restricted	\$ 2,140,936			\$ 2,140,936	\$ 1,915,429			\$ 1,915,429
<i>Cash on Hand - how many days organization could operate with no further cash</i>				257 days	257	8453	349	321 days
<i>Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations</i>				9.64				11.77
<b>Profit and Loss</b>								
<b>Total Income</b>	\$ 9,693,951	\$ 200,582	\$ 703,017	\$ 10,597,550	\$ 4,185,753	\$ 73,293	\$ 716,201	\$ 4,975,247
<b>Total Expenses</b>	\$10,128,130	\$ 151,986	\$ 703,017	\$ 10,983,133	\$ 4,569,340	\$ 35,984	\$ 436,903	\$ 5,042,227
<b>Net Income</b>	<b>\$ (434,179)</b>	<b>\$ 48,596</b>	<b>\$ -</b>	<b>\$ (385,583)</b>	<b>\$ (383,587)</b>	<b>\$ 34,409</b>	<b>\$ 279,298</b>	<b>\$ (69,880)</b>

## Balance Sheet

As of August 31, 2017

	Aug 31, 17
<b>ASSETS</b>	
Current Assets	
Checking/Savings	
1000.00 · Cash	3,512,505.34
Total Checking/Savings	3,512,505.34
Accounts Receivable	
1300.00 · Grants Receivable	213,400.77
1305.00 · Contributions Receivable	146,285.00
1320.00 · Due from CPCA Ventures	196,520.04
1323.00 · Due from CA Health+ Advocates	69.41
1350.00 · Other Receivables	158,606.42
1400.00 · IMIS Receivable	257,151.22
Total Accounts Receivable	972,032.86
Other Current Assets	
1490.00 · Prepaid Expenses	6,000.00
1499.00 · Undeposited Funds	1,665.66
Total Other Current Assets	7,665.66
Total Current Assets	4,492,203.86
Fixed Assets	
1600.00 · 1231 I Street Suite 400	6,407,085.91
1650.00 · Furniture	331,111.39
1660.00 · Equipment	406,259.55
1670.00 · Capitalized Interest	69,592.00
1700.00 · Accumulated Depreciation	-660,366.00
1710.00 · Building Depreciation	-1,627,309.00
1740.00 · Interest Amortization	-52,773.00
1750.00 · Loss on Disposal of Assets	-1,954.00
Total Fixed Assets	4,871,646.85
<b>TOTAL ASSETS</b>	<b><u>9,363,850.71</u></b>
<b>LIABILITIES &amp; EQUITY</b>	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 · Accounts Payable	3,922.09
Total Accounts Payable	3,922.09
Other Current Liabilities	
2025 · Accrued Vacation	281,728.81
2040.00 · Prepaid Dues	538,319.89
2050.01 · Payroll Clearing	-3,867.58
2055.01 · Payroll FSA	-3,077.71
2200.00 · Sales Tax Payable	10,397.62
Total Other Current Liabilities	823,501.03
Total Current Liabilities	827,423.12
Long Term Liabilities	
2510.00 · Loan Payable IronStone Bank	3,715,326.26
Total Long Term Liabilities	3,715,326.26
Total Liabilities	4,542,749.38
Equity	
3000.00 · Opening Bal Equity	1,095,702.47
4000.00 · Net Assets	4,107,485.54
Net Income	-382,086.68
Total Equity	4,821,101.33
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b><u>9,363,850.71</u></b>

**CALIFORNIA PRIMARY CARE ASSN**  
**Profit & Loss Budget vs. Actual**  
April through August 2017

	<u>Apr - Aug 17</u>	<u>Budget</u>	<u>\$ Over Budget</u>	<u>% of Budget</u>	
<b>Income</b>					
4500.00 · Dues	817,708.31	817,708.31	0.00	100.0%	
4600.00 · Grants	1,274,865.37	1,160,772.07	114,093.30	109.83%	
4621.00 · Contributions	495,000.00	1,062,626.42	-567,626.42	46.58%	Recvd BS, TCE CP3 & other CP3
4749.00 · Licensing Fees- Health+	0.00	0.00	0.00	0.0%	project renewals later in year
4750.00 · Sponsorship	5,000.00	90,666.62	-85,666.62	5.52%	
4900.01 · Interest	4,892.30	3,750.00	1,142.30	130.46%	
4950.01 · Clinic Operations Support	180,297.75	353,169.50	-172,871.75	51.05%	
4955.00 · Miscellaneous Income	23,657.72	24,666.62	-1,008.90	95.91%	
4956.00 · Legal Fund Donations	18,500.00	0.00	18,500.00	100.0%	
4960.00 · Conference Income	461,417.50	607,142.90	-145,725.40	76.0%	
4999.99 · Training Income	601,050.00	475,416.69	125,633.31	126.43%	
<b>Total Income</b>	<u>3,882,388.95</u>	<u>4,595,919.13</u>	<u>-713,530.18</u>	<u>84.48%</u>	
<b>Gross Profit</b>	<u>3,882,388.95</u>	<u>4,595,919.13</u>	<u>-713,530.18</u>	<u>84.48%</u>	
<b>Expense</b>					
6100.00 · Salaries	1,621,631.58	1,878,428.53	-256,796.95	86.33%	
6300.00 · Employee Benefits	366,118.96	489,121.72	-123,002.76	74.85%	
6500.00 · Occupancy	152,975.15	148,770.31	4,204.84	102.83%	
6505.10 · Building Repair	3,277.36	4,173.69	-896.33	78.52%	
6510.10 · Communications	21,120.34	21,590.40	-470.06	97.82%	
6520.10 · Postage & Delivery	5,889.42	3,749.94	2,139.48	157.05%	timing filling postage machine
6530.10 · Supplies	30,903.04	36,931.62	-6,028.58	83.68%	
6540.00 · Printing	13,101.91	20,291.58	-7,189.67	64.57%	
6552.10 · Equipment Lease/Maintenance	9,001.98	12,035.69	-3,033.71	74.79%	
6554.10 · Small Equipment	20,472.13	11,458.24	9,013.89	178.67%	\$8800 pd for by EP
6560.10 · Insurance	9,305.31	7,812.40	1,492.91	119.11%	
6565.10 · Dues & Licenses	4,608.20	6,424.49	-1,816.29	71.73%	
6570.10 · Subscriptions/Pubs	74,583.33	18,551.89	56,031.44	402.03%	iMIS,
6580.10 · Marketing and Outreach	39,086.92	41,666.55	-2,579.63	93.81%	
7010.10 · Audit/Accounting	22,192.13	15,173.51	7,018.62	146.26%	timing
7020.10 · Legal Services	12,043.25	3,125.00	8,918.25	385.38%	personnel matter
7040.10 · Temporary Staffing	36,827.65	34,000.00	2,827.65	108.32%	
7110.10 · Board of Directors	31,956.63	29,166.62	2,790.01	109.57%	
7200.10 · Travel & Registration Fees	149,539.29	98,490.98	51,048.31	151.83%	
7275.00 · Staff Development	20,582.05	18,749.97	1,832.08	109.77%	
7350.00 · Training Expense/Meetings	420,410.84	428,571.45	-8,160.61	98.1%	
7450.00 · Annual Conference	244,933.73	428,571.45	-183,637.72	57.15%	
7500.00 · Consultants	653,389.43	737,024.02	-83,634.59	88.65%	
7800.00 · Sub-Grants	300,000.00	404,166.62	-104,166.62	74.23%	
7900.10 · Bad Debt	525.00	2,083.62	-1,558.62	25.2%	
<b>Total Expense</b>	<u>4,264,475.63</u>	<u>4,900,130.29</u>	<u>-635,654.66</u>	<u>87.03%</u>	
<b>Net Income prior to release from restricted</b>	<u>-382,086.68</u>	<u>-304,211.16</u>	<u>-77,875.52</u>	<u>125.6%</u>	
<b>Released from temporarily restricted</b>	574,112.38	600,000.00	-25,887.62	95.69%	
<b>Net Income after release</b>	<u>192,025.70</u>	<u>295,788.84</u>	<u>-103,763.14</u>	<u>64.92%</u>	



FOR IMMEDIATE RELEASE

Contact: Amy Simmons Farber 202/309-0338

## **Bay State Health Center Leader Takes Helm of National Organization**

BETHESDA, MD— James Luisi, Chief Executive Officer of North End Waterfront Health in Boston, MA, has been inaugurated as Board Chair of the National Association of Community Health Centers (NACHC) at the association's 48<sup>th</sup> Community Health Institute (CHI) and EXPO in San Diego, CA. The conference assembles thousands of health center leaders from across the country. Mr. Luisi assumes the chair as new estimates show that health centers now serve more patients than ever at 27 million.

In remarks to the conference general session after assuming the chairmanship, Mr. Luisi called on health center leaders to strengthen their advocacy voices.

“I am calling upon all of you here today, as well as your staff, colleagues, board members and patients all across America back home to make advocacy as important as everything else we do at our health centers,” he said. “That is the only way we will survive in the future... Nothing is as powerful as a message delivered on behalf of the millions of people -- patients, community board members, and staff -- who are served by, work or volunteer for and support the health center mission.”

Mr. Luisi also underscored his commitment as NACHC Board Chair to help secure a fix for the primary care funding cliff, build the primary care workforce and fight against Medicaid cutbacks which will adversely impact a large portion of health center patients.

“Jim Luisi has been a powerful advocate and leader for Massachusetts community health centers over the last 30 years,” said James W. Hunt, Jr., president and CEO of the Massachusetts League of Community Health Centers. “Now more than ever, health centers at the national level need his clear and impassioned voice to ensure that they can continue to deliver high-quality, cost-effective care to 27 million patients, one million of whom are served right here in Massachusetts.”

Mr. Luisi has served at the helm of North End Waterfront Health since 1988 and is a longtime veteran of community health. He spent his early years working in public health, working in the Office of Grants Management at the U.S. Department of Health and Human Services. During his more than 20 years of service, he also developed a 140 bed skilled nursing facility and a senior center with elderly housing for the surrounding community's large elderly population. A graduate of Northeastern University, Mr. Luisi has a Master of Business Administration from Suffolk University in Boston. Leading up to his election as Board Chair, Mr. Luisi has served on numerous NACHC committees helping to shape legislative policies to strengthen and build

capacity at health centers. He also served as past Board Chair of the Massachusetts League of Community Health Centers and was chosen as Massachusetts Administrator of the Year in 2007 by the Boston Business Journal.

Community Health Centers started more than fifty years ago as a daring experiment as part of the War on Poverty. It is now the largest and most successful primary health care system in the United States, serving nearly 10,000 rural and urban communities. Health centers also save the U.S. health care system more than \$24 billion every year in reduced overall costs from preventable hospitalizations and avoidable emergency room visits. .

Founded in 1970, the National Association of Community Health Centers (NACHC) is a non-profit organization whose mission is to enhance and expand access to quality, community-responsive health care for America's medically underserved and uninsured. NACHC represents the nation's network of over 1,400 Federally Qualified Health Centers (FQHCs) which serve 27 million people through nearly 10,000 sites located in all of the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

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# CPCA Epic Board Oversight Committee

Proposal: Corporate Structure and Governance Model for CPCA-led Epic Program

*October 2, 2017*

## Process Summary

On August 29, 2017, law firm Stoel-Rives presented CPCA with a legal memo (Attachments A & B) that identified a set of decision-making criteria for an organizational structure for proceeding with a business plan to support a business line focused on delivery of a single-instance of Epic to CPCA members. This memo was reviewed with the Board oversight committee (aka the Board workgroup) appointed to serve in the capacity of overseeing the furtherance of the business plan for this initiative. The memo presented analysis of five (5) potential legal structures under which CPCA could offer this business line:

- **Option 1** - Offer the single-instance of Epic as a CPCA program, completely housed within the CPCA governance structure. Stoel-Rives advised that this structure could fit CPCA's needs as it minimized administrative burden and capitalizes on CPCA's leadership and vision, but given the Board's feedback, Options 4 or 5 would be a better fit.
- **Option 2** - Create a new and separate 501c3 and offer the single-instance of Epic through that new entity. Stoel-Rives advised against this structure due to reasons of administrative burden, additional expense, liability and the burden of maintaining tax exempt status through charitable activities.
- **Option 3** - Offer the single-instance of Epic through CPCA Ventures. Stoel-Rives advised against this structure as it did not provide protection to Ventures assets.
- **Option 4** - Create a separate, independent LLC of which CPCA and participating health centers (or additional partners) are joint owners and offer the single-instance of Epic through that entity. Stoel-Rives advised this structure was a good fit for CPCA's needs.
- **Option 5** - Create a single-member LLC of which CPCA is the sole owner and offer the single-instance of Epic through that entity. Stoel-Rives advised this structure was a good fit for CPCA's needs.

At that time, the oversight committee requested further analysis of the differences between Options 4 (Independent LLC) and Option 5 (Single-Member LLC.) (Attachment C).

Stoel-Rives has provided the attached decision matrix as a representation of that analysis. This matrix categorizes attributes of each legal structure as essential (fundamental to the model), desirable (beneficial to CPCA for the reasons highlighted), and of interest (does not influence

decision either way but should be noted.) The matrix compares attributes shared by both models, key attributes that are independent to each model but not in conflict, and conflicting attributes for which each model achieves a function distinct from the alternative.

## CPCA Management Recommendation: Option 5 – Single-Member LLC

With guidance from Stoel-Rives, CPCA is recommending that a single-member LLC be created to house the Epic initiative. This recommendation is based on several key factors:

### EPIC's interest in working with the leadership of CPCA

1. A single-member LLC allows for branding to directly connect CPCA to this work, and therefore, this model serves to enhance CPCA's and CPCA Members' reputations. (Option 4, through creating a new and separate LLC, dilutes the ability to enhance CPCA's brand and we believe is not the model that Epic has envisioned.) Epic has expressed to CPCA that they are interested in working with the leadership team of CPCA due to our national reputation and the strength of our organization. Epic has also expressed that they already have a relationship with an HCCN to deliver the Epic product and they are not necessarily interested in duplicating this model. Their interest from the beginning has been to partner with the PCA.

### Revenue associated with this model supports CPCA's strategic plan

2. A single-member LLC creates the greatest opportunity for revenue associated with this business-line to flow to CPCA programming, advocacy work, and other important CPCA-led activities on behalf of its members.

### Leverages CPCA's staff, especially our Health Center Operations Team

3. With a single-member LLC, CPCA has the ability to quickly and easily utilize current staff as needed to contribute key input, support and subject matter expertise. (Under a multi-member LLC, CPCA would need to execute a sub-contractor or shared services agreement in order for the program to benefit from the experience and expertise of current CPCA staff, and track hours down to the hour.)

### If CPCA participates in a meaningful way, we potentially lose protections afforded in Option #4

4. Stoel-Rives has advised that if CPCA were providing much of the staff and support to the organization, even if it is paid at fair market value, that CPCA would lose many of the liability protections afforded under this model. However, if CPCA does not participate in a significant manner, we are unsure that the new entity could get off the ground.

### Meets our desire to limit administrative burden and costs

5. Although the business plan envisions that the cost of the Epic program will be tracked separately from other CPCA lines of business and paid for out of program revenue, it does so at an FTE-allocation level. A multi-member LLC would create considerable administrative burden to CPCA participating meaningfully in this program.

CPCA worked closely with the oversight committee and Stoel-Rives to evaluate all options. However, one of the major reasons for examining Option #4 was to protect CPCA's finances and reputation should the program not be a success, but ultimately this would severely limit CPCA's ability to participate in the program and also to receive revenue to support our strategic plan. Additionally we don't believe that Option #4 would be attractive to Epic given that Epic has stated that they respect CPCA's leadership and reputation and want to work directly with the PCA. Finally, one of the goals of this initiative is to limit overhead costs and Option #4 does not allow us to leverage CPCA's existing staff and creates more administrative burden. Therefore, we feel the best option for meeting both Epic and CPCA's goals is Option #5.

## Proposed Governance Structure

CPCA proposes that the new single-member LLC have a Board distinct and separate from the CPCA Board. The Board will have seven (7) seats, and the seats will each be populated by the CPCA Board. Four (4) of the seats will be held at all times by CPCA Board members. The remaining three (3) seats will be held by CPCA members in good standing.

The initial Board member term will be 2 years (to cover the initial build) and will shift to annual (1 year) terms after that period. There will be no established limits on the number of terms that Board members may hold their seat, but the CPCA Board may wish to establish some guidelines for appropriate numbers of consecutive terms and other criteria for determining qualifications to serve.

Under this model, the CPCA Board will have direct oversight of key strategic decisions that might impact CPCA itself, such as the ability of the entity to take on debts beyond a certain limit or whether to fold the LLC. The new LLC Board will have rights to make key decisions about the operations of the business, such as budgeting, planning, and general strategies. Neither of these parties will make decisions related to the configuration of the Epic product, however, as these will be made by a series of advisory committees.

These advisory committees will be instantiated by policies and procedures adopted by the LLC Board. At a minimum, there will be an EHR Configuration Committee, a Revenue Cycle Committee, a Population Health Management Committee, a Health Information Exchange Committee, a Security and Privacy Committee, and an Analytics Committee. The LLC Board may choose to create additional advisory committees or sub-committees as needed to support the actual work of managing the product, and these additional committees may become standing committees or may serve a specific short-term purpose. Qualified professionals from any member Health Centers considering utilizing the CPCA single-instance of Epic will have opportunities to participate in these committees to strengthen the offering and assist in steering the business towards meeting the greater needs of California CHCs.



## M E M O R A N D U M

August 29, 2017

### ATTORNEY-CLIENT PRIVILEGE; ATTORNEY WORK PRODUCT

TO: CALIFORNIA PRIMARY CARE ASSOCIATION

FROM: ANTHONY R. MILES  
SASKIA M. DE BOER

RE: Considerations for Structuring a Community Electronic Health Record

California Primary Care Association (“CPCA”) engaged Stoel Rives LLP to review legal, operations, and governance considerations for CPCA to launch and implement a new community electronic health record program (“CEHR,”) as a new offering for its members. CPCA management and Stoel Rives attorneys have engaged in conversations about the risks inherent in the new CEHR venture, including financial liability from a plaintiff suit and health care/regulatory liability (breach notification and remediation costs, HIPAA fines and penalties, California state law penalties for unauthorized access or disclosure). We also discussed proactively pursuing risk mitigation measures (additional insurance, templates and agreements), tax matters and governance.

At its July meeting, CPCA Executive Committee reviewed a proposal to house the CEHR in CPCA and operate the new line of business as a CPCA program. The directors discussed governance, control and liability, and whether CEHR is best-suited as a CPCA program or better operated outside of CPCA. The Executive Committee requested review of other types of structures that could house the CEHR. We understand the CPCA Executive Committee’s goal is to find a structure that allows for a more independent governance structure and better insulates CPCA from financial liability.

The attached comparative options matrix summarizes seven characteristics across five structures. The seven characteristics listed down the left column are: (a) governance & management; (b) infrastructure, resources & staffing; (c) liability & exposure; (d) investment & revenue; (e) expansion/liquidity event; (f) external image & reputation; and (g) tax issues. Each of these issues is addressed in the column labeled across the top row for each structure: (1) operate CEHR in CPCA; (2) create a new 501(c)(3) organization for the CEHR; (3) house CEHR in Ventures; (4) create and operate a separate LLC; and (5) CPCA create a single-member LLC. The structure and content of the matrix is intended to assist with comparison across structure and by characteristic, and to prompt further board discussion about CPCA’s goals and concerns in launching a new line of business.

Attachment: Table 1

**Table 1: Matrix of Structures and Issues for CEHR**

	<b>Operate in CPCA</b>	<b>Create new 501(c)(3) nonprofit corporation</b>	<b>House in Ventures</b>	<b>Create &amp; Operate in Separate LLC</b>	<b>CPCA Create Single-member LLC</b>
<b>Governance &amp; Management</b>	<ul style="list-style-type: none"> <li>• CPCA board of directors would be ultimate decision-maker.</li> <li>• CPCA Executive Committee could be more deeply involved and keep full Board informed.</li> <li>• CPCA management would develop business plan and make decisions regarding implementation and operations of CEHR within framework established by Board.</li> <li>• A Technical Advisory Committee composed of dedicated members could provide CPCA staff with input from the user perspective.</li> </ul>	<ul style="list-style-type: none"> <li>• Governed by New Org board of directors, the composition &amp; structure of which would be outlined in New Org bylaws.</li> <li>• Some, but not all, New Org and CPCA board members may overlap.</li> </ul>	<ul style="list-style-type: none"> <li>• Governed by Ventures board of directors.</li> </ul>	<ul style="list-style-type: none"> <li>• NewCo Members would be CPCA and interested CPCA FQHCs</li> <li>• Governance addressed in Operating Agreement with broad latitude on how drafted</li> <li>• Option for Members to manage or to retain certain approval rights with manager-managed entity</li> <li>• Option to establish governance of NewCo by board of managers appointed by vote of Members or capital account</li> <li>• Option to contract for independent, third-party manager</li> <li>• Day-to-day management and operations could be handled by separate employees or, loaned employees</li> </ul>	<ul style="list-style-type: none"> <li>• CPCA would be sole Member of NewCo</li> <li>• Governance addressed in Operating Agreement with broad latitude on how drafted</li> <li>• CPCA Board could retain approval of some actions as Member</li> <li>• NewCo Could be managed directly by CPCA Board or by manager</li> <li>• Option to establish manager as, CPCA executive, independent 3rd party, or board of managers appointed by CPCA Board</li> <li>• NewCo Board members could include executives from those FQHCs most involved in the project</li> </ul>
<b>Infrastructure, Resources &amp; Staffing</b>	<ul style="list-style-type: none"> <li>• CPCA could utilize existing staff, resources, space and IT infrastructure to accomplish programs goals</li> </ul>	<ul style="list-style-type: none"> <li>• New Org would hire staff for operations, and could enter into contracts with CPCA and other organizations for support.</li> </ul>	<ul style="list-style-type: none"> <li>• Ventures would hire staff for operations, and could enter into contracts with CPCA and other organizations for support.</li> </ul>	<ul style="list-style-type: none"> <li>• NewCo will need to pay for space, IT and other resources at FMV</li> <li>• Independent employees; lease employees from Members; use independent contractors so long as compensation is FMV</li> <li>• All use/exchanges of value between NewCo and CPCA would require documentation</li> </ul>	<ul style="list-style-type: none"> <li>• CPCA could contribute space, personnel and IT infrastructure directly to NewCo operations in exchange for equity, reducing cost and administrative burden relative to a fully independent LLC</li> </ul>
<b>Liability &amp; Exposure</b>	<ul style="list-style-type: none"> <li>• CPCA would be subject to financial liability and privacy/health care liability.</li> <li>• We would recommend CPCA obtain appropriate types and levels of additional insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Financial liability for new line of business would be contained to New Org.</li> <li>• Privacy and health care liability would not be limited to New Org and would extend to</li> </ul>	<ul style="list-style-type: none"> <li>• Exposes Ventures' \$10 million to financial liability. In addition, privacy and health care liability would not be limited to New Org and would extend to CPCA to the extent</li> </ul>	<ul style="list-style-type: none"> <li>• Minimizes CPCA exposure to liability resulting from operations so long as all services and support provided to NewCo are FMV</li> <li>• Members exposed to loss of</li> </ul>	<ul style="list-style-type: none"> <li>• Contractual liability, regulatory penalties and similar types of liability from NewCo operations likely would be isolated in NewCo</li> <li>• Depending upon how NewCo</li> </ul>

	<b>Operate in CPCA</b>	<b>Create new 501(c)(3) nonprofit corporation</b>	<b>House in Ventures</b>	<b>Create &amp; Operate in Separate LLC</b>	<b>CPCA Create Single-member LLC</b>
	and engage in other risk mitigation measures before launching the CEHR.	CPCA to the extent it is involved in CEHR operations.	it is involved in CEHR's operations.	capital contribution <ul style="list-style-type: none"> <li>Members would not be exposed to consequential damages from NewCo operations</li> </ul>	was governed, staffed and resourced, CPCA could be exposed to liability for negligence or other tort damages resulting from NewCo operations
<b>Investment &amp; Revenue</b>	<ul style="list-style-type: none"> <li>For initial funding, CPCA could use its reputation and contacts to seek financial support from a private foundation via a grant or a low-interest loan in the form of a program-related investment.</li> </ul>	<ul style="list-style-type: none"> <li>As a 501(c)(3) organization, New Org's activities and assets must be dedicated for a charitable purpose and not used for private benefit.</li> <li>Any income generated by New Org, whether by operation or sale of the new line of business, must be used for New Org's charitable activities/purpose.</li> <li>Not attractive to outside investors, who would not recoup their capital.</li> <li>New Org could seek grants or loans to capitalize.</li> </ul>	<ul style="list-style-type: none"> <li>As a 501(c)(3) organization, Venture's activities and assets must be dedicated for a charitable purpose and not used for private benefit.</li> <li>Any income generated by Ventures, whether by operation or sale of the new line of business, must be used for Ventures and CPCA's charitable activities/purpose.</li> <li>Not attractive to outside investors, who would not recoup their capital.</li> </ul>	<ul style="list-style-type: none"> <li>Would require contributions of cash for seed capital</li> <li>Value of Membership interest but not NewCo assets would remain on CPCA balance sheet</li> <li>Revenue from operations could be retained within NewCo and excess could be distributed based on Membership preferences, capital accounts</li> </ul>	<ul style="list-style-type: none"> <li>NewCo would require separate capitalization but assets would roll-up to CPCA balance sheet due to disregarded entity status</li> <li>Revenue from NewCo operations likewise would be attributed to CPCA and need to be reported on CPCA's Form 990</li> </ul>
<b>Expansion/Liquidity Event</b>	<ul style="list-style-type: none"> <li>No avenues for additional investment or spin off of business except asset sale</li> </ul>	<ul style="list-style-type: none"> <li>No avenues for additional investment or spin off of business except asset sale</li> </ul>	<ul style="list-style-type: none"> <li>No avenues for additional investment or spin off of business except asset sale</li> </ul>	<ul style="list-style-type: none"> <li>Structure permits adding additional, non FQHC investors</li> <li>Possibility to merge entity or sell business more readily than within tax-exempt /nonprofit regime</li> </ul>	<ul style="list-style-type: none"> <li>CPCA could sell its interest in NewCo in exchange for cash to put toward CPCA's mission</li> </ul>
<b>External Image &amp; Reputation</b>	<ul style="list-style-type: none"> <li>Held out to public as a CPCA program.</li> </ul>	<ul style="list-style-type: none"> <li>Held out to public and branded as a separate organization from CPCA</li> </ul>	<ul style="list-style-type: none"> <li>Branded as Ventures program</li> </ul>	<ul style="list-style-type: none"> <li>Held out to public and branded as a separate organization from CPCA</li> </ul>	<ul style="list-style-type: none"> <li>CEHR could be held out to the public as a CPCA-affiliated program</li> </ul>
<b>Tax issues</b>	<ul style="list-style-type: none"> <li>Based on our understanding that CPCA will offer the CEHR to its members, all of whom are FQHC's, nonprofits or public charities, who do not have access to a similarly priced commercial alternative, and based on proposed fee CPCA will charge members relative to its cost, we believe</li> </ul>	<ul style="list-style-type: none"> <li>New Org would need to apply to the IRS for recognition of exemption. To achieve such status, New Org would need to prove that it is organized and operated exclusively for exempt purpose. It is unlikely the IRS would grant New Org 501(c)(3) status if its primary activity is licensing CEHR to</li> </ul>	<ul style="list-style-type: none"> <li>Ventures would seek approval from IRS of its expanded purpose and activities.</li> </ul>	<ul style="list-style-type: none"> <li>Subject to franchise and license fees</li> <li>No need to apply for exemption for NewCo</li> <li>Potential for NewCo distributions to generate UBTI for CPCA and NewCo members</li> </ul>	<ul style="list-style-type: none"> <li>So long as the CEHR is offered exclusively to nonprofits or public charities, we anticipate the tax analysis will be similar to operating in CPCA</li> </ul>

	Operate in CPCA	Create new 501(c)(3) nonprofit corporation	House in Ventures	Create & Operate in Separate LLC	CPCA Create Single-member LLC
	CEHR program has a causal relationship to CPCA's exempt purpose and is not unrelated business subject to UBIT.	health centers and organizations. To achieve tax-exempt status, New Org would need to replicate CPCA's structure and conduct additional charitable activities.			
<b>Other Considerations</b>				<ul style="list-style-type: none"> <li>• Would impose ancillary legal and accounting costs on FQHC members in connection with investment and any distributions or losses</li> <li>• Inability for CPCA or members to directly contribute personnel or resources except at FMV would add to NewCo's operating expense profile relative to other options</li> </ul>	
<b>Recommend for CPCA?</b>	<ul style="list-style-type: none"> <li>• Yes. This initial proposal minimizes administrative burden and capitalizes on CPCA's leadership and vision. However, in light of the board's feedback and goals, the single-member LLC structure appears to be a better fit, as it achieves independent governance and greater liability protection.</li> </ul>	<ul style="list-style-type: none"> <li>• No. To achieve tax-exempt status, New Org would need to conduct additional charitable activities that CPCA currently does or CPCA could take on. If there is another goal or other value in having a sister-organization to CPCA, this is a possibility, but the other goals should be the driver. Because additional activities would be in the NewOrg, so, too would additional assets, which would then also be exposed to CEHR liability. And with a separate organization, there would be administrative burden of operating a second separate entity.</li> </ul>	<ul style="list-style-type: none"> <li>• No. This option does not offer protection for Ventures endowed assets.</li> </ul>	<ul style="list-style-type: none"> <li>• Yes. This option achieves many of the goals established, especially in liability limitation and potential for expansion beyond CPCA's universe of users</li> <li>• More expensive and administratively cumbersome than other options</li> </ul>	<ul style="list-style-type: none"> <li>• Yes. This option appears to best balance the interests of supporting CPCA members, separating out an aspect of CEHR governance and achieve some degree of liability protection while providing for the potential for the initiative to grow into a self-sustaining business that could attract potential customers beyond the FQHC community</li> </ul>

**Table 2:** Decision Priorities<sup>i</sup> Matrix Comparing Option 4<sup>ii</sup> and Option 5<sup>iii</sup> from August 29, 2017 Memorandum<sup>iv</sup>

Priority	Shared Attributes	Independent Attributes		Conflicting Attributes	
		Option 4 (Independent LLC)	Option 5 (Single-member LLC)	Option 4 (Independent LLC)	Option 5 (Single-member LLC)
<b>Essential</b>	<ul style="list-style-type: none"> <li>Structure consistent with CPCA tax-exempt status</li> <li>Isolates contractual &amp; regulatory liability in NewCo</li> <li>Furtheres CPCA strategic plan</li> <li>CPCA Board can retain approval rights over some core actions as NewCo Member</li> <li>Would require separate D&amp;O and E&amp;O coverage</li> </ul>		<ul style="list-style-type: none"> <li>Restricting customers to FQHCs, nonprofits and public charities without access to commercial product on comparable terms (e.g., cost-based fee) should be causally related to CPCA exempt purposes and not raise risk of UBTI</li> </ul>	<ul style="list-style-type: none"> <li>Preserve independence of CPCA brand</li> <li>Shield CPCA from most vicarious liability risk</li> <li>Would require separate liability insurance coverage</li> <li>NewCo must have own employees or pay FMV for staffing &amp; other support from CPCA/Members</li> <li>NewCo profits remain within NewCo unless distributed based on capital accounts or Membership interests</li> </ul>	<ul style="list-style-type: none"> <li>Enhance CPCA reputation</li> <li>Increase CPCA earned income</li> <li>Activities potential covered under existing CPCA liability policies</li> <li>CPCA can contribute staff &amp; resources directly to NewCo operations</li> <li>NewCo profits available to cross-subsidize other CPCA functions</li> </ul>
<b>Desirable</b>	<ul style="list-style-type: none"> <li>Creates potential for access to aggregate clinical and financial data to support CPCA advocacy efforts, subject to applicable privacy laws</li> <li>Financial participation by interested CPCA members</li> </ul>	<ul style="list-style-type: none"> <li>Interested CPCA Members can participate as owners and share in NewCo governance</li> <li>No restriction on status of potential customers</li> </ul>	<ul style="list-style-type: none"> <li>Facilitates grant or low-interest loan based on CPCA reputation and exempt-status</li> <li>CPCA Board can designate representatives of interested members to serve on NewCo board</li> <li>Potential to grow into self-sustaining business entity that can attract customers beyond FQHC community</li> </ul>	<ul style="list-style-type: none"> <li>Shared governance structure furthers CPCA member involvement</li> </ul>	<ul style="list-style-type: none"> <li>CPCA Board control of appointments to LLC Manager Board maximizes CPCA control of venture</li> </ul>
<b>Of Interest</b>		<ul style="list-style-type: none"> <li>Requires payment of franchise and license fees</li> </ul>		<ul style="list-style-type: none"> <li>Value of NewCo membership interest remains on CPCA balance sheet</li> <li>Option to add other investors for growth/expansion</li> </ul>	<ul style="list-style-type: none"> <li>All NewCo assets, revenues and liabilities roll-up to CPCA balance sheet</li> <li>Report revenue and expenses on existing Form 990</li> <li>Sale of member interest primary option for exit strategy</li> </ul>

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<sup>i</sup> CPCA’s priorities identified for this assignment were (1) enhancing non-grant, non-dues revenue to support advocacy efforts; (2) minimizing administrative and implementation costs, including leveraging CPCA staff expertise to meet goals of project; (3) mitigating financial and reputational risk; (4) having NewCo governance that looks out for CPCA needs and interests; (5) obtaining access to good aggregated clinical and financial data to tell the story of the quality and value of community health centers; (6) furthering CPCA’s strategic plan and maintaining control over NewCo activities; and (7) building CPCA’s reputation.

<sup>ii</sup> Form independent manager-managed LLC (“NewCo”) with CPCA and individual CPCA-member FQHCs as Members; create board of Member representatives to oversee operations, while NewCo Members retain specific approval rights (e.g., dissolution, amendment to Operating Agreement; issuance of new shares).

<sup>iii</sup> Form single-member, manager-managed LLC (“NewCo”) with CPCA as sole member. Create board to oversee operations. CPCA Board in charge of appointing members of NewCo board of managers.

<sup>iv</sup> This matrix was prepared without the benefit of the opportunity to review and discuss the business plan for the project. Review of the contents of the business plan may materially change our analysis regarding priorities or areas of conflict and this analysis should be considered provisional until such review

***Privileged & Confidential—Attorney-client Communication***



# BUSINESS PLAN: CLOUD- BASED EHR FOR CALIFORNIA CLINICS AND COMMUNITY HEALTH CENTERS

California Primary Care Association

## Abstract

This business plan examines the opportunity to create a shared cloud-based Electronic Health Record (EHR) for California Clinics and Community Health Centers with the benefit of improving competitiveness of CHCs,

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## Executive Summary

The California Primary Care Association has a unique opportunity to partner with Epic Systems Corporation, the leader in delivering Health IT software to provider organizations around the world. This partnership would have the benefit of creating a California-specific EHR and Population Health Management system which would be made available to all CPCA Member CHCs.

A considerable number of CPCA Member CHCs have expressed interest in partnering with CPCA on this initiative, including some of the largest CHCs in the state. So many have expressed real interest, that any business pro-forma created suggests that the investment necessary to start and sustain this new business would return positively.

As in any business, there are risks, but CPCA has identified strategies to address each of these. The most considerable risk is ability to successfully execute on the vision laid out in this business plan. CPCA feels strongly that it is creating a truly unique partnership with the Epic Systems Corporation, and that there are sufficient mutual incentives to making this model successful. With Epic delivering on the most technically challenging aspects of the business, CPCA feels confident in its ability to execute in collaboration with, and on behalf of, its members.

CPCA seeks constructive input and critique from members of its Board and Executive Committee so as to strengthen this business plan and ensure that it becomes a success that all members who chose to can participate in. Doing so will create considerable leverage for California CHCs and new opportunities to invest in advocacy and programming to support CPCA Members.

## Business Description, Vision and Goals

### Business Description

The California Primary Care Association is proposing to create a single instance of the Epic Health IT Platform in partnership with its member Community Health Centers (“CHCs”.)

A single-instance of Epic will be configured specifically for the needs of California CHCs, with key features to support current and future payment models, population health approaches, and quality improvement and health exchange models in California.

The single-instance will be hosted by Epic in a cloud-like environment, minimizing local costs to support and maintain the software. The configuration of the software will be governed by the CHCs that participate in the initiative.

CHCs will pay for their implementation, which will include local configuration, conversion, and deployment. They will also pay a per-encounter price for the software, hosting, and support.

After achievement of critical mass, any margin will be used to reinvest in the services of CPCA related to population health, quality improvement, data and analytics, and advocacy.

### Vision and Goals

The vision for this business has been derived from an in-depth assessment of the trends in the Health IT market. These trends strongly suggest that California's CHCs will face strategic decisions about where and how to obtain their Health IT capabilities. These strategic decisions will have impact on CHC issues well beyond Health IT. They will impact autonomy in decision-making, contracting opportunities in Medi-Cal and beyond, and business viability as free-standing organizations.

To maximize competitiveness in the evolving market, all healthcare organizations are dealing with these trends:

- 1) Health IT platforms are increasingly moving to the "cloud."
- 2) Large Health Systems are using Health IT as a "physician engagement" strategy, giving them greater market presence and leverage.
- 3) Advanced Health IT allows providers to serve patients in otherwise challenging geographies, making them more competitive in CHC markets, without physical entry to these markets.
- 4) Advanced Health IT is allowing Health Systems to enter into value-based arrangements, making Medi-Cal a more desirable payer source and increasing likelihood they will compete for these patients.

Therefore, CPCA's vision for this program accounts for the fact that in order to remain competitive, CHCs must increase their leverage in how they acquire, use, maintain, and innovate in their use of Health IT.

Epic is a product that differentiates itself from other Electronic Health Records / Health IT platforms based on its usability (specifically provider usability) and its advanced population health management tools. In many markets, Epic is the dominant player amongst large Health Systems. Unfortunately, most CHCs are not large enough to garner much interest from Epic as direct customers. Therefore, most CHCs have two options for obtaining Epic:

- 1) Acquire Epic through a local Health System or Hospital or
- 2) Acquire Epic through an entity that consolidates multiple CHCs under one, single instance of the product.

Both of these strategies are viable, but each has different implications.

Acquiring Epic through a local Health System means relying on that Health System for support of the product. Typically, the Health System has considerable control over the configuration of the product, and the CHC is but one of many customers of their services. Longer term, Health Systems may look to consolidate the CHCs in other ways, such as contracting on their behalf or providing care coordination services to the CHC patients. Still, this option has advantages in that often the Health System will support some of the implementation and maintenance costs,

and some CHCs may wish to partner with their Health System on initiatives like contracting and care coordination.

Acquiring Epic through an entity that consolidates multiple CHCs under one, single instance means relying on a central, aggregating entity for support of the product. Currently there is only one organization whose sole focus is on delivering this model, and they do so on a national level. This model has the advantage of consolidating multiple CHCs for economy of scale, serving the specific needs of Health Centers, eliminating threats to consolidation that are posed by Health System led initiatives, and providing a Health Center-only governance model for the platform.

This business plan evaluates CPCA's interest in developing an entity that aggregates multiple California CHCs on one, single instance of Epic that will be professionally managed on behalf of the entity and its CHC customers. In doing so, it is CPCA's vision that it can accomplish four key strategic objectives that advance CPCA and its Members goals.

#### Goal #1: Develop a Robust, California-specific Cloud Based EHR and Population Health Management System

A primary goal of this initiative is to create a California-specific, hosted version of Epic. This provides California CHCs an additional option to use the Epic platform without having to work through a health system or an out-of-state vendor.

A California-specific version of Epic would have all necessary customizations to deal with Medi-Cal policy, California-specific Health Center billing rules, clinical tools and workflows to support payment reform in California, and reporting tools to meet California state-level regulatory reporting requirements.

Further, working together ensures that the money spent on EHR and Population Health tools is reinvested in California.

#### Goal #2: Leverage the Purchasing Scale of California's CHCs

With even a small percentage of CPCA's members participating in a single-instance shared Epic platform, the scale of such an undertaking will be considerable. Epic, known to prefer to only interact with large Health Systems, responded quickly and positively to explore some kind of relationship with CPCA. Since the formation of CalHIPSO in 2007, CPCA has exploring ways to capitalize on the considerable scale of the CPCA membership. This business opportunity can do that to achieve favorable terms for the product as well as leverage in other strategic areas.

First, this scale will create an opportunity to create a highly-favorable Epic program. This program will be cost competitive with other options, including other Health Center-specific aggregators. The advantages that it will have over other aggregators is that Epic will be hosting and maintaining the platform, essentially passing some of the most critical technical aspects of managing an EHR right to the vendor and the experts in the product. Also, the CPCA-led

initiative will include the most comprehensive product offering Epic makes available, giving CHCs access to tools that other implementation models do not.

Second, an initiative such as this will provide California CHCs considerable leverage negotiating terms and conditions around health information exchange. This platform will become the hub for exchange regarding CHC patients, instead of allowing Health Systems to serve in that capacity. That will help protect CHCs autonomy and data ownership from Health Systems that may see value in growing their footprint in the Medi-Cal business.

Third, the amassed data will provide CHCs, Regional Consortia, and CPCA with by far the most comprehensive data set on Medi-Cal patients throughout the State without the traditional burdens of data aggregation programs. This will strengthen advocacy at every level of the CHC industry in California.

#### Goal #3: Supporting Maximum Flexibility in Regional Models

The CPCA-led Epic platform will not only offer the ability for each CHC to operate a fully independent organization, it will also allow for groups of CHCs to partner on key contracting and other initiatives within their region. Users of the platform will gain access to tools that are optimized for State-level and Regional-level payment models. As they contemplate network configuration in their market, the product will be robust enough to create network-centric views of data. Therefore, the CHCs in a market would be able to participate in network partnerships with others in their region, including their Regional Consortia if appropriate, and do so without additional software systems or cost. No other Epic host is offering the same level of support for value-based initiatives.

#### Goal #4: Forming Natural Collaborations Around Best Practice and Innovation

A large-scale partnership amongst CHCs in California will serve as an incubator for innovation and best-practice definition in clinical care and technology-supported patient engagement. Rather than simply sharing ideas through webinars, and conferences, CHCs participating in the CPCA Epic model will be able to port best practices using the technology tools of Epic.

For example, analytics queries developed by one CHC could be shared by all others. Policies and procedures for data sharing with hospital partners could be largely standardized with the interfaces, role-based access controls, and audit reports to match. Approaches to patient engagement and population health management could be disseminated via technology. In essence, a shared, California CHC-governed Epic instance could become the hub of technology and patient care innovation for the Medi-Cal population.

#### Goal #5: Support a Recurring Funding Stream for CPCA Activities Around Technology, Quality Improvement, Population Health, and Value-Based Reimbursement

By sharing in the costs of running a standard-configuration, hosted version of Epic, California CHCs could lower their total cost of ownership for EHR and other related information systems technology. By doing this in partnership with CPCA instead of out of state or commercial

entities, a small portion of those savings could be funneled back into investments in programming to support those same CHCs.

The business model includes the development of a center for the use of advanced Health IT in providing comprehensive, high-quality primary care in Community Health Centers while continuing to strengthen the already excellent capacity at CPCA to be involved in key issues such as Medi-Cal value-based payment demonstration development.

## CPCA and the Business: Fitment

CPCA has a history of undertaking large, complex, multi-stakeholder projects and considers this an initiative to assist its members in obtaining the leading Health IT platform as an extension of its mission.

### Area of Fitment #1: Alignment with Mission

CPCA's view of Health IT is that it has become a key differentiator for healthcare providers, and that consumers and health plans favor primary care organizations with robust Health IT capacity. Highly competitive primary care must be able to allow patients to engage with providers using technology, and provider organizations will be under increased pressure to deliver on quality, utilization, cost, and patient experience results.

Therefore, Health IT is an area where CHCs must be able to compete against much larger, and better capitalized healthcare organizations. Large Health Systems are able to spend considerable amounts of money to create large scale Health IT programs. Most Health Centers do not have the same levels of capital for deep investment. Therefore, CHCs must be in a position to be nimble and precise in their implementation of robust Health IT.

CPCA can play a key role in supporting its CHC members in this way, which is directly related to CPCA's mission:

*"To lead and position community clinics, health centers, and networks through advocacy, education, and service as key players in the health care delivery system to improve the health status of their communities."*

This initiative goes directly to the leadership and positioning of community clinics, health centers, and networks through service, and robust Health IT is essential to continuing the role of these organizations as key players in the health care delivery system.

### Area of Fitment #2: Connection to CPCA Policy and Advocacy Work

There is a direct connection between the work necessary to support CHCs at the state level, and the results of successful implementation of robust Health IT. Current and future payment reform initiatives will require CHCs to be responsive in how they use Health IT to meet the expectation of the State and Medi-Cal Managed Care partners. Various initiatives to aggregate data have had success at a much smaller scale than could be possible should CPCA and its

members participate in a shared Health IT approach like the one proposed. Not only will this initiative help provide key data to important advocacy targets, but the resulting platform will be capable of pushing innovation informed by policy change faster than any current option on the market.

At a time when there are fewer and fewer options for funding advocacy work, this represents an opportunity to partner on an important need (EHR/Population Health) and leverage those investments to strengthen advocacy.

### Area of Fitment #3: History of Success with Large Scale Health IT Initiatives

CPCA has played a key role in the adoption of Health IT by CHCs throughout the state of California. The California Health Information Partnership & Services Organization (CalHIPSO) was formed through a partnership among three of California's largest health care provider organizations – The California Medical Association (CMA), the California Primary Care Association (CPCA), and the California Association of Public Hospitals and Health Systems (CAPH). CalHIPSO's primary objective is to enable safety net providers, including small and solo practice physicians and community clinics, to use health information technology to improve their practices and participate in payment reform. CalHIPSO is the largest of the 62 federally-designated Regional Extension Centers (RECs), which were created through the 2009 Stimulus Act to provide technical assistance to help providers implement EHRs and to achieve Meaningful Use of those systems.

The creation, management, and sustainability of CalHIPSO would not have been possible without the leadership of CPCA. CPCA played a lead role in developing the approach and application, standing up the entity, staffing the entity, providing guidance, and eventually managing the business.

As the largest REC in the country, CalHIPSO helped more than 8,500 physicians to adopt an EHR, and more than 6,300 to achieve Stage 1 of Meaningful Use. In both areas, CalHIPSO exceeded its original goal set through the REC program. *To date, CalHIPSO-affiliated providers have received almost \$200 million in EHR incentive payments.*

**First among the Top 5 Federally-Designated RECs**

*Listed by Number of Providers Who Have Achieved Meaningful Use*

REC Name	Providers
CalHIPSO <sup>1</sup>	6,302
Ohio Health Information Partnership	6,027
New Jersey HIT Extension Center	4,987
New York eHealth Collaborative	4,287
New York City REACH	4,207

CalHIPSO is now the largest of four contractors for the Department of Health Care Services’ California Technical Assistance Program (CTAP). This program focuses on providers whose practices are at least 30 percent Medi-Cal patients. CalHIPSO received an award of more than \$15 million to provide services to about 3,000 providers in 53 of California’s 58 counties over the next three years.

**Area of Fitment #4: Epic’s Desire to Work with CPCA**

Epic has expressed considerable interest in co-developing a relationship with California CHCs through a partnership with CPCA. A key to success for multi-tenant, standard configuration Health IT implementations is shared governance. Shared governance is built through a trusting relationship and a knowledge of how to convene participants in meaningful ways.

Epic views CPCA as a natural aggregator around key issues affecting CHCs, and Health IT is an increasingly important one. Epic sees CPCA as a strong partner in ensuring the success of implementation of the Epic platform in Health Centers throughout California.

Epic’s interest in CPCA is a unique partnership, and a new venture for Epic. They are interested in exploring this model because they see CPCA as a stable partner, with a strong reputation, and considerable size and scale. Although they may seek to replicate this model elsewhere, they view CPCA as the ideal partner to initiate this approach. They would have considerably less interest without CPCA at the table.

**Area of Fitment #5: Critical Mass of CPCA Members with Interest in Working Together**

Over the course of 2017, CPCA has worked with interested member organizations to better understand the Epic platform, the implications on CHC workflow and processes, and the Epic approach to serving CHCs. As noted in the Market Demand Analysis below, enough CHCs of all sizes have expressed interest in partnering with CPCA on such an initiative as to make it paramount that the CPCA Board evaluate such an option and consider moving forward.

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<sup>1</sup> CalHIPSO received two federal REC awards – one for Northern California and one for Southern California. The number in this chart reflects the total of both awards. Numbers published by the Office of the National Coordinator for Health IT will often reflect the two awards separately.

## Analysis of Market Demand

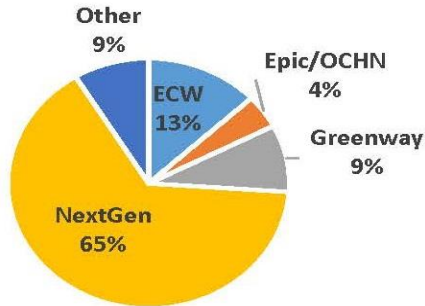
As part of this partnership exploration, the CPCA team conducted a member survey from March 2017 through August 2017 to assess current EHR and HIT related member needs, as well as specific interest in the EPIC platform. Seventy-two (72) CPCA members from across the state completed the survey with another two providing verbal responses to CPCA’s Vice President and Chief Operating Officer. This response rate represents approximately half of CPCA’s membership, or 47%. Twenty-three (23) members indicated an interest in switching their CEHRT in the next three years, and of those respondents, 83% indicated interest, or possible interest, in engaging with an EPIC offering under terms negotiated through CPCA. On the next page, you’ll find analysis regarding the respondent’s RAC affiliation, current EHR utilization, and primary reasons for considering an EHR switch. Note that of the 23 respondents, two CHCs belong to two RAC each, and one CHC does not have a RAC affiliation.

Level of Interest in EPIC Platform:

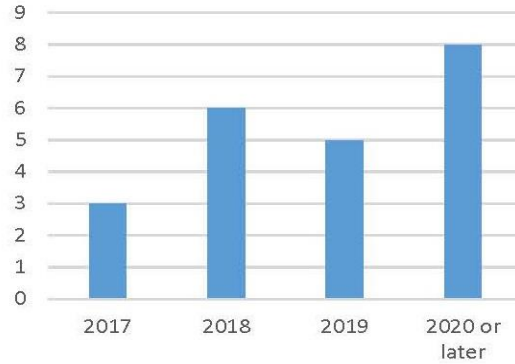
<b>Question</b>	<b>Percent of Respondents</b>	<b>Clinical Providers Represented (Total FTEs)</b>
<b>Considering replacing their Certified Electronic Health Record (CEHRT) at some point between 2017-2020</b>	32% of total survey respondents	758.43
<b>Considering EPIC in some capacity, either in partnership with a local hospital, with OCHIN or by some other means</b>	74% of those respondents considering changing their CEHRT	626.51
<b>Are interested, or possibly are interested in an EPIC offering under terms negotiated through CPCA</b>	83% of those respondents considering a move to the EPIC platform	634.84

Further Analysis of the 32% of Respondents Considering a Switch:

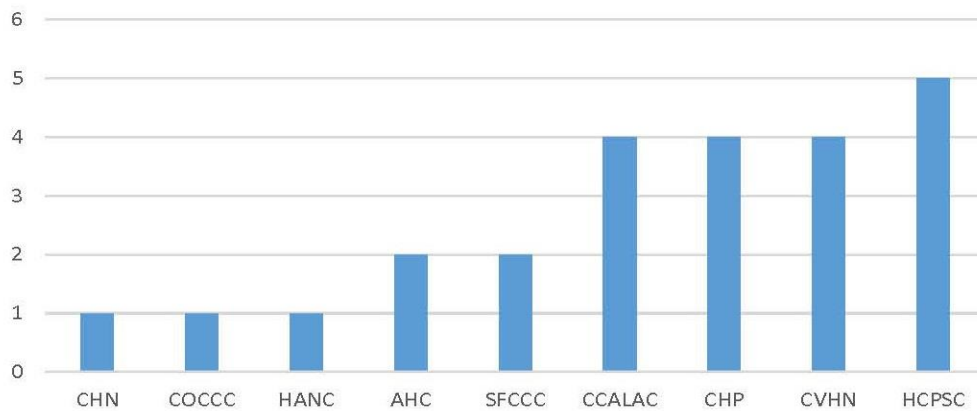
Current CEHRT Usage



When Are Interested Sites Considering a Switch?



Resondent RAC Affiliation



As part of this survey, CPCA asked respondents to provide their motivation for considering switching their CEHRT. The top three reasons provided by those respondents who were considering a switch were:

1. 61% indicated their consideration was due to **provider dissatisfaction** with their current tool.
2. 43% indicated they need **better data analytics and reporting functionality**.
3. 43% indicated they need better **continuity of care support** through data sharing capability.

The EPIC platform and its functionality are a strong fit for addressing these specific concerns. In a 2017, Epic was awarded the top ranking Overall Software Suite by KLAS research.<sup>2</sup> KLAS polls provider satisfaction on an annual basis to determine their software rankings and this is the seventh consecutive year EPIC has been awarded top billing. EPIC's HealthyPlanet Care Management and Cogito business intelligence provide a complete and integrated suite of analytics tools, replacing many of the disparate systems CPCA members currently utilize. Lastly, EPIC is the prominent EHR implemented in CA hospital and health systems, making data sharing and HIE much more feasible for primary care providers considering this platform. Epic is a national leader on interoperability (via Epic Care Everywhere and Epic CareLink) with all Epic instances nationally interoperating. Epic currently has interoperability working with eClinicalWorks, NextGen and several other EHR products. EPIC also received the top KLAS ranking for Health Information Exchange in 2017.

## Pro-forma and Capital Requirements

### Introduction to Financial Pro-forma and Capital Requirements

Included for consideration of the CPCA Board are five-year pro-forma analysis for this investment. There are considerable assumptions made in preparing these pro-forma, and they are presented in priority based on their impact on the business plan.

1. All of the financial projects are based on Epic pricing prior to negotiation of a contract. Thus far, Epic has presented a basic term sheet, and no attempt has been made to negotiate better terms with the leverage of a group of committed Health Centers. We anticipate the financial assumptions made to be "worst case scenario" and that there is room to negotiate unit costs down. This will improve all aspects of the financial pro-forma including capital requirements, operating cost, and total cost of ownership.
2. We have presented three separate pro-forma analyses.
  - a. Realistic. This is based on a randomized mix of Health Centers partnering with CPCA to implement the Epic platform. It assumes a total of 2.5M total encounters are implemented on the Epic platform. To achieve this number of encounters, all current Health Centers who have indicated they are "very interested" in partnering with CPCA on this initiative implement the platform, and an additional two large (200+ encounter) Health Centers join the initiative in the first five years.
  - b. Optimistic. This is based on a randomized mix of Health Centers partnering with CPCA to implement the Epic platform. It assumes a total of 3.3M total encounters are implemented on the Epic platform. To achieve this number, all of the Health Centers who have indicated they are "very interested" in partnering with CPCA on this initiative implement the platform, with 3 large and 2 medium additional Health Centers joining over the five-year period. We consider this to optimistic because it involves recruiting an additional 7 Health

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<sup>2</sup> Landi, Heather. "Epic Tops Best in KLAS for Seventh Straight Year." *Healthcare Informatics*, February 1, 2017. Retrieved from <https://www.healthcare-informatics.com/news-item/ehr/epic-tops-best-klas-seventh-straight-year>

Centers to participate in the initiative. Despite this being optimistic, we consider there to be considerable market potential beyond 3M encounters.

- c. Pessimistic. This is based on a randomized mix of Health Centers partnering with CPCA to implement the Epic platform. It assumes a total of 2M total encounters are implemented on the Epic platform. To achieve this number, all of the Health Centers who have indicated they are “very interested” in partnering with CPCA on this initiative implement the platform, with no others joining. We consider this to be realistic because for every Health Center that has indicated they are “very interested” in joining, there are others likely to take interest in the platform and ultimately join.
3. We assume a per encounter cost to the Health Centers of \$6 per encounter. This includes all Medical, Dental, and Behavioral Health encounters as reported on the UDS, but does not include any alternative touch encounters, phone encounters, or other encounters not reported on UDS. While this number is higher than what we hope will be the final per-encounter cost, it does not take into consideration any additional discounting to be negotiated, nor the ability to reduce cost based on higher levels of adoption. For example, the optimistic scenario nets over \$5M in margin in years 4 and 5, and thus, the price of the platform will be lowered.

#### Five Year Pro-forma (Realistic)

Category	Type	Year 1	Year 2	Year 3	Year 4	Year 5
<b>COSTS</b>						
	Hosting	\$ 592,495	\$ 2,117,850	\$ 3,139,200	\$ 3,566,310	\$ 3,770,580
	Software	\$ -	\$ 1,004,605	\$ 1,999,464	\$ 2,379,464	\$ 2,591,344
	Implementation	\$ 2,057,143	\$ 1,542,857	\$ 1,800,000	\$ 600,000	\$ -
	Staffing	\$ 1,510,100	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400
	<b>TOTAL COST</b>	<b>\$ 4,159,738</b>	<b>\$ 6,581,712</b>	<b>\$ 8,855,064</b>	<b>\$ 8,462,174</b>	<b>\$ 8,278,324</b>
<b>REVENUE</b>						
	Implementation	\$ 1,371,429	\$ 1,028,571	\$ 1,800,000	\$ 600,000	\$ -
	Subscription Fees	\$ -	\$ 4,706,510	\$ 9,255,134	\$ 11,006,747	\$ 11,993,406
	<b>TOTAL REVENUE</b>	<b>\$ 1,371,429</b>	<b>\$ 5,735,081</b>	<b>\$ 11,055,134</b>	<b>\$ 11,606,747</b>	<b>\$ 11,993,406</b>
	<b>PROFIT / LOSS</b>	<b>\$ (2,788,309)</b>	<b>\$ (846,631)</b>	<b>\$ 2,200,070</b>	<b>\$ 3,144,573</b>	<b>\$ 3,715,082</b>
	<b>CUMULATIVE PROFIT/LOSS</b>	<b>\$ (2,788,309)</b>	<b>\$ (3,634,941)</b>	<b>\$ (1,434,871)</b>	<b>\$ 1,709,702</b>	<b>\$ 5,424,784</b>

In the Realistic scenario, a total of 2.4M annual encounters is reached by the end of year 5. In this model, a total cumulative profit of \$5.4M will be generated unless fees were reduced. The business could consider reducing fees as early as year 3.

### Five Year Pro-forma (Optimistic)

Category	Type	Year 1	Year 2	Year 3	Year 4	Year 5
<b>COSTS</b>						
	Hosting	\$ 592,495	\$ 2,117,850	\$ 3,139,200	\$ 3,566,310	\$ 4,476,240
	Software	\$ -	\$ 1,004,605	\$ 1,999,464	\$ 2,379,464	\$ 3,231,185
	Implementation	\$ 2,057,143	\$ 1,542,857	\$ 1,800,000	\$ 600,000	\$ 2,400,000
	Staffing	\$ 1,510,100	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400
<b>TOTAL COST</b>		<b>\$ 4,159,738</b>	<b>\$ 6,581,712</b>	<b>\$ 8,855,064</b>	<b>\$ 8,462,174</b>	<b>\$ 12,023,825</b>
<b>Revenue</b>						
	Implementation	\$ 1,371,429	\$ 1,028,571	\$ 1,800,000	\$ 600,000	\$ 2,400,000
	Subscription Fees	\$ -	\$ 4,706,510	\$ 9,255,134	\$ 11,006,747	\$ 14,958,906
<b>TOTAL REVENUE</b>		<b>\$ 1,371,429</b>	<b>\$ 5,735,081</b>	<b>\$ 11,055,134</b>	<b>\$ 11,606,747</b>	<b>\$ 17,358,906</b>
<b>PROFIT / LOSS</b>		<b>\$ (2,788,309)</b>	<b>\$ (846,631)</b>	<b>\$ 2,200,070</b>	<b>\$ 3,144,573</b>	<b>\$ 5,335,081</b>
<b>CUMULATIVE PROFIT/LOSS</b>		<b>\$ (2,788,309)</b>	<b>\$ (3,634,941)</b>	<b>\$ (1,434,871)</b>	<b>\$ 1,709,702</b>	<b>\$ 7,044,782</b>

In the Optimistic scenario, a total of 3.3M annual encounters is reached by the end of year 5. In this model, a significant annual profit (\$5.3M) in profit is generated. At this level of adoption, there are many options for what to do with the surplus. For example, pricing could be reduced for all participants thus reducing the profit and delivering at a lower cost. In addition, credits could be given to all participants based on the total number of encounters they had purchase over the course of the first several years.

### Five Year Pro-forma (Pessimistic)

Category	Type	Year 1	Year 2	Year 3	Year 4	Year 5
<b>COSTS</b>						
	Hosting	\$ 592,495	\$ 2,117,850	\$ 3,102,060	\$ 3,250,620	\$ 3,250,620
	Software	\$ -	\$ 1,004,605	\$ 1,972,647	\$ 2,129,778	\$ 2,129,778
	Implementation	\$ 2,057,143	\$ 1,542,857	\$ 800,000	\$ -	\$ -
	Staffing	\$ 1,510,100	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400	\$ 1,916,400
<b>TOTAL COST</b>		<b>\$ 4,159,738</b>	<b>\$ 6,581,712</b>	<b>\$ 7,791,107</b>	<b>\$ 7,296,798</b>	<b>\$ 7,296,798</b>
<b>REVENUE</b>						
	Implementation	\$ 1,371,429	\$ 1,028,571	\$ 800,000	\$ -	\$ -
	Subscription Fees	\$ -	\$ 4,706,510	\$ 9,130,850	\$ 9,846,576	\$ 9,846,576
<b>TOTAL REVENUE</b>		<b>\$ 1,371,429</b>	<b>\$ 5,735,081</b>	<b>\$ 9,930,850</b>	<b>\$ 9,846,576</b>	<b>\$ 9,846,576</b>
<b>PROFIT / LOSS</b>		<b>\$ (2,788,309)</b>	<b>\$ (846,631)</b>	<b>\$ 2,139,743</b>	<b>\$ 2,549,778</b>	<b>\$ 2,549,778</b>
<b>CUMULATIVE PROFIT/LOSS</b>		<b>\$ (2,788,309)</b>	<b>\$ (3,634,941)</b>	<b>\$ (1,495,198)</b>	<b>\$ 1,054,580</b>	<b>\$ 3,604,358</b>

In the Pessimistic scenario, a total of 1.9M annual encounters is reached by the end of year 3. In this model, a total cumulative profit of \$3.6M is generated. Even at the lowest levels of adoption, which essentially would only involve implementing in those CHCs that are already expressing considerable interest in partnering with CPCA, the business plan is sustainable and pays back the initial investment.

Here are additional key pieces of information for consideration:

- Fixed costs total approximately \$4.2M, assuming no less than 3 health centers participate. All other costs are variable. Fixed costs include:
  - \$3.6M in initial implementation costs.
  - \$592k in hosting cost to build out the CPCA environment.
- To break even, the program must recruit at a minimum 3 large Health Centers (total 1.3M encounters) within the first 2 years. This assumes that the pricing would not change even if the total encounters was below 2M, as Epic has indicated that the pricing is currently based on reaching 2M annual encounters by the end of year 5. In this scenario, break-even occurs at the end of 5 years.
  - Given the uncertainty in the pricing, it is recommended that any configuration of Health Centers reaching 2M encounters implanting within the first 5 years is the safest bet for break-even purposes.

### Operating Revenue and Capital Requirements

The capitalization necessary to start the business is the same for all three models. The impact of accelerated adoption is on strength of financial return, and therefore ability to reduce rates.

Although the goal will be to reduce rates as various levels of adoption trigger different levels of discount, and thus enhanced profitability per marginal encounter, we will assume that the “profit” in each model is actual economic value delivered to participants and CPCA members through some vehicle. (Meaning: whether they are returned to subscribers, invested in programming, or reserved in a vehicle such as CPCA Ventures, they represent economic value captured by CPCA and CPCA members versus passed to an external entity.)

Model	Recommended Capitalization	Total Economic Value Created by Year 5	5 Year Return on Capital
Pessimistic	\$4.0M	\$3.6M	90%
Realistic	\$4.0M	\$5.4M	154%
Optimistic	\$4.0M	\$7.0M	200%

### Funding Strategy

The funding strategy for the business depends on both terms that can be negotiated with Epic and the governance model determined by the CPCA Board. That said, a four-part funding strategy is recommended.



### Low-Interest Loans:

Strategy number one, which can be undertaken alone, is to fund the business through low-interest loans. Per the pro forma, the business has a positive return and the ability to deliver the product to CPCA members below market rates. This dual impact creates the possibility of generating margin while reducing total cost of ownership for participants. Given this potential for strong return, there exists an ability to fulfill loan obligations quickly. With options of borrowing from the Ventures Loan Fund, the Primary Care Development Corporation (PCDC), CPCA's financial institution and other options; low-interest loans are a sound and viable funding option.

### Seek Grants and/or Foundation Support:

Like all programs in the "Safety Net" a program such as this one may be of interest to funders, including public grant funding and private Foundation support. This should be a secondary strategy. Given the pro forma suggest potential for return that exceeds current market bank interest rates, this should be seen as a supplemental strategy and not a primary strategy.

### Attempt to Reduce Upfront Investment:

There may be ways to reduce the upfront investment, reducing the need for capital outlay and reducing the risk of the capital investment in the business. The most likely strategy to reduce upfront investment will be to spread payment for implementation and hosting services out over time. This will, in theory, operate as a loan but will not trigger the liabilities typically associated with loans. This will need to be negotiated with the vendor, and no such negotiation has occurred.

### Create Mechanisms for Participants to Support Upfront Costs:

There are still ways to reduce the total capital outlay necessary to start the business. The most obvious of which will be to offer incentives for pre-payment of implementation and other costs necessary to begin the program. For example, pre-payment could lock in a slot on the implementation calendar, or could trigger additional discounts. We have not modeled these approaches financially, but needless to say, they will have the benefit of funding operating capital that therefore will not need be funded by one of the other strategies.

## Risks and Risk Mitigation

### Risk of financial harm / liability to CPCA:

Per legal counsel, to mitigate risk of financial liability, CPCA will obtain appropriate types and levels of additional insurance; develop and use its own BAA template; draft User license

agreements; conduct comprehensive review of existing policies, procedures, risk management plan and other safeguards to update and include CEHR requirements; implement audit controls, hardware and software, and procedural mechanisms.

#### Risk of technical failure / inability to achieve implementation base:

The most pressing concern of the members is an inability to successfully deliver on creating and maintaining a shared EHR/Population Health platform to the members. This is reasonable given some of the experiences nationally of Health Center-led Health IT initiatives.

CPCA is taking this risk seriously and has intentionally designed this program to address this risk.

First, CPCA will maintain a direct relationship with EPIC, the product vendor, who will provide hosting, support, and perform all product upgrades. There are no data centers for CPCA to build and manage, no software and databases for CPCA to administer. This is all handled by the product vendor and is included in the package price.

Second, CPCA will employ a third-party firm with experience in managing Health IT software vendors, to ensure that there is a strong working relationship between CPCA and the vendor. This third-party will be accountable for tracking vendor issues and making sure that participants are satisfied with performance and the configuration of the system.

Third, CPCA has designed a business plan that has considerable margin. This creates flexibility in being able to staff up as needed to address challenges in delivering to users. Although the estimates provided in this business plan have been vetted and are considered to be realistic, there is always the ability to scale the program faster.

#### Availability of capital to start program:

The level of capital investment required at the onset of such a program is significant, between 2-4 million in the varying implementation scenarios modeled. To mitigate the risk of lack of availability of sufficient initial capital, CPCA has cultivated partnerships with larger health centers to serve as the first implementation cohort. Larger health centers will be much more likely to have sufficient capital to fund their implementation activities, in return for payback as more Health Centers come online in later cohorts. CPCA is also considering negotiation for deferred payment terms to smooth cash flow needs as well as evaluating the possibility of outside partnership.

#### Marketing and Sales

A joint marketing plan will be part of final contract negotiations with EPIC; however below is an outline of the approach CPCA proposes for 2018.

	Jan	Feb	March	April	May	June	July	Aug	Sept	Nov	Oct	Dec
<b>Demo Webinars</b>	X	X	X	X	X	X	X	X	X	X	X	X
<b>State Roadshow @ RAC</b>		X		X		X		X		X		
<b>Exhibit at CPCA events</b>			X	X		X		X			X	
<b>Panel Featuring Cohort 1</b>			X	X		X		X			X	
<b>Webinar w/ Cohort 1</b>				X	X	X	X	X	X	X	X	
<b>Clinicians Visit Cohort 1 Sites</b>			X			X				X		
<b>Board Updates</b>	X			X			X				X	

At the current time, CPCA believes it has enough backlog to fill the first two years of its implementation calendar and capacity. Additional marketing and sales plans will be developed over the first two years to ensure growth to or beyond the 3M encounter threshold.

## Operating Model and Plan

### Governance

In order to execute this program, CPCA is exploring three potential program governance scenarios:

- 1) Create the Epic offering as a program of CPCA, with no new business entity formed.
- 2) Create a wholly-owned (by CPCA) limited liability company (“LLC”) with distinct governance, with limited decisions under the auspices of the CPCA Board.
- 3) Create a limited liability company, and offer ownership positions in this LLC to CHCs that chose to adopt the CPCA-led Epic platform.

CPCA has received opinion from legal counsel that any of these options are viable, and the differences tend to revolve around liability concerns, governance styles, and mechanisms for raising capital.

### Governance Concerns

In all three models, the CPCA Board will have some authority over the program. In model 1, the Board must delegate day-to-day operations of the business to staff and management of those operations to a separate governing body separate from the Board. Formally chartering this group and defining the scope of its decision-making authority will be key to success.

In model 2, the same dynamic exists, except there is a formal document in place (an “operating agreement”) that creates a second and distinct Board of the new LLC, and clearly delineates the decision-making rights between CPCA Board and LLC Board.

In model 3, there are generally, but not always, governance rights tied to ownership stake. Therefore, it is likely that the LLC Board in this model will have a composition whereby it was weighted towards those who have an ownership stake. Depending on the size of CPCA’s

ownership stake, the CPCA Board will have the right to cast votes with various weights in the decisions the new LLC makes.

All three models can work, and have worked in other states where PCAs have created new business lines. CPCA has experience delivering on programs that are similar to each of the three models proposed: occasionally running programs within CPCA that may only serve a subset of the members, creating wholly-owned new entities (such as Ventures), and creating partnership entities (such as CalHIPSO.)

### Staffing /Management

CPCA has developed a staffing plan taking into consideration both the guidance from EPIC with regard to the level of program support necessary for a successful implementation as well as direction from the Board not to overextend CPCA infrastructure and resources. The staffing model that balances these needs is one with dedicated program staff located at CPCA, a contracted arrangement with a Third-Party Administrator for implementation, training, and IT support, and key support positions retained at EPIC per the terms of final contracted agreement.

#### Staffing Levels

CPCA	TPA	EPIC*
1.0 FTE Program Director	1.0 FTE Interface Analyst	0.5 FTE Security Manager
1.0 FTE Clinical Systems Lead	1.0 FTE Conversion Analyst	0.5 FTE Data Courier
1.0 FTE Revenue Systems Lead	1.0 FTE Technical Analyst Manager	
1.0 FTE Training Director	1.0 FTE Clinical Systems	
1.0 FTE Analytics Systems Lead	1.0 FTE Revenue Systems Manager	
0.2 FTE Physician Champion	1.0 FTE Project Manager	

\*Does not include the staff at EPIC that directly manage the hosted instance of Epic. These resource are not line items in the pro-forma but instead are included in the hosting costs paid to Epic.

#### Staffing Timeline Year 1-2

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
<b>CPCA</b>	Finalize CPCA position descriptions	Post program director	Interview candidates	Interview candidates	Hire program director	Recruit remaining positions	Training @EPIC	Evaluate & reassess staffing levels
<b>TPA</b>		Evaluate TPA Partners	Draft TPA contract	Executive TPA contract	Training @ EPIC	Training @EPIC	Support Cohort	Support Cohort
<b>EPIC</b>			Execute complete contract	Train CPCA Staff	Train CPCA Staff	Support Cohort	Support Cohort	Support Cohort

# Appendix A: CPCA Balance Sheet

11:21 AM

## CALIFORNIA PRIMARY CARE ASSN

08/22/17

### Balance Sheet

Accrual Basis

As of July 31, 2017

	Jul 31, 17
<b>ASSETS</b>	
Current Assets	
Checking/Savings	
1000.00 - Cash	3,721,349.46
<b>Total Checking/Savings</b>	<b>3,721,349.46</b>
Accounts Receivable	
1300.00 - Grants Receivable	315,161.41
1305.00 - Contributions Receivable	146,285.00
1320.00 - Due from CPCA Ventures	182,736.46
1350.00 - Other Receivables	103,779.92
1400.00 - IMIS Receivable	155,375.88
<b>Total Accounts Receivable</b>	<b>903,338.67</b>
Other Current Assets	
1490.00 - Prepaid Expenses	6,000.00
<b>Total Other Current Assets</b>	<b>6,000.00</b>
<b>Total Current Assets</b>	<b>4,630,688.13</b>
Fixed Assets	
1600.00 - 1231 I Street Suite 400	6,407,085.91
1650.00 - Furniture	331,111.39
1660.00 - Equipment	406,259.55
1670.00 - Capitalized Interest	69,592.00
1700.00 - Accumulated Depreciation	-860,366.00
1710.00 - Building Depreciation	-1,627,309.00
1740.00 - Interest Amortization	-52,773.00
1750.00 - Loss on Disposal of Assets	-1,954.00
<b>Total Fixed Assets</b>	<b>4,871,646.85</b>
<b>TOTAL ASSETS</b>	<b><u>9,502,334.98</u></b>
<b>LIABILITIES &amp; EQUITY</b>	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 - Accounts Payable	72,943.58
2026.00 - Due to CA Health + Advocates	6,779.98
<b>Total Accounts Payable</b>	<b>79,723.56</b>
Other Current Liabilities	
2025 - Accrued Vacation	281,728.81
2040.00 - Prepaid Dues	621,578.34
2050.01 - Payroll Clearing	-10,956.52
2055.01 - Payroll FSA	1,596.19
2200 - Sales Tax Payable	10,122.42
<b>Total Other Current Liabilities</b>	<b>904,069.24</b>
<b>Total Current Liabilities</b>	<b>983,792.80</b>
Long Term Liabilities	
2510.00 - Loan Payable IronStone Bank	3,725,774.76
<b>Total Long Term Liabilities</b>	<b>3,725,774.76</b>
<b>Total Liabilities</b>	<b>4,709,567.56</b>
Equity	
3000.00 - Opening Bal Equity	1,095,702.47
4000.00 - Net Assets	4,107,485.54
Net Income	-410,420.59
<b>Total Equity</b>	<b>4,792,767.42</b>
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b><u>9,502,334.98</u></b>

## Appendix B: CPCA Ventures Balance Sheet

11:45 AM

08/22/17

Accrual Basis

### CPCA Ventures Balance Sheet As of July 31, 2017

	Jul 31, 17
<b>ASSETS</b>	
Current Assets	
Checking/Savings	
1000.00 · Cash	
1012.00 · First Citizens - checking	75,089.18
1060.00 · NCBFSB Checking	3,213,776.98
1065.00 · NCBFSB MMDA	1,264,490.50
Total 1000.00 · Cash	4,553,356.66
Total Checking/Savings	4,553,356.66
Accounts Receivable	
1450.00 · Current Portion Loans Receivabl	2,278,219.73
1461.00 · Acct. Rec. Loan - Long Term	4,215,153.56
Total Accounts Receivable	6,493,373.29
Other Current Assets	
1465.00 · Loan Loss Reserve	-458,340.00
Total Other Current Assets	-458,340.00
Total Current Assets	10,588,389.95
<b>TOTAL ASSETS</b>	<b>10,588,389.95</b>
<b>LIABILITIES &amp; EQUITY</b>	
Liabilities	
Current Liabilities	
Accounts Payable	
2020.00 · Due to CPCA	182,736.49
Total Accounts Payable	182,736.49
Total Current Liabilities	182,736.49
Total Liabilities	182,736.49
Equity	
3000.00 · Opening Bal Equity	-0.13
3900 · Retained Earnings	10,371,961.32
Net Income	33,692.27
Total Equity	10,405,653.46
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b>10,588,389.95</b>

# CPCA Epic Business Plan Addendum

Technical Advisory Group – Summary Report and Analysis

*October 13, 2017*

## Technical Advisory Group Process

In order to evaluate the capacity and functionality of the Epic platform, as well as the appropriateness of fit for CA health center needs, CPCA convened a Technical Advisory Group (TAG) composed of CPCA members considering Epic for their health centers. This group includes CIOs, CFOs, clinicians and executives from 7-10 health centers and has met on a bi-monthly basis July-September.

The group worked with CPCA and the Epic team to fully understand and vet what a CA specific single instance of Epic would offer CPCA members. TAG members attended two full day site visits, first in July and again in early October. These visits` are in addition to the CPCA staff and member visit in March 2017. After the July site visit, TAG members submitted extensive follow-up questions and clarifying requests regarding Epic tools and capacity, and has reviewed Epic's responses. As part of this follow-up, the group also viewed in depth demonstrations of Epic's Population Health and Analytics module, OB/GYN module, Practice Management capacity and an integrated user experience demonstration.

Going forward, this group will evolve to serve as the series of technical committees that advise the development of the CA Epic offering.

## Technical Advisory Group Roster

1. Paul Daly, Assoc. VP IT, Alta Med
2. Michael Eaton, Alta Med
3. Yolanda Lantz, HIT Manager – Clinicas de Salud del Pueblo
4. David Hyder, HIT Director – Community Medical Centers, Inc.
5. Wunna Mine, CIO - Golden Valley Health Centers
6. Dr. Ellen Piernot, CMO - Golden Valley Health Centers
7. Scott Putman, CIO – Mountain Valley Health Centers
8. Shannon Gerig, Associate CMO - Mountain Valley Health Center
9. Jim Schultz, CMO – Neighborhood Healthcare
10. Kenneth Morris, Associate Medical Director - North County Health Services
11. Jon Smith, VP of IT - North County Health Services
12. Ted Li, Associate Medical Director – North East Medical Services
13. Clifton Yuen, Director if Informatics – North East Medical Services
14. Deborah Villar, CEO - Via Care Health Center

15. Lourdes Olivares, CCO - Via Care Health Center

## Technical Advisory Group Assessment of Epic Capacity/Fit

### #1 Group confident in ability of Epic to meet Health Center needs

The participants in the Technical Advisory Group has participated in two site visits, and multiple hours of demonstration of the Epic product. Although technical design considerations remain, the group is confident that Epic is a platform capable of supporting the needs of Health Centers as they transition to value-based payment models in the State of California.

This assessment is based on an evaluation of the enhanced platform including the analytics and population health management tools, and an understanding of the organization's capacity to meet changing needs in the environment.

### #2 The upside of a "Single Instance" of Epic outweighs the challenges associated with a single instance

The group acknowledges that collaborating will create some challenges, specifically with regards to loss of autonomy for customization of the product. It has been the experience of the group, however, that over customization of EHR and other Health IT platforms has led to considerable extra effort and cost.

Going forward, the group recommends further development of a Program Governance model that addresses the need for customization while ensuring that the integrity of the underlying data model be preserved. This will require active participation from the Health Centers using the platform, professional IT management, and creativity in how to address the unique needs of some but the overall strategic direction of all.

### #3 Group is interested in supporting a full-scale negotiation with Epic, with specific focus on better understanding implementation issues such as data conversion, interfaces, and training and support

Generally speaking, the group has indicated that the estimated per-encounter cost to participate in the initiative are within expectation. That said, they have additional questions regarding, for example, the detailed scope and cost of any data conversion beyond the most basic proposed by Epic. These types of detailed implementation planning steps should be taken ahead of CPCA signing any contract with Epic, but will be necessary to answer ahead of any Health Center signing a contract with CPCA.

The group, therefore, is very interested in moving into and supporting a negotiation phase with Epic.

#4 The group understands the need to make interim commitments to the initiative, and is willing to do so as required to demonstrate momentum of this as a new CPCA business line

The group has discussed and is willing to enter into agreements that are less formal than signed contracts but more formal than participation in the Technical Advisory Group conference calls. These more formal agreements would be used to demonstrated the seriousness of the CPCA membership in uptake of this platform. These interim commitments would support moving into a negotiation with Epic.

## The Ongoing Role for the Technical Advisory Group

The Technical Advisory Group recommends that it remain intact through the negotiation of the Epic contract with CPCA in order to provide oversight of key technical issues through the negotiation process.

The group has identified five key areas where their input will be important during negotiation.

Topic	Goals	Timeline
<b>Technical connectivity</b>	<ul style="list-style-type: none"> <li>Determine best option for high-speed connectivity from Madison WI main hosting site and Minneapolis, MN secondary hosting site.</li> </ul>	<ul style="list-style-type: none"> <li>October / November</li> </ul>
<b>Review options with Epic for Data Segmentation</b>	<ul style="list-style-type: none"> <li>Understand how data is segmented in a multi-tenant instance of Epic to ensure patient privacy and security as well as organizational privacy.</li> <li>Reach decision on implementation planning to support privacy and security model.</li> </ul>	<ul style="list-style-type: none"> <li>November / December</li> </ul>
<b>Detailed review of Epic implementation model</b>	<ul style="list-style-type: none"> <li>Understand staffing requirements, time commitments, and training approaches for multi-tenant Epic implementation.</li> </ul>	<ul style="list-style-type: none"> <li>November / December</li> </ul>
<b>Data Conversion Approach and Pricing</b>	<ul style="list-style-type: none"> <li>Understand the options for data conversion, and the associated costs</li> </ul>	<ul style="list-style-type: none"> <li>November</li> </ul>

<b>Finalize Epic platform governance model</b>	<ul style="list-style-type: none"> <li>• Define and publish a final approach to managing the single instance of Epic</li> <li>• Reach understanding of “personalization” options (local) and “customization” options (central.)</li> <li>• Understand how to include participants and future participants in the governance process.</li> </ul>	<ul style="list-style-type: none"> <li>• December</li> </ul>
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At the end of the negotiation process, as CPCA finalizes its offer to the Health Centers, the Technical Advisory Group will theoretically disband as the governance model is implemented. It is anticipated that members of the Technical Advisory Group will play key roles in the future governing bodies.

# Epic Board Workgroup Call Summaries

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August 30, 2017

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**Member Attendance:** Ben Flores, Deborah Lerner, Kevin Mattson, Naomi Fuchs, Christine Noguera, David Vliet, Robin Affrime

**Staff & Consultants in Attendance:** Carmela Castellano-Garcia, Robert Beaudry, Christina Hicks, Roopak Manchanda (BlueNovo), and Tony Miles (Stoel Rieves)

*The purpose of this call was to discuss five possible legal entities or organizational structures for the purposes of housing and implementing a CHC-specific instance of Epic.*

The Comparative Options Matrix outlined five possible organizational structures and compares them against the following organizational components:

- Governance & Management
- Infrastructure, Resources & Staffing
- Liability and Exposure
- Investment & Revenue
- Expansion/Liquidity Event
- External Image & Reputation
- Tax Issues
- Other Considerations

Stoel Rives suggests the most viable options for housing the Epic program are either to:

- Operate as a program within CPCA's current portfolio of programs and services (Option #1).
- Create and operate a separate LLC jointly owned by CPCA and participating members (Option #4).
- Create a single-member LLC, within which CPCA is the sole members (Option #5).

Creating a separate 501(c)3 (Option #2) or housing the program in Ventures (Option #3) were not recommended as these would require an inordinate amount of resources, would duplicate existing staffing structures, or open up the entity to undue liability (as would be the case if the program were to be housed in Ventures).

## Discussion

Members generally agreed that operating the Epic program within CPCA opened up the Association to undue liability and didn't allow for independent oversight and governance. **For this reason, members preferred to have more discussion on Options #4 and #5.** Members asked for additional information before a better decision could be reached.

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September 19, 2017

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**Member Attendance:** Ben Flores, David Vliet, Deborah Lerner, Doreen Bradshaw, Kevin Mattson, Naomi Fuchs, Scott McFarland, Tracy Ream, Louise McCarthy, and Dr. Danielle Myers.

**Staff & Consultants in Attendance:** Carmela Castellano-Garcia, Robert Beaudry, Christina Hicks, Andy Principe & Sam Jones (Starling Consultants).

*The purpose of this call was to discuss the proposed CHC-specific Epic Instance Business Plan, with the understanding that the business will not be complete UNTIL a legal organizational structure is identified/agreed to, along with approval around a capital investment plan.*

#### Business Strategy

Overall, the workgroup agreed that the business strategy outlined in the business plan was a sound and reasonable strategy. However, there remains questions about whether CPCA is the right aggregating entity to coordinate this strategy, and whether or not there exists enough member interest/participants to warrant the effort and resources required launch this program.

#### Pro Forma feedback

The primary points of discussion during this section of the business included:

- **Risk:** are the scenarios accurate or realistic? Even the worst case scenario works out positive in CPCA's favor, just over a longer period of time. Is this really realistic?
- **Cost:** It was confirmed that much of the costs accounted for in the pro forma are variable costs. The only fixed costs are hosting costs in Year 1, as well as implementation costs in Year and 2. Staffing costs are also somewhat fixed. It was noted that costs would change based on the legal structure chosen for the program AND that eventual negotiations with Epic would also impact the pro forma –neither of which have been approved.

#### Funding Strategy

The workgroup discussed the implication of self-funding the project (using a combination of resources from the Ventures loan fund and private loans/grants/investments). A Ventures loan would include low interest, which would need to be built into the pro forma (it is currently not included). The ultimate risk is that CPCA is not able to pay the loan fund back, though it was confirmed that loan funds could be used for funding this project (i.e. there are no restrictions on the funds from the initial Endowment investment).

***Ultimately, the workgroup unanimously supported CPCA leadership to enter into negotiations with Epic in order to confirm pricing terms, which will better inform the business plan and investment needs. The Workgroup also approved for CPCA leadership to begin researching capital investment resources, as 100% self-funded is not feasible.***

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October 2, 2017

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**Member Attendance:** David Vliet, Doreen Bradshaw, Naomi Fuchs, Tracy Ream, Christine Noguera, Debra Lerner, and Danielle Myers

**Staff/Consultants Attendance:** Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Christina Hicks, Andy Principe and Sam Jones (Starling Consulting), and Tony Miles (Stoel Rieves)

*The purpose of this call was to dive deeper into the two legal structures that the Workgroup felt best suited this endeavor – jointly owned LLC (equitable memberships from CPCA and participating members) and a sole-member LLC (sole member would be CPCA) – or Option #4 and Option #5 respectively on the Decision Priorities Matrix.*

**Brief description of each legal structure:**

- Option #4 – partly owned by CPCA and party owned by participating health centers. Members would each have voting rights into governance decisions.
- Option #5 – CPCA sole member and would invest capital and staff into new LLC. There exists some legal protection over contractual and legal matters, but it does not necessarily protect from tort claims. While CPCA would solely contribute staff and cash; CPCA also solely benefits from revenue to reinvest in advocacy and services. As sole member to the LLC, CPCA Board would appoint LLC governing Board.

**Staff recommends Option #5 for the following reasons:**

- This option let's CPCA leverage existing staff while minimizing overhead costs to the LLC.
- This option allows CPCA to reinvest 100% of profit back into CHC services, technical assistance and advocacy – thereby further diversifying CPCA revenue and minimizing reliance on grant funding.
- This option more closely aligns with Epic's desire to partner directly with CPCA on this endeavor. They already have an HCCN business model through which they offer Epic, and they have admitted they are not interested in replicating this model.

**Discussion**

There remains ongoing concern about risk mitigation and upholding CPCA's reputation. CPCA's attorney noted that there while there is liability coverage in each option, it is simply a matter of the degree to which CPCA is protected and the trade-offs that are valued by membership. While there is more legal liability protection in Option #4, there will be less available resources to be invested back into CPCA programs and advocacy efforts because of development costs and a revenue share. To the question about risk mitigation for health centers in Option #4, it was noted that the maximum liability to CHCs in Option #4 is losing their capital investment in the project.

Another point of discussion was the fundamental notion behind each option, which is to strengthen CPCA's financial viability by diversifying revenue streams and allowing unencumbered dollars to be reinvested into CPCA advocacy efforts and programs. CPCA leadership acknowledged that the product cannot be priced such that CPCA gains come at the expense of member budgets; however, it needs to be transparent that this is a business venture that helps diversify revenue and financial strengthen the Association.

**A straw poll showed that at this time, five of the six members in attendance are leaning towards Option #5 (as opposed to approving/recommending), and that they all agree that more discussion is needed with the full Executive Committee before a final decision is adopted.**

Date: October 11, 2017

To: Board of Directors

From: Carmela Castellano-Garcia, President and CEO

Re: Designation of CaliforniaHealth+ Advocates Board Members for 2018

## MEMORANDUM

### I. Summary

The Advocates bylaws, which were ratified by the CPCA Board of Directors on January 15, 2016 and by CaliforniaHealth+ Advocates on February 23, 2016, state that the CPCA Board of Directors will be Advocates' "Designator." As the Designator, CPCA is charged with designating the Advocates Board of Directors. The Designator retains the right to add or remove directors at any time, with or without cause. The Designator has the discretion to select whatever process it deems necessary to select candidates for designation.

### II. 2018 Proposed Designation

In 2018 there are three individuals that have terms that expire in October 2017, and one member who has retired and is interested in being replaced.

- Tracy Ream, Board Chair- CPCA Board Member (exp 10-2017)
- Dean Germano, Member at large (exp 10-2017)
- Leslie McGowan- Vice Chair (exp 10-2017)
- Kathy Kneer, soon to be retired CEO of PPAC (exp 10-2019)

In taking into consideration regional representation, 501(c)(4) operational experience, and representation from the CPCA board, staff recommends replacing:

- Tracy Ream with Central Valley representative Steve Schilling, CEO of Clinica Sierra Vista \*
- Dean Germano's rural seat will be filled with incoming CPCA board chair Scott McFarland,
- Kathy Kneer with Lisa Maas, CEO of CAAP,
- Re-elect Leslie McGowan.

\* Steve Schilling is retiring as CEO from Clinica Sierra Vista; however, he will become CEO of the Foundation the health center is establishing to house its assets.

The changes between the current board and the proposed board can be seen in the tables below.

III. Analysis of current and proposed

<b>2017 Advocates Board Member</b>	<b>Term</b>	<b>Position</b>	<b>CPCA board member</b>	<b>Region</b>
Tracy Ream	Oct-17	Board Chair	X	SoCal
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Dean Germano	Oct-17	Director at large		Rural
Reymundo Espinoza	Oct-19	Director at large		Bay
Richard Veloz	Oct-19	Director at large	x	SoCal
Kathy Kneer	Oct-19	Director at large		Statewide
Carmela Castellano- Garcia	none	President	x	Statewide

<b>2018 Advocates Board Member</b>	<b>Term</b>	<b>Position</b>	<b>CPCA board member</b>	<b>Region</b>
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Reymundo Espinoza	Oct-19	Director at large		Bay
Richard Veloz	Oct-19	Director at large	x	SoCal
Lisa Maas	Oct-19	Director at large		Statewide
Carmela Castellano- Garcia	none	President	x	Statewide

**THE CODE OF CONDUCT**

- Mutual respect and courtesy shall prevail at all times between all participants.
- Listen fully to others.
- Encourage diverse perspectives.
- Disagree openly and courteously.
- Share all relevant information. Confidentiality shall be strictly adhered to.
- Strive for consensus.
- Ask, rather than assume.
- Discuss interests, not positions.
- Be a good team player.
- Treat the staff with dignity and respect.
- Maintain appropriate communication boundaries with staff concerning internal operational and personnel issues.

### Attendance at Board Of Directors Meetings Policy

Members of the Board of Directors of the California Primary Care Association (CPCA) have a responsibility to the members who elected them to oversee the management and affairs of the Association and to set policies which guide CPCA in all of its activities.

1. All members of the CPCA Board of Directors have a duty to be present at all official meetings of the Board. The current practice is to have four Board meetings each year, however special Board Meetings may be called as necessary for items that are time sensitive.
2. Per Bylaws, "Directors shall participate in at least 50% of regularly scheduled Board of Directors meetings in a given Board year. Directors who do not participate as so described shall be subject to removal from office by a majority of the Board." A Board year will be considered October through September 30<sup>th</sup>. The Board of Directors Job Description outlines a desire for a higher attendance rate at 75% in order for a Director to act in the best interest of CPCA as a whole and to exercise the legal and financial duties of the organization.
3. All minutes will reflect not only those Directors present, but those absent.
4. The Board Chair at his/her sole discretion, may (a) excuse (i.e., not count as a missed meeting) one (1) absence per Director per year and/or (b) grant a leave of absence for a Director without forfeiture of the Director's Board seat.
5. After one absence by a Director, a letter will be sent by staff to remind them of this policy.
6. After two absences, a call will be made by the Chair of the Board.
7. On the third absence in any given year, continued participation of any board member who has been unable to be present will be put to vote of the Board for removal.
8. Attendance will be tracked and reviewed regularly and a report made to the Governance Committee and Chair. All candidates running for reelection will have their attendance records in the prior year noted in election materials. Directors not meeting the 50% criteria for each year of their prior term will not be eligible to run for re-election.



**Ventures Board**  
 Wed., October 11, 2017  
 12:15p – 2:30p  
**Naomi Fuchs, Chair**

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION <small>A = Approval  D = Discussion  I = Information</small>
I. Call to Order		Naomi Fuchs, Chair	A
II. Approval of Agenda		Naomi Fuchs, Chair	A
III. Consent Calendar <ul style="list-style-type: none"> <li>• Approval of Minutes</li> <li>• Approval of Financials</li> </ul>	<ul style="list-style-type: none"> <li>• Minutes of July 14, 2017</li> <li>• <i>See Ventures Finance packet</i></li> </ul>	Naomi Fuchs, Chair	I/D/A
IV. Approval of Financial Audit FY 2016-17	<ul style="list-style-type: none"> <li>• <i>See Board of Directors packet</i></li> </ul>	Carmela Castellano-Garcia	I/D/A
V. CEO Report		Carmela Castellano-Garcia	I/D
VI. Seating of FY 2017-18 Ventures Board of Directors (Chair Elect 2017-18 immediately assumes the role of Chair)		Naomi Fuchs, Outgoing Chair & Scott McFarland, Incoming Chair	A
VII. Election of FY 2017-18 Ventures Board Officers <ul style="list-style-type: none"> <li>A. Chair-Elect</li> <li>B. Vice-Chair</li> <li>C. Secretary</li> <li>D. Treasurer</li> </ul>		Scott McFarland, Chair	A
VIII. Adjourn Ventures Board		Scott McFarland, Chair	A

## Ventures Board of Directors Meeting

July 14, 2017

### Meeting Minutes

**Board Members Present :** *Chair-Elect:* Scott McFarland, Robin Affrime, Isabel Becerra, Doreen Bradshaw, Ben Flores, Cathy Frey, Jane Garcia, Britta Guerrero, Nik Gupta, Kerry Hydash, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, Tim Rine, Jackie Ritacco, Ralph Silber, Paulo Soares, Graciela Soto-Perez, Mary Szecsey, David Vliet, Paula Wilson

**Members Absent:** Deb Farmer, Naomi Fuchs, Sherry Hirota, Richard Veloz

**Guests:** No guests signed in.

**Staff:** Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Sandy Birkman, Andie Patterson, Ginger Smith, Robert Beaudry, Val Sheehan, Erin Perry, Jodi Samuels

#### **1. Call to Order**

Chair-elect Scott McFarland called the meeting to order at 12:35p.

#### **2. Approval of Agenda**

##### **Motion**

A motion was made and seconded to approve the agenda as presented (Frey/Hydash). **The motion carried.**

#### **3. Consent Calendar**

##### **Motion**

A motion was made and seconded to approve the Consent Calendar as presented. (Gupta/Bradshaw). **The motion carried.**

#### **4. CEO Report**

Carmela provided a brief report.

CEO report - she'd like input on exploring using ventures as legal structure for the EMR. May need restructuring but we've got a structure. She;d propose to attnys. It would evolve since currently the Boards are identical. WE still have some lending business so that would be a part of it. WE'd always dreamed Ventures could do more. Can we explore? Yes.

Motion to adjourn. 12:38p.

## Board of Directors

Wednesday, October 11, 2017

2:30 – 3:30 p.m.

Leslie McGowan, Vice Chair

## Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Leslie McGowan, Vice Chair	
II. Approval of Agenda		Leslie McGowan, Vice Chair	A
III. Consent Calendar • Approval of Minutes	• Minutes from July 2017	Leslie McGowan, Vice Chair	A
IV. Financial Report	• Financial Report as of August 31, 2017	Sandy Birkman	A
V. Board Seats	• Memo: Board Seat Proposed Changes	Carmela Castellano Garcia	A
VI. Staff Report	• Memo: Staff Report • Memo: Proposal to Advance the C4	Andie Patterson	A
VII. Public Affairs Peer Network Update	• Memo: Staff Update	Victor Christy	D
VIII. Adjourn		Leslie McGowan, Vice Chair	A

# californiahealth<sup>+</sup> advocates

ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

## BOARD OF DIRECTORS MEETING

July 14, 2017

### Meeting Minutes

**Board Members:** Tracy Ream (Chair), Leslie McGowan, Reymundo Espinoza, and Carmela Castellano-Garcia

**Members Absent:** Naomi Fuchs, Dean Germano, Kathy Kneer, Corinne Sanchez, Richard Veloz

**Guests:** Isabel Becerra, Christine Noguera, Cathy Frey, Anitha Mullangi, Danielle Myers, Jane Garcia, Nik Gupta, Deborah Lerner, Marty Lynch, Gary Rotto, Scott McFarland, Cynthia Carmona, and Ralph Silber

**Staff:** Andie Patterson, Heather Barclay, Sandy Birkman, Liz Oseguera, Erin Perry, Mike Witte, Jodi Samuels, Val Sheehan, Victor Christy, and Meaghan McCamman

#### **1. Call to Order**

Chair Tracy Ream called the meeting to order at 12:50p and it was noted that quorum is not present so the consent calendar will be held until the October 2017 meeting.

#### **2. Approval of Agenda**

There was no official approval of agenda.

#### **3. Consent Calendar**

A quorum is not present so the Consent Calendar will be held for approval at the October 2017 meeting.

#### **4. Financial Report**

Sandy Birkman, Director of Finance and Operations, provided a brief report and noted the financial report in the meeting packet.

#### **6. Staff Report**

Andie Patterson, Director of Government Affairs, provided a brief report. She discussed “reasonable separation” issues and reminded the Board that the mission of the Advocates Board is to serve the interests of the CPCA Board (the c3). The CPCA Legislative Committee sets the legislative agenda for approval by the CPCA Board, and the c4 helps carry out those related activities. The Advocates Board can still discuss any related issues as needed. There was a brief discussion of other political opportunities the c4 could be pursuing and the Board asked to be presented with recommendations from staff. The Advocacy Committee will be reviewing first.

**7. Public Affairs Peer Network Update**

There was no update provided.

**8. Adjournment**

The meeting was unofficially adjourned at approx. 1:15p.

**Balance Sheet**

As of August 31, 2017

	Aug 31, 17
<b>ASSETS</b>	
Current Assets	
Checking/Savings	
1000.00 · Cash	
1012.00 · First Citizens - checking	312,634.37
Total 1000.00 · Cash	312,634.37
Total Checking/Savings	312,634.37
Total Current Assets	312,634.37
<b>TOTAL ASSETS</b>	<b><u>312,634.37</u></b>
<b>LIABILITIES &amp; EQUITY</b>	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 · Accounts Payable	1,750.00
2020.00 · Due to CPCA	69.41
Total Accounts Payable	1,819.41
Total Current Liabilities	1,819.41
Total Liabilities	1,819.41
Equity	
3900 · Retained Earnings	31,516.79
Net Income	279,298.17
Total Equity	310,814.96
<b>TOTAL LIABILITIES &amp; EQUITY</b>	<b><u>312,634.37</u></b>

**CaliforniaHealth Plus Advocates**  
**Profit & Loss Budget vs. Actual**  
 April through August 2017

	<u>Apr - Aug 17</u>	<u>Budget</u>	<u>\$ Over Budget</u>	<u>% of Budget</u>
<b>Income</b>				
4600.00 · Grants	300,000.00	125,000.00	175,000.00	240.0%
4700.00 · Donations	1,000.00	0.00	0.00	100.0%
4800.00 · Membership Dues Donations	415,201.50	244,791.62	170,409.88	169.61%
<b>Total Income</b>	<b>716,201.50</b>	<b>369,791.62</b>	<b>346,409.88</b>	<b>193.68%</b>
<b>Expense</b>				
6100.00 · Salaries	84,362.56	88,397.50	-4,034.94	95.44%
6300.00 · Employee Benefits	18,939.21	22,983.31	-4,044.10	82.4%
6500.00 · Occupancy	7,958.60	6,250.00	1,708.60	127.34%
6510.10 · Communications	993.91	447.50	546.41	222.1%
6520.10 · Postage & Delivery	144.79	0.00	144.79	100.0%
6530.10 · Supplies	1,222.31	1,750.00	-527.69	69.85%
6540.10 · Printing	2,234.80	3,125.00	-890.20	71.51%
6552.10 · Equipment Lease/Maintenance	479.37	425.00	54.37	112.79%
6560.10 · Insurance	516.37	416.62	99.75	123.94%
6565.10 · Dues & Licenses	0.00	1,666.70	-1,666.70	0.0%
6570.10 · Subscriptions/Publications	219.19	6,875.00	-6,655.81	3.19%
6580.10 · Marketing and Outreach	162,120.32	62,500.00	99,620.32	259.39%
7010.10 · Audit/Accounting	-35.00	937.50	-972.50	-3.73%
7110.10 · Board of Directors	0.00	2,083.31	-2,083.31	0.0%
7200.10 · Travel & Registration Fees	1,274.40	625.00	649.40	203.9%
7300.00 · Meetings	794.86	8,333.31	-7,538.45	9.54%
7350.00 · Training	50.00	4,166.62	-4,116.62	1.2%
7500.00 · Consultants	155,627.64	158,809.12	-3,181.48	98.0%
<b>Total Expense</b>	<b>436,903.33</b>	<b>369,791.49</b>	<b>67,111.84</b>	<b>118.15%</b>
<b>Net Income</b>	<b><u>279,298.17</u></b>	<b><u>0.13</u></b>	<b><u>279,298.04</u></b>	

CaliforniaHealth Plus Advocates  
**Profit & Loss Budget vs. Actual**  
April through August 2017

Income

- 4600.00 · Grants
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Total Income

Expense

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- 6500.00 · Occupancy
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- 6520.10 · Postage & Delivery
- 6530.10 · Supplies
- 6540.10 · Printing
- 6552.10 · Equipment Lease/Maintenance
- 6560.10 · Insurance
- 6565.10 · Dues & Licenses
- 6570.10 · Subscriptions/Publications
- 6580.10 · Marketing and Outreach      Day at the Capitol
- 7010.10 · Audit/Accounting
- 7110.10 · Board of Directors
- 7200.10 · Travel & Registration Fees
- 7300.00 · Meetings
- 7350.00 · Training
- 7500.00 · Consultants

Total Expense

Net Income

Date: September 22, 2017

To: CaliforniaHealth+ Advocates Board

From: Carmela Castellano-Garcia, President and CEO

Re: Designation of CaliforniaHealth+ Advocates Board Members for 2018

## MEMORANDUM

### I. Summary

The Advocates bylaws, which were ratified by the CPCA Board of Directors on January 15, 2016 and by CaliforniaHealth+ Advocates on February 23, 2016, state that the CPCA Board of Directors will be Advocates' "Designator." As the Designator, CPCA is charged with designating the Advocates Board of Directors. The Designator retains the right to add or remove directors at any time, with or without cause. The Designator has the discretion to select whatever process it deems necessary to select candidates for designation.

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In taking into consideration regional representation, 501(c)(4) operational experience, and representation from the CPCA Executive Board staff recommend replacing:

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The changes between the current board and the proposed board can be seen in the tables below.

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Lisa Maas	Oct-19	Director at large		Statewide
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Date: October 11, 2017  
To: Board of Directors  
From: Andie Patterson, Director of Government Affairs  
Re: Staff Report

## MEMORANDUM

### **I. Legislative Victories!**

#### Sponsored Bills

SB 323 (Mitchell) - Improving Access to Drug Medi-Cal and Specialty Mental Health Services. We are pleased to share that SB 323 received unanimous support on the Senate and Assembly Floors. The bill is now on the Governor's desk. [Click here](#) to send a message to the Governor to show your support.

SB 456 (Pan) - Medi-Cal Managed Care and Services that Follow the Patient. In an effort to create a more workable bill, and have greater opportunity for dialog with DHCS, this bill is now a two-year bill.

#### Other Bills of Interest

AB 1250 (Jones-Sawyer) - Counties and Contracts for Personal Services. AB 1250 was held in the Senate Rules Committee and was not brought to the floor. This is a significant short-term victory that could not have happened without the close coordination of health centers, consortia and partners across the state. Additionally, this effort provided an important opportunity to educate the legislature on the role of county and health center contracts in providing for the needs of our underserved communities. As this bill could move again in 2018, we cannot drop our guard and will be strategizing on how to proceed next session.

AB 224 (Thurmond) - Dentistry: Anesthesia and Sedation. This bill, in its earlier form, was of significant concern to a number of dental directors. While the bill has gone through significant amendments, and no longer presents staffing concerns, the bill was held by the author in the Senate Business and Professions Committee, and is now a two year bill.

AB 387 (Thurmond) - Minimum wage: Health Professionals Interns. As was previously reported, this bill failed to meet a key deadline in the Assembly, but can technically move when the Legislature comes back in January. The legislature would be on a relatively tight timeline to move it out of the house of origin. Advocates will be vigilant in 2018 to track this bill and/or similar bill efforts.

Lastly, just because it is recess, it does not mean that our work will stop. This fall we will be following hearings on key efforts, like universal coverage and sugar-sweetened beverage tax. After honing our policy priorities, we will be meeting with partners and legislative staff to prepare for 2018.

## **II. Advocacy Committee**

The Advocacy met in August to review the action item before the Board. The Advocacy Committee unanimously voted to forward the staff recommendation to begin endorsements and create a PAC to the Board with the added note that should the Board approve the staff recommendation the Advocacy Committee would like to keep discussing whether or not we engage in constitutional officer races.

Date: September 27, 2017  
To: Board of Directors  
From: Andie Patterson, Director of Government Affairs  
Re: Proposal to advance the c4

## MEMORANDUM

### Overview

In July the Board requested that staff explore how to further the political opportunities now available to California Health+ Advocates, the C4 Corporation. Since that time, staff have spoken at length with our attorneys as well as other experts in the political field. Special consideration to how the work is done and what work is done is necessary because staff at California Health+ Advocates while a part of the c4 are paid for by a grant coming from the California Primary Care Association, a c3, as well as member health centers, also c3's. C3 corporations may not engage in any overtly political work or electioneering. Staff have taken strides to mind this important distinction with counsel from tax attorneys. This memo serves as the aggregation of that research and forwards an approved proposal by the Advocacy Committee to the Board of Directors.

### Proposal

Staff recommend that the California Health+ Advocates board create a new bank account (known as a 527 bank account) and file with the Secretary of State as a general purpose recipient committee also known as a Political Action Committee (PAC), in order that the organization can begin to engage in overtly political work. This account and affiliated PAC will keep monies fundraised from non-c3 organizations and individual persons, and pay for the work that currently is not allowed in the c4.

Staff further recommend that the PAC engage in state level endorsements, and should there be sufficient monies raised, also directly contribute to state elected officials.

*Note we do not recommend forming a state ballot PAC as there are no ballot propositions we believe we need to engage with at this time. We further do not recommend engaging in federal elections as the rules are more complicated and it is harder to influence congressional races with limited resources.*

### Rationale

Adding a 527 and commencing political activity- endorsements and contributions- affords the health center advocacy infrastructure additional tools to advance the mission of health centers.

Endorsements afford us the opportunity to educate elected officials and candidates about health centers and our mission. We have a major opportunity with open races with candidates to begin a dialogue about health centers with individuals who may not be familiar with health centers. With incumbents we can honor the good work they have done for us, and encourage a deeper relationship by offering an endorsement. We also have the power to withhold an endorsement from elected officials that do not further our mission, providing us an opportunity to engage in deeper discussion with such elected official and maybe eventually find avenues to work together. The more we build up the California Health+ Advocates brand the more the endorsement will mean.

While we have strong support in the legislature, this support can be trumped by interests that have PACs if those interests are not aligned with ours. While we will not, at least at the beginning, have a large enough PAC to compete dollar for dollar, we can secure stronger footing with legislators, and we can begin to cultivate health center champions in a deeper way. Providing financial contributions will demonstrate our commitment to the legislator, hopefully creating the opportunity for them to engage more deeply with health centers.

Further if we align existing health center staff giving with the 527 we can deepen the relationship between California Health+ Advocates and its affiliated PAC, and the local health centers with an elected official and in many cases gain more direct access to a given elected official because of events or meetings we conduct to provide the contribution.

## **Details**

### **A. Development of the 527 account/ Political Action Committee**

The easiest way in which to develop a PAC would be to create a 527 bank account that is overseen by the California Health+ Advocates board, the same directors that oversee the c4 today, and the logistics involve opening the account, naming it, and revising the existing bylaws in such a way that authorizes the work and creation of the account. The timeline to implement the account and register with the Secretary of State is only a matter of days.

### **B. Endorsements: State Assembly and Senate**

Staff recommends focusing strictly on endorsements at the state level at this early stage of political activity.

We further recommend endorsing for every Assembly and Senate seat. For incumbents we advise conducting an internal review based on a yet to be developed set of criteria, and for open races inviting candidates to answer questionnaires and engage in a face to face interview with members of the board.

If we were to proceed we would need to develop a questionnaire for all candidates to respond to, a framework for in person interviews, and a rubric for scoring candidates. For incumbents,

we would conduct internal research using a scoring rubric and provide analysis to the board with a recommendation of whether to endorse or not.

For any seat where it is too controversial we reserve the right to remain neutral and make no endorsement.

The endorsement would come from California Health+ Advocates (as c4's may engage in endorsements just not direct candidate contributions). An endorsement would enable the candidate to use Advocates' name in electioneering materials. Any usage further would need to be determined with the board as requests are made.

C. Financial Contributions to Candidates and Elected Officials: State Assembly and Senate

Should we secure sufficient resources, staff further recommend providing a financial contribution to a subset of candidates. Staff recommend prioritizing leadership, then identified health center champions, and lastly potential health center champions.

*Tier 1- Leadership*

- Assembly Health, Chair
- Senate Health, Chair
- Assembly Appropriations, Chair
- Senate Appropriations, Chair
- Assembly Budget, sub health, chair
- Senate Budget, sub health, chair
- Assembly Speaker
- Senate Pro Tem
- Governor
- Lt. Governor

*Tier 2- Health Center Champions*

*Tier 3- Potential Health Center Champions*

Contribution Limits

Should we create a 527 it would likely be considered a major donor. Major donor committees can contribute \$4400 in a primary and \$440 in a general election. Staff do not anticipate having sufficient resources to max out to any candidates.

**Funding Needs**

In order to engage in this work and future work we need new and separate monies. Only c3 monies are currently supporting staff salaries and in order to follow through on the proposal and continue research and fundraising we need seed capital.

Seed Capital need: \$3,200

- Research- 20 hours
- Legal/ Bank account/ bylaw changes
- Accounting- 5 hours

Annual Accounting/Legal/Reporting costs: \$6000

- Accounting and reporting- \$500/month  
(Potentially cheaper if we use a “professional treasurer” as opposed to Olson Hagle)

Endorsements-- \$9,200

Open races—assumes members pay for their own transportation

- Research on races- 10 hours
- Development of questionnaire- 5 hours
- Development of scoring rubric- 5 hours
- Scheduling / Conducting the meetings- 36 hours
  - Assumption: 10 races with 3 candidates in each, 4 days of meetings with a total of 30 interviews
- Food- \$2500
- Sharing the endorsements – 3 hours
- TOTAL: \$6600

Incumbents

- Research candidate history- 20 hours
- Development of recommendations using scoring rubric- 5 hours
- Meeting – 3 hours
- Sharing the endorsements – 10 hours
- TOTAL: \$2600

Fundraising without events- \$ 3600

- Creation of materials- 5 hours
- Communication direct and indirect with members- 40 hours

**Timeline**

If we proceed with endorsements, to be most impactful we would want to endorse in the primaries. This would mean endorsing between February-April.

We would need to fundraise approximately \$20,000 between now and January in order to commence the work in time.

**Important Cautions for Board Members and guests**

Any individual on the Advocacy Committee or Board that engages in direct political work, including endorsements and political contributions cannot be supported by a nonprofit (c3) resources. If the board moves forward proactively board and guests of the board and Advocacy committee must ensure they are volunteering their time.

Date: October 11, 2017  
To: Board of Directors  
From: Janalynn Castillo, Advocacy Coordinator  
Re: Public Affairs Peer Network Update

MEMORANDUM

**I. Overview**

The Public Affairs Peer Network (PAPN), which meets once a month, provides a forum for health center and consortia staff who engage in public affairs work (government, community, media, advocacy, etc.) to share best practices and learn from one another.

**II. Work to Date**

The PAPN, chaired by Gary Rotto from the Borrego Community Health Foundation, has met two times during the third quarter of the year. There are two telephonic meetings calendared going forward, with the next one scheduled for October 31.

July's PAPN call focused on California's strategy for National Health Center Week 2017. Members shared regional activities planned for NHCW and feedback on NACHC's NHCW website and resources. Earlier this year, PAPN members provided suggestions on how the Advocates website could be improved to be the main source of advocacy information, key contacts best practices, and strategies for improving messaging. PAPN's feedback was taken into consideration and Advocates created a California-specific webpage to include resources to utilize during NHCW. In addition, updates to other subpages of the Advocates website were implemented to reflect PAPN suggestions.

September's PAPN call focused on the current federal attacks on Community Health Centers. PAPN members shared what advocacy activities they are participating in to defeat the latest ACA Repeal efforts and regional efforts to contact Members of Congress on the Health Center Funding Cliff.

**III. Next Steps**

Going forward, it is the intent of the PAPN to continue dialogue on ways to strengthen advocacy and to provide feedback to CaliforniaHealth+ Advocates' staff on how to best support health centers in state and federal legislative engagement.

If you would like to be included in future PAPN meetings, please contact Advocacy Coordinator, Janalynn Castillo at [jana@healthplusadvocates.org](mailto:jana@healthplusadvocates.org).