HEALTH CENTER PARTNERS
of Southern California

CELEBRATING 40 YEARS 1977 2017

MEMBER BULLETIN

FEB 2018

Submitted By:
Vernita Todd, EVP, External Affairs

www.HCPSOCAL.org @HCPSOCAL

INTRODUCTION

The **Quarterly Bulletin** is designed to be a resource for the leaders of HCP member organizations. It provides a 3-month overview of the key issues facing community health centers including summary reports from HRSA / Bureau of Primary Care, National and State associations, and information from the Department of Health Care Services (DHCS) and County Health & Human Services.

It is best shared electronically, so users can access the online resource links provided. Please use as a resource to develop managers throughout your organization.

Contents

LEGISLATIVE UPDATE

The **"Fix the Cliff"** advocacy that began almost a year ago at NACHC's Policy and Issues forum 2017 has finally resulted in reauthorized funding for Community Health Centers, the National Health Service Corps, Teaching Health Center Graduate Medical Education and several other health care extender programs. **Thanks to your leadership, consistent advocacy and dedication, on February 8th Congress passed a final budget deal which included a $600 million increase to our two-year community health center funding totaling a $7 billion-dollar reauthorization.** The bill was signed by President Trump and passed into law, bringing much relief to our funding crisis and allowing the government to operate for the next two years under the new budget.

The **Bipartisan Budget Act of 2018** (H.R. 1892) is a two-year budget deal providing funding for the federal government through 3/23/18. The deal paves the way for consideration of *additional spending bill(s)* that will appropriate funds for specific programs. The bill is also a *major health care bill*. It addresses many health care provisions that have been delayed for months, such as CHCs and CHIP, among others. CBO estimates say H.R. 1892 will increase the deficit by more than $300 billion over the next 10 years, we know Congress will be anxious to find opportunities to cut spending; therefore health care spending (for programs like Medicaid and Medicare) will be at the top of the list.

The final vote in both the Senate and House came as a **bipartisan** effort with the Senate voting 71-28 and the House voting 240–186 in favor of passage. The passage of the bill included a bit of drama with several Democratic and Republican members voting against the bill either because of a non-fix to DACA or because the spending bill added to the debt.

- Several of our own Democratic delegation members voted "no" to the bill due to the lack of DACA fix. They include: Senators Feinstein and Harris, House Members Peters, Davis, Vargas and Takano.

- Our three Republican delegation members Hunter, Issa and Calvert along with Democratic Representative Raul Ruiz voted in favor of the bill.

Use this section by section link for a summary of the health provisions in the bill. *Health Center and related funding begins on page 17.*

Looking toward the future, continued and consistent advocacy must occur for other pending issues which could threaten community health centers. HCP is developing a new set of advocacy goals which will be discussed at the P&I Prep meeting on February 27th. Though the funding cliff has been resolved, the fight is not over for health center patients. We encourage you and your staff to participate in the upcoming NACHC Policy and Issues Forum next month.

REGULATORY UPDATES

HRSA's Bureau of Primary Care (BPHC) All-Programs
Webcast was held on January 30th. Below is a summary of key points.
You can review the slide deck here or watch the archived version of the call.

Since this time of this call, the funding cliff has been addressed, but this is the call summary in its entirety.

Jim Macrae, BPHC Associate Administrator, reiterated all health center funding is **safe** through April 2018. **Importantly, as long as HRSA funding is being made to grantees, health centers will be responsible for upholding the program requirements (SFS, Quality measures, Patient targets).** If HRSA must change funding, health centers will be given the opportunity to update their budgets and/or change their applications, but this is NOT YET THE CASE. HRSA is optimistic Congress will address the long-term health center funding prior to the end of March but has committed to regular communication with grantees in the event no solution has been reached.

The focus of the call was the new **Site Visit Protocol** for grantees. Five hundred (500) site visits have been scheduled for calendar year 2018. It is HRSA's goal that each of these visits will include a federal representative (either *your* Project Officer or another BPHC staff member.) Site visits will be clearly focused on ensuring health centers can demonstrate compliance to the HRSA program requirements using the new Compliance Manual. Additionally, Diabetes Control will be the key clinical measure of interest, with the goal of improving performance and developing effective action steps for implementation. BPHC will be looking for health centers to identify root cause(s) and the contributing/restricting factors for improvement.

Secondly, BPHC will be identifying promising practices to share with all grantees. This is described as "Policy that leads to or will likely lead to improved outcomes or increased efficiencies for health centers." If your health centers have made breakthroughs in the areas below, be prepared to share with the reviewers. Your "promising practice" could help sister health centers all around the country. For additional information, please refer to the OSV Website.

- Program Requirements
- Medical, Oral, Behavioral Health or Enabling Services
- Clinical Performance
- Innovation in Population Health

Each year HRSA expects grantees to update their Sliding Fee Scales using the new poverty thresholds. The Poverty Guidelines for 2018 can be found at this link.

The new HHS Secretary is **Alex M. Azar II**. He was sworn in 1/29/18. On February 15th he testified in front of Congress stating that the CDC should be allowed to again research the causes of gun violence, a positive departure from the Administration's position.

Azar's stated goal is to lead the health care system toward value-based care, that's something we can all agree on. Read his bio.

HHS Office of the Secretary
E-mail Address: Secretary@HHS.gov
Phone Number: 202-690-7000

Did you know Health Centers represent more than **half** of the annual HRSA budget?

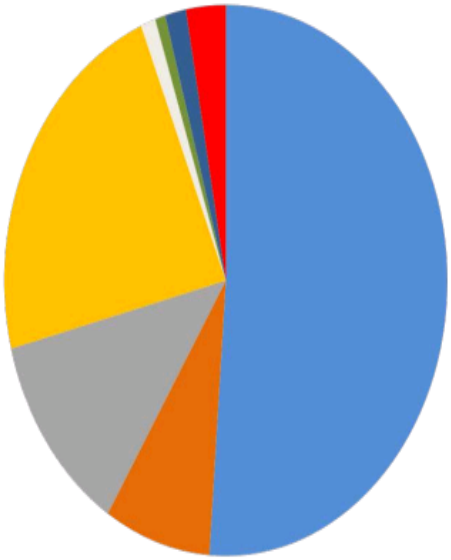
HRSA FY 2018 BUDGET REQUEST: $9.9 BILLION

Ryan White HIV/AIDS
$2.3 billion to support cities, states, and local community-based organizations to help those patients living with HIV have access to health services.

Maternal & Child Health
$1.2 billion to improve the health of all mothers, children and their families.

Rural Health Policy
$74 million to promote better health care service in rural America.

Healthcare Systems
$108 million to provide oversight to organ and tissue donation and transplantation systems, poison control, vaccine injury compensation, and drug discount programs.



Primary Health Care
$5.1 billion for comprehensive primary and preventive health care services in medically underserved communities.

Health Workforce
$771 million to educate, train, and connect health care professionals to communities in need.

Family Planning
$287 million to expand family planning services to individuals in need by improving access to family planning centers and preventive services.

Program Management
$152 million to support HRSA's program oversight and operations.

Current HRSA Funding Opportunities

Learn more about the Bureau of Primary Health Care here.

If you have questions, contact HRSA/BPHC online or by phone at 877-974-BPHC (2742).

Please have your health center grant number available.

Department of Health Care Services (DHCS)

Medicaid Integrity Program Audits (MIP) Update

In late 2016, community health centers were embroiled in a major battle with DHCS and CMS against inconsistent and overly punitive Medicaid Integrity Program Dental audit findings. After months of advocacy from individual health centers, CPCA, HCP, and local elected officials, DHCS nullified the financial payback for health centers who had been issued a formal MIP audit report. The Department would further go on to require a set of standards to be put in place prior to any additional MIP dental audits. **To date, DHCS has not established the dental standards.** Once finalized, FQHCs will have an *18-month grace period* before the standards are applicable for audits completed by the Audits & Investigations (A&I) Department.

Useful Links

- Audits & Investigations is a function of DHCS and houses many of the forms health centers must submit to the state (e.g. change in scope, rate setting, and cost reports.)
- Need information about DHCS? Start here on the DHCS website for Providers and Partners
- Find out who's who at DHCS: (DHCS) Executive Organizational Chart with phone numbers
- The California Health and Human Services agency oversees departments in a variety of fields including mental health, public health and managed care.
- A one-stop resource page for public health services, materials and resources has been released. Materials are available in the 5 most spoken languages in San Diego County: Spanish, Chinese, Vietnamese, Tagalog and Arabic. Follow the link above to learn more.
- To find information on reports, maps, health equity and regional data, check out SD County's Community Health Statistics Unit webpage. The 2016 Demographic Profiles have recently been released.

ADVOCACY

Thank you for all your efforts over this past year to fix the CHC funding cliff. Our collective actions have paid off! Two years of funding have been secured. We hope it's been educational and empowering, along with some fun times thrown in, like the #RedAlert4CHCs day. To see more of your colleagues in action, check out pictures on the HCP Facebook page.

Advocacy Center of Excellence (ACE)

In the coming year we will need engaged supporters to help us fend off attacks to the Medicaid program and 340B program. Building a culture of advocacy can begin with establishing your health center as an Advocacy Center of Excellence (ACE). There are three levels of ACE status – Bronze, Silver and Gold – which is good for 2 years. See the link above for checklists and resources to help you achieve Gold!

It will take all of us, working together, to protect Medi-Cal and the 340B discount drug program!

It's never too late to sign up as a CHC supporter. Join our health care coalition to protect access to care for California families! You will receive information on policy impacting CHCs and the patients we serve. When needed (on average 2-3 times per year), HCP will ask you to ACT by emailing, calling or posting to your elected official. We supply the language, **you supply the people power**!

In just 6 months,

our 440 advocates made more than

949 Legislator Connections!

NACHC Winter Strategy Summary | January 2018

To review the presentations from NACHC's recent Winter Strategy meeting in Delray, FL – click here.

This year the NACHC Winter Strategy session focused on scenario planning, just as CHCs have been advised to do considering the current funding uncertainty. A variety of speakers made presentations on the current state and possible future of the health care system.

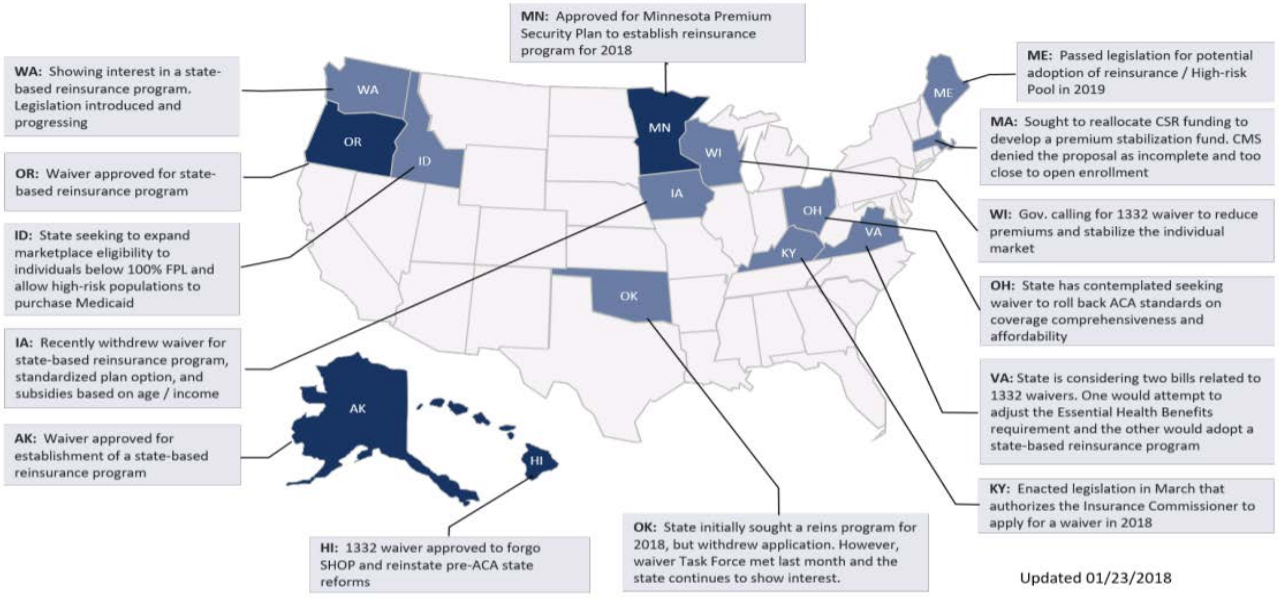
Currently 55% of the revenue in the health care system is financed by the federal government; and, each year, 3% of private employers drop insurance coverage for their employees. Every assumption about the future of health care is that it will get more expensive with experts predicting *5.6% annual growth*. It has been quietly reported the five major insurers in the country don't plan to be in the health insurance business in the next five years.

Questions CHCs should consider for the future:

- What will primary care look like in 5-7 years?
- How much money/sources of capital will we need in that system?
- What do we assume in this future system – will government still represent 55% of revenues?
- What could change and how does it impact FQHCs? Your specific CHC?
- How are you responding to the current situation? How would you like to respond? What new thinking would allow you to do this?

Despite three unsuccessful federal attempts to repeal the Affordable Care Act, there are still credible threats to the program from state legislatures in the form of Section 1332 waivers. States may also submit requested changes to their Medicaid programs through Section 1115 waivers, like the recently approved addition of work requirements to the Kentucky Medicaid program. Collectively, CHCs should keep a close watch on the waivers being approved in state legislatures. *(Leavitt Partners 2018)*

Interest in 1332 waivers has grown as states seek urgent policy solutions as federal uncertainty is sustained.



CPCA Committee Meetings Summary: January 2018

Below is a summary of the Committee meetings. To review the entire board packet, use this link: CPCA January Board Packet 2018. Each committee is also linked to its specific documentation in the packet, for easier reference. Additional links and resources are provided by HCP to supplement summaries.

Government Programs

Managed Care:

Nearly 9 million Californians are covered by Medi-Cal Managed Care, but not every county operates in the same way. The three counties in HCP's service area all operate under different models of managed care. This is important to note as state workgroups research the Managed Care environment in an attempt to influence strategies influential to CHCs and beneficial for patient outcomes.

All Plan Letters - All Plan Letters (APLs) are how Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels.

OSHPD3:

Legislators haven't been keen to take on the issue of OSHPD3 in the last two cycles, and it's not likely to be attractive in this election year. CPCA proposes to work in cycles to impact change, until policy change is feasible. This would include building standards, proposing licensure waivers with CDPH, and possibly a report by the Little Hoover Commission.

OSHPD 3 requirements vary depending on a facility's license. Private physician practices choose not to be licensed by the Department of Public Health; and therefore, are not held to OSHPD 3 building regulations. Even some surgical centers aren't held to OSHPD 3 standards, simply because they are not licensed under *Health and Safety Code (H&S) Section 1200*. Now a decision needs to be made by Community Health Centers regarding the importance of licensure. *What are the benefits of retaining the licensing? Are there any detriments to not seeking licensing?* CPCA is researching the possibility of a licensure exemption and will share information with legal counsel to garner an opinion whether CHCs should pursue exemption.

Take a Deeper Dive into OSHPD3

OSHPD 3 – "Regulations promulgated by OSHPD that apply to licensed clinics and hospital outpatient clinical services provided in a freestanding, nonhospital building." OSHPD 3 regulations and other applicable requirements are found in the following parts of Title 24:

- Part 1, 2010 California Administrative Code (CAC), Article 21
- Part 2, 2010 California Building Code (CBC), including Section 1226
- Part 3, 2010 California Electrical Code (CEC)
- Part 4, 2010 California Mechanical Code (CMC), including Tables 4-A and 4-B
- Part 5, 2010 California Plumbing Code (CPC)

See what this means for your site. Review the Compliance Checklist for OSHPD3 Primary Care Clinics

Licensing:

The California Department of Public Health (CDPH) is the agency responsible for licensing health care facilities in the state. Recently CDPH has changed its application process to a Centralized Application Unit (CAU) and will no longer complete applications in district offices. This change, along with the hiring of 24 staff (6 dedicated solely to primary care), should help streamline the process to make it more timely and efficient. The new staff will be working through a significant backlog in the first quarter of the year then rolling out a new electronic application. Watch out for notification of the electronic application in *All Facilities Letter* from CDPH. *See current and previous notices at the Facilities Letters Library.* The initial electronic application will only be for comprehensive (full) primary care facilities. Affiliate and consolidated electronic applications will follow shortly. Legal counsel has been engaged by CPCA to review the electronic application.

Clinic Lifeline Grants

Clinic Lifeline Grants will be available in the first week of March. Regulations are at their final step in process and have been submitted to the Office of Administrative Law. They will be posted for ten days, allowing for public comment. If no significant changes are necessary in response to comments, the grant application window should open *around* the first week of March. **The application is only open for 30 days.** Decisions for funding will be made 45 days after submission. Grants are available for up to $250,000 per site. Some proposals may not be funded at the full amount so the amount of grants available may vary. Applicants must clearly explain the triggering federal event that has caused this application and supply supporting documents to validate the financial need. *FQHCs, Look-Alikes, and RHCs each receive a 5 point scoring bonus.* Review the latest Clinic Lifeline webinar, slides, or transcript.

Immigration

The immigration debate continues publicly in the fight for DACA, but also regarding changes proposed to the public charge law. Public Charge is a way to deny admission into the United States if the government feels the individual is likely to rely on the government to survive. It's possible the Administration will make changes to the 100+year old law negatively impacting legal immigrants. This issue has remained on the forefront of Advocates' minds since a draft Executive Order was leaked early in 2017. *It's important to note there are many factors considered for admission into the US and numerous exemptions exist (refugees, asylees, survivors of domestic violence or human trafficking); public charge is only one factor*. Deportation under public charge is extremely limited and the individual must have: created a legal debt by using cash assistance or long-term care; they must have received a notice to repay the debt within five years and the immigrant must have refused to repay the debt.

Health centers continue to be a trusted voice for our immigrant patients, highlighting the importance of CHCs creating welcoming, open and inclusive spaces where the truth always resides. CPCA is working closely with the National Immigration Law Center (NILC), in partnership with trusted FQHC counsel, Feldsman & Tucker. Refer to the NILC link above for additional information and resources for patients.

330 Committee

- The State Plan Amendment (SPA) was the vehicle CHCs, in partnership with DHCS, were going to use to pilot the Alternative Payment Methodology. This was denied by CMS. The state can only move forward with this model through an 1115 waiver, which is essentially a contract between the state and federal government. With signs of impending threats to Medicaid coming from the federal government this doesn't seem like a responsible option to pursue at this time.
- Each year in October, health center rates are adjusted according to the Medicare Economic Index (MEI). There are proposed changes for 2018, which will raise the rates increased by a new indicator called the Market Basket (MB) rate. By comparison, in 2017, the MEI rate was 1.2 while the MB rate was 1.6. This year, due to the confusion the increased rates were not added to your payments in October 2017. They have since been added as of January 1st and will retro back to October 1, 2017**. CHCs should see those payments in the first quarter of 2018**. The rate increase was based on the MEI.
- Mobile Units cannot have their own PPS rate, but must use the parent rate. *This only applies to new mobile units.* Existing mobile units with a separate PPS rate will be grandfathered in and the rate may remain in place.
- *Legal Update*: San Mateo P4P Decision –CPCA is following the legal process and expecting to hear a decision on April 6th. Review your P4P incentives with this Best Practices resource from CPCA!

Clinicians Committee

Clinicians committee welcomed Dr. Lee for a presentation on Implementing Team-Based Care. The slides are posted, in the link above, for your review.

HCP made an inquiry during the Clinicians Committee to see if other CHC physicians had received a letter from the Medical Board of California (MBC) requesting data related to 2012-2013 opioid deaths. It was a mixed response. HCP shared that our internal Physician Council had agreed to submit a letter to MBC objecting to the methodology used. The major concerns are:

- No standard dosage standard existed in 2012-13,
- Cures database was not consistently functional during the period,
- Physicians had just completed mandated CME on pain management in response to their perceived inaction for patients with chronic pain, and;
- This type of punitive process could decrease access to pain management for patients and alienate the provider community.

After some discussion, it was determined CPCA would also weigh with the MBC with similar objections. Read the HCP letter to MBC.

Legislative Committee

The Governor's 2018-19 Budget was released in January and is consistent with the previous year, including language designed to change the 340B discount drug program so that the savings go the state instead of health centers. Current bill language suggests this would be accomplished by eliminating 340B from Medi-Cal Managed Care and Medi-Cal FFS programs. If that approval is denied by the federal government, the trailer bill would then eliminate the use of contract pharmacies for 340B. Both scenarios are harmful for CHCs; health centers utilize 340B savings to grow and expand access for patients, and often rely on contract pharmacies instead of operating expensive, in-house pharmacies at multiple sites. The 340B program for Medicare and the uninsured would **not** be affected. If successful, changes would not go into effect until January 1, 2019. Last year the Legislature rejected the Governor's attempt to influence policy with the budget. We will be working toward a similar result in our 2018 advocacy efforts.

The following bills will be the primary legislative focus for health centers in the second year of session:

- **SB 456 (Pan)** Allows CHCs to be reimbursed for continuity of care services not covered by PPS (such as those identified in some Whole Person Care projects.)
- **SB 1125 (Atkins)** Allows CHCs to be reimbursed for 2 Medi-Cal visits per day, regardless of type. This would allow a medical and behavioral health visit on the same day which is currently prohibited. We're proud this is sponsored by our very own, Senator Toni Atkins!
- **Consolidated Licensing Fix (Gonzalez-Fletcher)** A modification of the consolidated license bill passed last year. Implementation challenges require legislative fixes to allow choice on the determination of PPS rate for the consolidated site. We appreciate Asm. Gonzalez-Fletcher's continued support.
- **Prop 64 (Recreational Marijuana)** A portion of revenues (up to $650M) generated from the legalization of recreational marijuana are to be used to provide substance use disorder (SUD) education, prevention, intervention and treatment to kids. Will seek policy that directs revenues to training opportunities for SUD providers.

The Legislative Committee will now hold *monthly* calls. The February 28th call requires registration.

Election year brings new ballot initiatives to consider. The *California Tax on Incomes Exceeding $1 Million for Hospitals, Health Clinics, and Workforce Training Initiative* (#17-0047) proposes a 1% tax on incomes above $1M with revenues used to support safety net hospitals (70%), community health centers (25%) and workforce training programs (5%). **We support Initiative 17-0047!**

Other choices on the ballot will include a new Governor and several new members of the Senate and Assembly. This is an opportunity for health centers to influence the next generation of leaders by educating them on key health center and patient access concerns, and providing innovative solutions.

Voter Registration and *Get Out The Vote* campaigns are parts of our Advocacy strategy in 2018. HCP stands in partnership with member health centers to engage and mobilize patients to the polls!

RIVERSIDE NEWS

The first of several introductory meetings in Riverside County was held at UC Riverside on February 8th. Participants included HCP member health centers: Borrego Health, Community Health Services, Inc., Clinicas de Salud del Pueblo, Neighborhood Healthcare, North County Health Services, Planned Parenthood of the Pacific Southwest and Vista Community Clinics and representatives from: Riverside County Outreach & Enrollment, Behavioral Health, Riverside County's Clinically Integrated Network (CIN), Supervisor Manny Perez, and the Interim CEO of Riverside County FQHCs.

The group quickly gained consensus on the need for additional services for Riverside families, particularly in the area of behavioral health and oral health. Participants learned County FQHCs are planning to grow rapidly, opening 4 sites within the next six months, and have plans to begin a dental residency program. With numerous possibilities for collaboration, the group decided to reconvene on a regular basis to develop working partnerships.

The **inaugural Riverside Legislative Briefing** was held January 10th in Palm Springs. More than 25 stakeholders participated, included representatives from state and county elected officials. Legislative Briefings will be held quarterly and focus on state and regional issues pertinent to health centers in addition to Riverside centric concerns.

For members in Riverside, or those considering expansion, HCP has dedicated a web page to Riverside County resources. Check it often for updates. **Resource Link – Riverside County**

FOR YOUR INFORMATION

The activities/requirements now in place for all CMS providers have greatly expanded for Emergency Preparedness (since the new rule came into effect 11/2016 for implementation by 11/2017.) The current year will be a busy one for entities to get up to speed on the *four major elements* of the rule.

Once in place, these documents must be reviewed and updated annually, and training and exercises are an on-going requirement. HCP has devoted a page on our website to **Emergency Preparedness (EP).** Find out more at this **EP Resource Link.**

Deeper Dive: Four Core Elements of Emergency Preparedness

1. **Develop Risk Assessment and Emergency Plan** *(Including but not limited to):*
   a) Hazards likely in geographic area
   b) Care-related emergencies
   c) Equipment and Power failures
   d) Interruption in Communications, including cyber attacks
   e) Loss of all/portion of facility
   f) Loss of all/portion of supplies
   g) Plan is to be reviewed and updated at least annually

2. **Establish Policies and Procedures**
   - Complies with Federal and State laws

3. **Develop a Communication Plan**
   a) Complies with Federal and State laws
   b) System to Contact Staff, including patients' physicians, other necessary persons
   c) Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies

4. **Training and Testing**
   - Complies with Federal and State laws
   - Maintain and at a minimum update annually

Health centers are required to participate in the next County exercise scheduled for April 20th.

PURSUIT of KNOWLEDGE

Managing Ambulatory Health Care 2

NACHC, in partnership with CPCA, will host a Managing Ambulatory Health Care 2 (MAHC2) course in San Francisco, **June 25-28, 2018**. Clinical leaders can participate in a **4-day intensive** training (with CME available) focusing on essential and advanced skills including: *Financial Management, Clinical Leadership Challenges, Recruitment, Retention and Reducing Turnover, Leadership Styles and Leadership in Emergency Preparedness and Response*. Pre-requisites: Individual works at a community health center (or at a look-alike) and **maintains both an administrative and clinical** (providing direct patient care) **role**.

This course fills up quickly. To learn more, please refer to this link: *2018 MACH2-San Francisco*. **Apply online** by: downloading the application. Once complete, email Cindy Thomas using the subject line: *MACHC2-San Francisco*.

HITEQ UDS Clinical Analysis Dashboard

The Health Information Technology Training and Technical Assistance Center (HITEQ), a HRSA-funded NCA, has created UDS Clinical Analysis Dashboards to help HRSA partner organizations examine trends in clinical results and the impact of electronic health record (EHR) usage at both the individual organization and group levels. Learn more.

Dashboards include a national view, accessible to all organizations, as well as a view that reflects information related to individual health center results over time, and group comparisons of the members of a HCCN or state compared to all others. These dynamic customizable dashboards provide organization-specific analyses of all 14 clinical measures across six years of reporting. Authorized individuals from each organization should have received an email in recent weeks with log-in details. For additional information, please view the archived webinar, Accessing and Using the HITEQ UDS Clinical Analysis Dashboard, or email hiteqinfo@jsi.com.

HITEQ Highlights: Measuring Return on Investment for Your Population Health Management Program

Hosted by HITEQ, a HRSA-funded NCA

Thursday, March 1, 2018 3:00-4:00 p.m.

Register here

Riverside County Preparedness Summit - **April 4**

Expert speakers will share lessons learned from real-world incidents on topics at the forefront of emergency management, including incident response and recovery, emergency medical services response, cost recovery and procurement, as well as health care business continuity and recovery. Please forward this save the date to anyone within your organization who may have an interest in attending. CEs are available for the EMS presentation track. Visit www.RivCoEMD.org/Summit for more detail

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