March 23, 2018

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

Re: Proposed State Plan Amendment 18-003

Dear DHCS Director Kent:

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

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

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

Overarching Comments

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

1. Implementation

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

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

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

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

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

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

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

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

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

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

Specific Comments

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

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

1. Clarifying Language

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Section 5. Effective Date of a New Rate

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

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

Further, WIC § 14043.15(e) provides:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inpatient Settings

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

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

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

Dental Services Rendered to FQHC Patients by a Private Dental Provider

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

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

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

Telehealth Services

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

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

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

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

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

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

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

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

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

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

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

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

Homeless Services

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

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

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

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

Additional Services Provided Outside the Four Walls

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

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

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

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

Regards,

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