



330 Committee
January 14, 2019
3:00 p.m. – 4:00 p.m.
Louise McCarthy, January Chair

Registration URL: <https://attendee.gototraining.com/r/3616032454911471617>

Agenda

| ORDER OF BUSINESS | RELEVANT ATTACHMENTS | REPORTING | ACTION A = Approval D = Discussion I = Information |
|---|---|---------------------------------|---|
| I. Call to Order | | Louise McCarthy | A |
| II. Approval of Agenda | <ul style="list-style-type: none"> Executive Summary | Louise McCarthy | A |
| III. Approval of Minutes | <ul style="list-style-type: none"> Oct 2018 Minutes | Louise McCarthy | A |
| IV. Year in Review | <ul style="list-style-type: none"> 2018 Year in Review | Andie Patterson | I |
| V. SPA Negotiations | <ul style="list-style-type: none"> Memo: SPA(s) Status Update and Next Steps | Ginger Smith Andie Patterson | D |
| VI. Dental Manual Update (e.g. MIP audit related) | <ul style="list-style-type: none"> Memo: Status Update | Meghan Nousaine | A |
| VII. APMs & Managed Care Plans and Full PPS | <ul style="list-style-type: none"> Memo: Managed Care Plans and Full PPS | Andie Patterson | D |
| VIII. A&I Challenges and Solutions | <ul style="list-style-type: none"> Memo: Status Update | Ginger Smith Andie Patterson | D |
| IX. P4P | | Andie Patterson | I |
| X. Legal Update: Retrospective Dental Claims Litigation | <ul style="list-style-type: none"> Memo: Legal Update | Andie Patterson Ginger Smith | I |
| XI. Adjourn | | Louise McCarthy | A |



Executive Summary

Date: December 28, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

SPA Negotiations

- SPA 18-003 includes MFTs as billable providers, revised and improved productivity standards, clarification on effective date of a rate setting application, and new provisions with the change in scope process.
- SPA 18-003 was submitted to CMS March 30th and although still not approved by CMS will be effective January 1, 2018.
- CPCA continues to push for a meeting with DHCS to discuss our areas of disagreement with SPA 18-003.
- Proposed SPA 18-0055 addresses the services FQHCs can provide outside their four walls and receive PPS for those services, and provides clarity for assigning a PPS rate to an immediate site or mobile unit.
- CPCA submitted formal comments on SPA 18-0055 November 2nd. SPA 18-0055 remains a proposed SPA that has yet to be submitted to CMS and has a proposed implementation date of January 1, 2019.
- SPA 18-0032 was approved by CMS and allows PPS reimbursement for residents performing services in a qualifying THCGME program.
- CPCA was successful in broadening SPA 18-0032 to include state sponsored programs as well.

Dental Manual Update/MIP Audit Follow up

- This is an update on our dental related Medicaid Integrity Program (MIP) audit discussions with the California Department of Health Care Services (DHCS).
- On November 30, we submitted our second round of comments and feedback to the State. In our letter to DHCS there were three primary asks including: slowing down the process, sharing with us their top concerns and acknowledgment that the Mandatory FQHC Dental Benefit and the Optional Medi-Cal Dental Benefit are Distinct and Different Benefits requiring different guidance.
- DHCS convened a small workgroup to further discuss FQHC dental documentation in December
- On January 9 the MIP Work group will convene and discuss the outcomes from the working meeting with DHCS. The work group will also review, discuss and vote on next steps.
- Those recommendations will be shared with this Committee via a verbal update on January 14.
- Provider Manual proposed edits will be shared with DHCS on January 17.
- A final meeting with DHCS to review proposed edits will be held the week of January 21.

APMs & Managed Care Plans and Full PPS Payment

- In October, during the Care Coordination Convening DHCS convened Mari Cantwell agendaized FQHC payment reform
- She proposed to take a further step in the direction of health plan and health center alignment would be for the plans to fully pay PPS to FQHCs
- It would create efficiency at DHCS eliminating the need for reconciliation and the wrap around payment
- She was interested in this model per a recent TX lawsuit
- CPCA is exploring the proposal in the event it is proposed in the budget or the next waiver
- In late December, CPCA Board members met with Ana Matasantos, the Cabinet Secretary, and during the discussion on APM and finding a way to implement SB147 she asked how FQHCs would mitigate over utilization of PPS if it were done in SPA.
- Her question provides an opening for new ideas to present to the Administration.
- CPCA will reconvene the Wrap Cap WG in the late winter to commence brainstorming.

A&I Challenges and Solutions

- CPCA continues meeting with DHCS to address the challenges health centers experience with A&I around rate setting, change in scope, and reconciliation.
- A strategy resulting from the meetings with DHCS includes a process for escalating issues within A&I. CPCA continues to encourage health centers usage of this protocol.
- The issue of DHCS applying provider compensation caps was surfaced to CPCA's attention through the escalation process. CPCA has requested a meeting with DHCS to discuss the issue further.

P4P

- On April 27 the Superior Court of Sacramento denied a Writ of Administrative Mandate filed by the County of San Mateo FQHCs, which upheld the decision that DHCS auditors were correct in including the San Mateo incentive payments in the reconciliation.
- CPCA has advocated to DHCS to stop the recoupments and DHCS has confirmed that A&I auditors have been instructed to stop including quality payments/P4P payments in annual reconciliations, until DHCS policy has been finalized.
- At this point in time we are still awaiting the policy proposal from DHCS directing how P4P payments should be structured for FQHCs

Legal Update: Retrospective Dental Claims Litigation

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

**CALIFORNIA PRIMARY CARE
ASSOCIATION**

330 COMMITTEE

October 2, 2018

1:00pm-2:00pm

Members: Louise McCarthy – Chair, Robin Affrime, Antonio Alatorre, Doreen Bradshaw, Warren Brodine, Deb Farmer, Ben Flores, Susie Foster, Aaron Fox, Cathy Frey, Naomi Fuchs, Greg Garrett, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Virginia Hedrick, Sherry Hirota, Kerry Hydash, Dave Jones, Deena Lahn, David Lavine, Deborah Lerner, Jyl Marden, Alicia Mardini, Burt Margolin, Kevin Mattson, Leslie McGowan, Nichole Mosqueda, Anitha Mullangi, Christine Noguera, Rakesh Patel, Justin Preas, Joanne Preece, Carole Press, Tim Pusateri, Tim Rine, Gary Rotto, Esen Sainz, Paulo Soares, Graciela Soto-Perez, Brenda Storey, Teeri Lee Stratton, Dong Suh, Mary Szecsey, Vernita Todd, Ana Valdes, Denis Vega Tapia, Richard Veloz, David Vliet, Christy Ward, Paula Zandi

Guests: Kathryn Power, Laura Sheckler, Ryan Yamamoto, Teresa Tillman, Yamilet Valladolid, Ellen Piernot, John Blaine, John Price, Chad Vargas, Raphael Irving, Karen Lauterbach, Maria Paz, Sergio Bautista, Erika Sockaci

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Ginger Smith, Meghan Nousaine, Cindy Keltner, Allie Budenz, Beth Malinowski, Liz Oseguera, Mike Witte

I. Call to Order

Louise McCarthy, Committee Chair, called the meeting to order at 1:01pm.

II. Approval of Agenda

A motion was made to approve the agenda as presented. **The motion carried. (V. Todd, D. Stover)**

III. Approval of Minutes

A motion was made to approve the minutes of July 12, 2018. **The motion carried. (N. Gupta, K. Mattson)**

IV. SPA Negotiations

CPCA has continued to engage and monitor the pending SPA 18-003 regarding the area we disagree with- Change in Scope. CPCA, in partnership with CAPH, submitted a letter outlining our legal arguments as to why the state's amendments regarding change in scope were not consistent with state and federal law. We continue to push for a meeting with the DHCS attorneys. The 4 walls SPA discussion with DHCS is underway. CPCA has aggregated pages of feedback and every three weeks staff meet with the state to review. CPCA with member input has drafted a 4 walls SPA from a health center perspective which will be shared if the state's updates are not as robust as we need.

DHCS submitted SPA 18-0032 to CMS on June 29, 2018 to authorize PPS reimbursement for services performed by qualifying Teaching Health Center Graduate Medical Education (THCGME) Primary Care Resident Physicians at participating FQHCs and RHCs. CPCA submitted formal comments on June 29, 2018. The SPA is still pending CMS approval.

V. Pay-for-Performance

CPCA has advocated to DHCS to stop the recoupments and DHCS has confirmed that A&I auditors have been instructed to stop including quality payments/P4P payments in annual reconciliations, until DHCS policy has been finalized. CPCA supported Assemblymember Wood's efforts through AB180 to protect FQHCs' rights to P4P, but the bill was vetoed. CPCA has reached out to the state to engage on the policy and developing the appropriate guidelines.

VI. A&I Challenges

Per the challenges with A&I auditors, CPCA and a small group of CFOs have commenced a process to work through the challenges and find agreeable solutions. Two meetings have already been conducted and many more

are in process. Working with A&I a roadmap for escalating issues within A&I has been circulated to members.

VII. MIPS

Between the end of 2016 and August 2018, California Department of Healthcare Services (DHCS) did not engage CPCA or our health centers in this work regarding the development of “educational materials”. We remained concerned about the provision stipulated by CMS regarding “consistent with state policies” as one of our main issues was that there are no clear policies regarding clinical care nor provision of services. As of late September 2018, DHCS reached out to CPCA requesting comments on what are the confirmed CMS required “educational materials” in the form of updates to their PRIHD Provider Manual Dental Handbook.

CPCA staff responded to their outreach with a request to meet and discuss in person thru an iterative process similar to the process we’ve undertaken with the State Plan Amendments in 2017 and 2018. The proposed plan of action includes: Meetings with DHCS with small member workgroup; all member update webinars and comment periods; and legal review and guidance.

Additional updates were provided to the group regarding the first meeting with DHCS which took place on October 1, 2018. CPCA staff shared the participants on the member driven MIP Work Group tasked with reviewing DHCS feedback and providing comments back to the state. Finally, CPCA staff shared first deadline to submit comments, October 19, 2018.

Motion – MIP Audits & Educational Materials Development

A motion was made and seconded to approve the outlined proposed plan of action for the development of the educational materials known as the PRIHD Provider Manual Dental Handbook updates.

A second motion was made and seconded to support the recommendations of the Dental MIP Work Group as it relates to the development of educational materials, scope of dental services, and updates to the PRIHD Provider Manual Dental Handbook and future iterations. However, if the final recommendation includes limiting the scope of services provided, a meeting will be held to update the Board. **The motions carried. (Fuchs, N., Mattson, K.)**

VIII. Payment Reform

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

IX. Legal Update

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

X. HRSA

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

XI. Adjourn

The meeting was adjourned at 1:55pm.

Respectfully submitted,

Daisy Po’oi
Meeting Minutes Recorder



INFORMATIONAL

Date: January 5, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs
Re: 2018 Year in Review

MEMORANDUM

2018: 330 Committee = What we predicted

- **SPA/PPS**
 - Will continue working with DHCS/ A&I through March to resolve any outstanding ambiguity on 4 walls, Administrative / Executive Compensation Caps, and 3 comparable clinic rate setting, all three issues brought forward by the state in the initial SPA notice in December 2016.
 - Final SPA will be submitted that is fair to FQHCs at the end of March and will be effective beginning July 2018.
- **Payment Reform**
 - CPCA will work at first with a subset of health plans to identify manners by which capitation with risk could work if implemented through a SPA.
 - The wrap cap workgroup will vet ideas that are generated with the smaller set of plans and ultimately CPCA will take a more refined set of strategies to a larger body of health plans to discuss how to forward an APM in 2019.
 - CPCA and health plans in partnership will pitch the new idea to the new administration in late 2018.
- **P4P**
 - CPCA staff will communicate the P4P best practices and strategy to all FQHCs in California.
 - Health centers will discuss their personal P4P arrangements with health plans and make changes to conform to the best practices.
- **PPS/DHCS Issues**
 - CPCA and DHCS will agree on a training for A&I auditors and FQHC CFOs.
 - The training will be conducted in 2018.
 - Challenges during individual audits and rate settings will decline significantly after the training.
- **Legal**
 - The dental retrospective claims litigation will finally be resolved and health centers will get some of their deserved money for services provided back.

2018: 330 Committee Year-in-Review = What happened

- **SPA/PPS**
 - Successfully negotiated with DHCS to remove four walls from the original SPA
 - Finalized negotiations and submitted final comments on SPA 18-003
 - Continued to challenge DHCS on their proposed language changes to Change in Scope
 - SPA 18-003 was submitted to CMS- CMS had many comments, SPA is still pending and CPCA does not know when it will be approved
 - Commenced discussions on 4 Walls with DHCS in July, negotiations lasted through September
 - Met with members at times every two weeks, but at least monthly to review the conversations and proposals from DHCS.
 - Actively secured and shared feedback from members which ultimately influenced all the final decisions.
 - Secured exemptions for homeless and migrant farmworkers, and other vulnerable populations
 - Four walls SPA is not yet submitted but is intended to have an effective date of January 1, 2019
- **Payment Reform**
 - Attempted to reinvigorate work on APM 2.0 to review using P4P payments as the risk element
 - Concluded that with an incoming administration we need to try one more time with the first APM and implement through a SPA
- **P4P**
 - A&I commenced recouping P4P payments from a few health centers
 - CPCA pushed to stop recoupment and work with health centers to develop fair policies and allow plans and health centers to update their policies before P4P is reviewed again as part of reconciliation
 - DHCS stopped recouping P4P and said they would stop until they develop policies
 - Assemblymember Wood introduced AB180 that would have required the state to develop a stakeholder process for P4P and payback any recouped P4P
 - AB180 was vetoed but the payments were paid back
 - DHCS is supposed to issue a proposed policy at end of 2018 or early 2019
- **PPS/A&I Issues**
 - CPCA with a small cohort of CFOs and consultants (including Pat Aguilera and Steve Rousso) began meeting with A&I leadership on a regular basis to work through the array of challenges CPCA members identified
 - An escalation process was provided by A&I and health centers were offered this course of appeal in Spring 2018.
 - CPCA and CFOs will continue to meet with A&I leadership in 2019 until we work through the array of issues and identify solutions
 - CPCA is also working to identify financial best practices at health centers to promulgate amongst the members

- **Legal**
 - The dental retrospective claims litigation was won and named plaintiffs were allowed to submit for past claims.
 - A second motion was filed to allow ALL FQHCs/RHCs to submit past claims, not just named plaintiffs.
 - A motion was made to recoup attorney fees for all the cases.

2019: 330 Committee = What we predict

- SPA
 - CPCA will learn what level of policy and detail CMS wants to engage on
 - This will determine what CMS ultimately will approve and will help CPCA determine where to continue advocacy on the elements we do not agree with, of particular note Change in Scope
 - If DHCS is not allowed to keep in the level of detail they want, they may try a state policy vehicle which depending on the content may warrant further engagement and advocacy by CPCA and members
- Dental Manual Update/ MIP continuation
 - For the early part of 2019 CPCA and members will meet with DHCS to determine the level of documentation necessary for dental encounters
 - The expectation from DHCS may mean further advocacy on the dental benefit in Medi-Cal or defense of the FQHC PPS visit
- P4P
 - DHCS will issue a proposed policy on P4P for health centers and CPCA along with the health plan associations will negotiate the ultimate policy
- Managed Care Wrap Around
 - Should an 1115 Waiver renegotiation commence, full PPS payments through health plans may be a topic of discussion
 - CPCA will ensure thorough research is done – understanding health center concerns, plan concerns, experiences in other states and legal allowances and barriers
- APM
 - CPCA will recommence discussions with members on how to mitigate excess unnecessary utilization if we move an APM through a SPA
 - We then will present ideas to the new administration
- Legal
 - Health centers will be paid for past claims
 - Health centers who were not named plaintiffs will be allowed to submit
 - A large portion of our attorney fees will be repaid



DISCUSSION

Date: January 14, 2019

To: 330 Committee

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

Re: State Plan Amendments (SPAs) Update

MEMORANDUM

I. SPA 18-003

The Department of Health Care Services (DHCS) submitted SPA 18-003 to CMS on March 30, 2018 and although not yet approved, has an intended effective date of January 1, 2018. This SPA includes: MFTs as a billable provider in a Federally Qualified Health Center (FQHC), revised and improved productivity standards with an exception process, clarification on the effective date of an initial rate setting application, and a provision to require a full fiscal year of costs and visits for a Changed in Scope of Service Request (CSOSR) with the new rate retroactive to the date the change occurred, not the year the CSOSR was submitted as it is today. The SPA also contains additional amendments with the CSOSR that will require a FQHC to prove there was an increase in cost attributable to the scope change vs. a comparison between the old and new PPS rate and redefines what DHCS sees as “type, intensity, duration, etc.” for a triggering event.

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

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

There is no set date for when SPA 18-003 has to be approved. The timeline on the SPA at this point has been paused so that DHCS and CMS can engage in informal dialogue. CPCA will continue pushing for a meeting with DHCS to discuss our areas of disagreement and intends to

work with CMS on DHCS' proposed changes once we have more clarity on what CMS' position is on the proposed SPA.

II. SPA 18-003 Issue with “Optional Benefits”

We found post DHCS submission of SPA 18-003 incorrect language that limits the chiropractic and podiatry benefits to only a certain group of beneficiaries. This language contradicts the CARHC case which established that chiropractic and podiatry services are not ‘optional benefits’ when provided by a FQHC or Rural Health Center (RHC). We raised the issue with DHCS and asked that they make the necessary updates to reflect that these services are not limited to the two groups listed. DHCS shared they continue to review our concern but have no additional feedback.

Reference:

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

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

III. SPA 18-0055

SPA 18-0055, at the time of this writing on December 21, 2018, remains a proposed SPA that has yet to be submitted to CMS by DHCS and has a proposed implementation date of January 1, 2019. The date in which DHCS plans on submitting the SPA to CMS is unknown at this time. This SPA includes provisions for when a FQHC can deliver services outside of the four walls of a health center and receive PPS reimbursement for the services and provides clarity for determining what PPS rate to affiliate with an immediate site or mobile unit.

Discussions on the SPA began in July of 2018, and included numerous face to face meetings between CPCA, CAPH, members of the CPCA board, attorneys, and DHCS, and multiple webinars with health centers to ascertain all of the challenges and all of the proposed revisions. On October 19, 2018, DHCS released their proposed SPA language for stakeholder comments and CPCA submitted formal comments and edits to the SPA on November 2, 2018. Ultimately, the state shifted significantly from their original concept, and the proposed SPA contains a great deal of exceptions for how health centers can provide care to patients outside of their four walls. It is clear the state appreciates the critical role of health centers and the unique needs of vulnerable populations like homeless, elderly in skilled nursing facilities, and migrant and seasonal farmworkers.

There remains a few challenges to the SPA, as well as clarifications necessary in the language. The two major outstanding items include providing care to non-established patients within a hospital setting and providing dental to non-established children in a school that is not an intermittent site. One concept CPCA has discussed with DHCS for non-established patients seen in a hospital is to allow for a three month retro eligibility for newborns. During our last meeting, DHCS appeared to be open to this idea, but it is still unknown if DHCS has made any

language changes to reflect the suggestion. For the issue of dental care to non-established children in a school, CPCA is exploring potential legislation for 2019. CPCA will continue working to secure solutions to the challenged areas for ensuring continuity of care for patients and that allows health centers to continue providing care for all.

Once DHCS submits SPA 18-0055 to CMS, CPCA will develop a FAQ which will be reviewed first by DHCS, to confirm the understanding we have with the state's intent with the language in the SPA. We believe it is necessary for DHCS to review because the SPA language can be interpreted in many different ways and we want health centers to be best positioned for when this SPA becomes effective.

IV. SPA 18-0032: GME/PPS

In September of 2018, CMS approved SPA 18-0032 that authorizes reimbursement, under the PPS methodology, for services performed by qualifying Teaching Health Center Graduate Medical Education (THCGME) primary care resident physicians at participating FQHCs and RHCs. Initially, DHCS included only HRSA funded THCGME programs but with CPCA's advocacy we were successful in broadening to include state sponsored Community Health Center Residency programs as well. SPA 18-0032 is effective April 1, 2018.

V. Resources

- DHCS December 2016 SPA notice can be found here:
http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001_PN.pdf
- SPA 18-003 submitted to CMS on March 30, 2018 and posted in the "Pending" category here:
http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending_2018.aspx
- [CPCA formal letter to DHCS on SPA 18-003](#)
- [CPCA submitted edits to the proposed SPA 18-003](#)
- [CMS response to DHCS on SPA 18-003](#)
- [CPCA analysis of CMS Response of SPA 18-003](#)
- SPA 18-0055 Public Notice and Proposed language:
https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA_18-0055PN.pdf
- [CPCA formal letter to DHCS on SPA 18-0055](#)
- [CPCA submitted edits to SPA 18-0055](#)
- Approved SPA 18-0032 is available here:
https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Approved_2018.aspx



Action

Date: January 14, 2019
To: 330 Committee
From: Meghan Nousaine, Assistant Director of Health Center Operations
Re: **ADDENDUM:** DHCS FQHC Dental Provider Manual Project

MEMORANDUM

I. Background

This is an ADDENDUM to the Memo dated 1/14/19 with additional updates on our dental related Medicaid Integrity Program (MIP) audit discussions with the California Department of Health Care Services (DHCS). This update includes activities which took place between December 21, 2018 – January 10, 2019.

II. Update

Comments will be submitted on January 17, 2019 and will maintain our stance that the FQHC dental benefit is different than the Medi-Cal Dental (Denti-Cal) benefit. However, we strongly predict that DHCS will not be moved on our continued stance and DHCS continues to state that FQHCs should only be allowed to bill PPS for medically necessary services that are included in the Medi-Cal Dental Provider Handbook.

Additionally, we expect them to illustrate this stance in formal guidance issued in the newest version of the Provider Manual edits despite our advocacy over the past 3 months. We have continued to cite our legal interpretation and court precedence that supports our stance, but are not optimistic. CPCA staff is seeking guidance from members as to what our course of action shall be if part of the guidance DHCS releases includes the following statement:

*Safety Net Clinics (Federally Qualified Health Centers, Rural Health Clinics, Indian Health Clinics) may render any dental service **listed in the Medi-Cal Dental Manual of Criteria** in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice and determined to be medically necessary pursuant to California Welfare & Institutions Code §14059.5."*

CPCA's legal counsel and the MIP workgroup consideration potential options for next steps, weighing risks and benefits of each option. (For a detailed description of the options and known risks and benefits reference **Appendix A**).

Legal Opinion and Recommended Action: CPCA legal counsel believes that there are strong legal and policy grounds to challenge the State’s attempt to limit the scope of FQHC dental services via the Provider Manual based on the definition of an FQHC visit as a face-to-face encounter. However, a strategy that involves negotiating for and agreeing to limitations that would allow FQHCs to provide an acceptable range of the services that their patients need would not foreclose a future legal challenge should circumstances change.

Action: None stated

MIP Workgroup Opinion and Recommended Action: In a verbal vote the MIP Workgroup agreed (Agree 7, Absent 1, Abstain 1, Disagree 0) on the proposed action below be presented to 330 for consideration.

Considerations Further Informing the Recommended Action:

- We know from collected survey data with over 96 respondents that 70% of health centers in California are already following the Denti-Cal Manual explicitly to (including scope of services, utilization limits, etc.).
- Of the 30% of respondents who stated that they do not follow it explicitly, when asked what portions of the manual they do reference, over 80% cited reference to list of covered services.
- 66% of survey respondents (N=65) stated that although they do provide services to their Medi-Cal patients that are not included in the Denti-Cal Scope of services, only 9% (n=5) are currently billing it as a Dental PPS visit, most are billing a sliding fee (67%).

Action 1: *In response to expected DHCS’ issued guidance CPCA will respond to DHCS by stating “while we disagree with the Departments guidance and reserve our right to legal or legislative action to this regard” should FQHCs have to be aligned with the Denti-Cal manual we want to ensure both a list of additional medically necessary services be added for all Medicaid Dental Providers and confirm FQHCs are exempt from the utilization limits and global service requirements. (For list of potential services that would be added reference **Appendix B**).*

Additional CPCA Staff Recommended Action: In order to alleviate confusion on guidance in the interim, while DHCS guidance is issued and we negotiate on additional issues, staff recommend 330 and our Board consider the following action item as well.

Considerations Further Informing the Recommended Action:

- We are still confirming the process which must be taken to add services to the Denti-Cal Scope.
- FQHCs are already exempt from the pre-authorization and TAR requirements of the Denti-Cal program.
- We assume and plan to confirm, that upon issuance of the DHCS guidance, which is expected in February 2019, the 18-month count down begins for when Dental Audits can restart in the State.

Action 2: *Immediately following DHCS’ issued guidance, CPCA’s interim guidance to health centers would be that the Denti-Cal Manual applies to the Medi-Cal dental benefit in California, regardless of the setting. This would mark a change from the guidance that is currently being provided as a result of the Board of Director’s decision in July 2014.*

APPENDIX A

Option 1 – Denti-Cal Scope of Services for All

Formally recognize and adopt the system wide perspective that the Denti-Cal Manual applies to the dental benefit in California, regardless of the setting.

- **Benefits**

1. Clarity around what is and is not allowed for Medi-Cal beneficiaries through the dental benefit- regardless of the setting;
2. Same scope of allowable services for providers and auditors to use as a guide leaves little room for subjectivity in the audits re: standards of care and medical necessity;
3. Statewide compliance and standards that can help FQHC dental programs operate their programs confidently.
4. This option could be exercised while making clear that CPCA is not conceding that the scope is limited as a matter of law, i.e., reserving the right to challenge it later.
5. In 2018 the scope of covered services was recently expanded to include 51 additional services that were not included in 2009.

- **Risks**

1. Conceding on the billable visit concept (which simply is that the only relevant factors for billing PPS at an FQHC are whether it's an FQHC billable provider and a Medicaid patient);
2. Conceding on the billable visit concept in dental could lead to closer scrutiny with medical visit billing. Additional research would need to be done to explore the scope of Medi-Cal services in primary care to fully understand the risk;
3. Rates for FQHCs were set on historical services provided (cost, visits, etc.) and if the final agreement concludes different expectations than were built into rates, then rates would need to be adjusted to account for that- per the current proposal this could be a negative for health centers if the state expects twice as many, or more, services delivered in a single visit and with the high level of scrutiny the state is applying to rates, PPS rates could be negatively impacted;
4. Scope of services as currently approved is limited (utilization caps) and patients will have diminished access;
5. Some best practice procedures (for example SDF) are not covered limiting the reimbursable preventive services patients need;
6. Does not account for the services some FQHCs are already providing to their Medi-Cal patients which leads to a series of challenging questions;
 - Would the health center need to stop providing these services?
 - Could they become sliding fee scale services?
 - What are the implications with the HRSA scope?
 - What are the implications to a PPS rate?
 - Would FQHCs be allowed to bundle covered services with non-covered services in multiple visits with a single patient?
 - Would the auditors accuse FQHCs of not providing all of the covered services in one visit in order to be paid the PPS rate for multiple visits?

- **Alternatives/or additions to Option 1**

1. 1a. *Addition - in addition to billing PPS for services in the Denti-Cal scope, we'd advocate for inclusion of additional medically necessary services in the manual for all Medicaid Dental Providers.*

- Benefits - Same as Option 1 and additionally:
 - More opportunities for our patients to receive necessary care
 - FQs would potentially get higher reimbursement thru PPS than with sliding fee
- Risks – same as Option 1:
 - But we'd potentially mitigate points 4-5;
 - Depending on the service, PPS may be less than Sliding Fee

2. 1b. *Addition – in addition to billing PPS for services in the Denti-Cal scope, formalize a mechanism (either through DHCS or legislation) for the billing sliding fee for non-covered services for Medi-Cal beneficiaries.*

- Benefits – Allows FQHCs to provide services outside of the Denti-Cal approved scope of services
- Risks – Complicated for FQHCs who are currently billing PPS for all services
 - See Option 1 Risks, with specific emphasis on point 6

3. 1c. *Addition – in addition to billing PPS for services in the Denti-Cal scope, we'd confirm FQHCs are exempt from the utilization limits, global service requirements, TARs and pre-authorizations.*

- **Considerations Pertaining to Option 1:**

1. HRSA only mandates preventive and emergency services. An FQHC may elect to only provide those services and is still in compliance with HRSA requirements. All other services are optional and are up to the health centers to decide whether to provide.¹
2. However, a distinction should be made between HRSA-mandated services and FQHC "visits" with billable providers, the latter of which are covered services under the California State Plan. We should not concede that only HRSA-mandated services are required covered services in California given the visit definition.
3. In 2018 the scope of covered services was recently expanded to include 51 additional services that were not included in 2009.

Option 2 – PPS for all Dental Visits

Stand firm on our position that all medically necessary dental services provided to Medi-Cal beneficiaries are covered FQHC/RHC services, that the Denti-Cal Manual of covered services does not apply, and that it is proper for FQHCs to bill their PPS rate for ALL medically necessary Medi-Cal visits per the WIC code and the California State Plan.

- **Benefits**

1

<https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf>

1. Holds firm on our legal interpretation of the WIC code and the State Plan
 2. Allows dental programs to provide all services to their patient population
- **Risks**
 1. This will likely lead to costly litigation if DHCS implements the policy regardless of our position
 2. Litigation could potentially result in a ruling that is not in our favor
 3. The federal regulations allow the state Medicaid agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Presumably, the state should engage in a public process before imposing such limitations.
 4. Losing on this issue could have an impact on the scope of medical benefits, as well.
 - **Addition to Option 2 :**
 1. *2a. Addition – While standing firm, we could seek legislation clarifying that all medically necessary services within a FQHCs' scope that are provided in a face-to-face encounter with a billable provider are to be paid at the PPS rate.*
 - Benefits – maintains status quo
 - Risks - running legislation has risks generally including getting support, not passing, being amended, “spending” political capital etc.
 - DHCS may issue guidance in the interim resulting in the 18 month countdown until audit restart in the State.
 - **Comments related to Option 2:**
 1. We'll need to discuss the practice of sliding fee for some services and billing PPS for others. If this is REALLY what we believe is the best course, FQHCs should consider billing **all medically necessary** face to face Medi-Cal encounters with a billable provider as a PPS visit.

Option 3 – Push DHCS into a Formal Rulemaking Process / Challenge Process as an Underground Reg

Agree with the State that there should be a formal process (Referred to as: a Notice and Comment Rulemaking Process) to determine the appropriate scope of services. A constant problematic theme of the Medi-Cal program is the issuance of policy by fiat rather than engaging in a real public process with stakeholders and experts.

- **Benefits**
 1. CPCA members see us playing hard ball.
 2. This would slow down the process and force the Medi-Cal program to engage with stakeholders and respond to their concerns.
 3. This would be a public process and would shine a light on the Medi-Cal program's activities/process.
 4. This would provide an opportunity for patients and patient advocates to participate in the process as well.
- **Risks**

5. It is possible the outcome would be the same, since the rulemaking process requires the agency to listen to and respond to comments, but not to change their ultimate course of action (although if they run roughshod over the process, it can be challenged in court).

Option 4– Legislative Advocacy to be defined by desired position *(Not an option on its own, but is coupled with a position)*

- **Considerations**

1. The legislature is unlikely to be friendly to a concept of no rules for FQHCs in billing or services provided. This undermines their own authority.
2. If we determine that PPS is PPS, but the Denti-Cal benefit is not sufficient we could do legislation to push for expanded offerings. If we want this we need to be very clear about what exactly and why. It would be for everyone not just FQ providers.
3. An advocacy approach that illustrates that FQHCs get to do special things that no one else does will likely leave us alone in our advocacy and makes folks dislike us for being above the rules.

APPENDIX B

What Additional Medically Necessary Service Should be added to the Denti-Cal Scope of Approved Benefits?

(Collected through two member surveys conducted in October & December 2018)

| Category | Service Type | Frequency (FQHCs who DO already provide services outside of the Denti-Cal Scope) N=33 | Frequency (FQHCs who DO NOT provide services outside of the Denti-Cal Scope) N=12 |
|--------------|---|---|---|
| Restorative | Crowns | 9 | 8 |
| | Dentures (Full & Partial) | 4 | 4 |
| | Occlusal Guard | 4 | 2 |
| | Bridges | 2 | |
| | Root Canal Therapy | 1 | |
| | Implants | 1 | |
| Preventative | Higher Utilization Limit for Cleanings | 4 | 6 |
| | SDF | 3 | 3 |
| | Sealants | 2 | |
| Other | Behavior Management for non-special needs | | 1 |
| | Screening for Under-4 Year Old No radiograph required | | 1 |



Date: December 27, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs
Re: Managed Care Plans and Full PPS

Overview

DHCS convened Care Coordination full day meetings in the fall. The meetings were originally to better understand the challenges in Medi-Cal with care coordination but they ended up including a wide array of disparate issues from the number of aid categories in Medi-Cal to FQHC payment reform.

In October, DHCS agendaized FQHC payment reform and Mari Cantwell, Medi-Cal Director, presented. She opened the discussion by saying that since stakeholders and the state could not figure out payment reform one way to better align the system and create efficiency for DHCS would be for the managed care plans to fully pay PPS to the FQHCs.

She laid out the following description:

- Current CMS policy allows for simplification through an approved APM in the State Plan.
 - Each FQHC/RHC must agree to use the APM and it must be at least full PPS.
- But, CMS requires states to retain reconciliation and oversight responsibilities for PPS payments under an approved APM.
 - This, along with the voluntariness requirement above, diminishes the utility of PPS delegation via an APM.
- Evolving area currently subject to litigation
- Recent Fifth Circuit ruling that the Medicaid Act did not prohibit TX from requiring is managed care plans to fully reimburse FQHC/RHCs at the PPS rate
 - Legacy Community Health Services v. Smith (881 F.3d 358)
- Petition for review of this decision currently pending at the U.S. Supreme Court.

Very little discussion was had, and CPCA offered that there were actually ways to make the original APM work, but Mari indicated she was not interested. CPCA also noted at the Care Coordination meeting that in TX the plans were not being fully paid the amount of PPS, but Mari shared the state would of course ensure plans had the sufficient resources.

No further discussions with DHCS have been had since this short exchange, but CPCA has commenced research on the idea in the event it is presented by the Administration in a budget or in the next 1115 Waiver discussions.

Further Research

Subsequent to the DHCS proposal in October, CPCA reached out to the Texas PCA as well as NACHC. In short what happened in Texas is as follows:

- The Texas Medicaid Program required health plans to pay FQHCs PPS
- Ultimately there was a lag in full payment to the plan for the requisite amount to pay PPS
- There were also coding and billing form challenges on the part of the FQHCs, and then the plans perceived the FQHCs as far too expensive which was largely due to inadequate coding in the claim submissions
- Ultimately some of the health plans stopped contracting with FQHCs- Legacy FQHC was one of them
- Legacy FQHC sued the state of Texas because their claims to the plan after the contract was cut were not paid, and won
- The State of Texas appealed and won at the District Court level.
- Legacy appealed but the Supreme Court denied the hearing saying they had no standing as they had no contract with the managed care plan they were alleging of doing them wrong.
 - So the Fifth Circuit Court Decision stands.
- The court ruled that FQHCs are not entitled PPS for out of network other than emergency services.
- States can have plans pay PPS so long as its through an APM
- The Fifth Circuit did not deal with the issue of whether the State would be obligated to pay the FQHC the difference if the MCO did not receive full PPS payment from the MCO.

Of important note, there are many states that have plans that pay the full PPS and the arrangement works well. Texas has also improved their process and plans file monthly claims to the state to get made whole, and there is a new form FQHCs use to receive PPS from the plans.

Concerns with the arrangement include:

- Plans denying payments and then not being able to bill the state
- Plans having more resources at their disposal with the full amount of PPS and wanting to use the resources differently than paying per visit to FQHCs (only would be allowed if the system were not set up appropriately)
- Plans being able to deny contracts to FQHCs or meeting the obligation and only contracting with 1 FQHC

Next Steps

CPCA will be monitoring the state's interest in this idea and pay close to attention to the national landscape.

Discussion

- Does this court case and DHCS' proposal raise concerns?
- Would members prefer to be paid by their health plans, and thus CPCA should proactively work to secure an APM allowing this?

Resources

- [Memorandum Legacy Post-US S Ct Decision \(Nov. 2018\)](#)



Date: January 14, 2019
 To: 330 Committee
 From: Ginger Smith, Director of Health Center Operations; Andie Patterson, Director of Government Affairs
 Re: Audits and Investigations Challenges: Status Update

MEMORANDUM

A&I Challenges

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

This work commenced post the CPCA 2017 CFO conference, took the form of a membership-wide survey and workgroup to better grasp the problems as well as identify potential solutions, and ultimately has led to several face to face meetings with DHCS policy and A&I leadership. We have been working systematically through the areas of identified top concern and although the conversations have been helpful, the products and resolve are slower to come by as a main challenge remains “getting everyone on the same page”.

Escalation Process

One strategy that has resulted from meetings with DHCS includes the Escalation Process. This was shared earlier in 2018 with all CFOs and CPCA cannot stress enough the importance of health centers usage of this protocol. The process, found under Resources, provides a health center with a higher level of contacts within A&I so that issues can be surfaced to the state and clarification can be offered before waiting until the appeals process. To date, few CFOs have used the protocol and so A&I leadership still remains unclear of the problems. CPCA staff requests that all health centers use this protocol whenever they encounter a challenge so that we (CPCA and A&I leadership) can identify trends and resolve them at the state level, and we can identify what training auditors need and where confusion exists in the local offices.

Progress with Top Areas of Concern

| Area | Progress |
|-------------------|---|
| Incident to costs | Health centers are encouraged to use the Escalation Process to mitigate the challenges and DHCS will use the escalated topics as training opportunities for their auditors. CPCA and DHCS continue to have a conversation on different pharmacy arrangements and the required cost allocations associated with each. |

| | |
|--|---|
| Medicare imputation of revenue | DHCS is in the process of revising the DHCS Reconciliation form and instructions. They agreed to add language on the revised instructions that supporting documentation of the payments reported can be submitted with the reconciliation form. The data is still subject to audit by DHCS but should give DHCS better data instead of imputing the payment amount. |
| Reasonableness criteria for cost allowability | This one has been harder to resolve; Solutions are for CPCA to circulate a listing of best practices for learning and health centers using the Escalation Process when necessary. |
| Three Comparable Clinic FAQ | CPCA believes the FAQ needs to be revised. We are making the suggested revisions for DHCS review. |
| Outline of situations where health center must submit a mandatory change of scope of service request (pharmacy contracting, deletion of intermittent site, etc.) | Still pending for discussion |
| Relationship of what costs are allowable on a rate setting/change in scope of service to what gets reported on the reconciliation | Still pending for discussion |
| Trying to tie trail balance or audited financials (accrual) to reconciliations (cash basis) | CPCA and DHCS agreed that this issue should be included in a future FAQ. |
| Provider compensation caps | See below |
| Calculation of late payments on reconciliations | Still pending for discussion |

Provider Compensation Caps

Recently, as part of the escalation process, CPCA has seen the issue of DHCS applying provider compensation caps escalated within A&I by at least three health centers. It appears DHCS is capping a provider's compensation at \$197,000 inclusive of fringe benefits which according to the health centers experiencing the issue is unrealistic especially in areas of provider shortages and high cost of living. However, one of the health centers impacted by DHCS applying a compensation cap was successful with getting DHCS to drop the adjustment once they provided documentation to support the provider compensation reported.

DHCS is citing 42 CFR Section 415.70(b)(2) which states in part, "CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty using the best available data." It is our understanding from members that many are using multiple data sources such as the CPCA Salary Survey, MGMA, local market evaluations, and recruiting agencies for determining the compensation ranges of their providers. The application of provider compensation caps feels very similar to productivity standards where CMS supported DHCS application as a test of reasonableness but recommended DHCS work with stakeholders on the policy clarifications.

CPCA has requested a meeting with DHCS to discuss this issue further and asked that A&I refrain from applying provider compensation caps until we agree on an approach. In addition, CPCA has asked Kathryn Doi, Hanson Bridgett LLP, to analyze if DHCS has any legal basis for applying the caps. We are still waiting on a response from DHCS.

Best Practices

One lesson learned from the conversations with CFOs and A&I is that some CFOs do not encounter the same challenges as other CFOs. In an effort to better understand what has been successful for some CFOs, CPCA is requesting health centers to share their best practices on a few specific areas. Once we capture the best practices, CPCA will compile, review, and circulate to the membership.

Next Steps

Our meetings with DHCS will continue into 2019 with the workgroup working to identify solutions to the array of outstanding issues, albeit slowly. The solutions are taking many different forms ranging from small tweaks to a process, new clarifying language on DHCS forms and instructions, A&I conducting monthly training with their auditors, and working towards DHCS and CPCA developing FAQs together.

In addition, CPCA will continue pushing for a separate meeting with DHCS to address the challenges around DHCS applying provider compensation caps.

Updates on progress are provided regularly to the CFO Peer Network.

Resources

[Escalation Process](#)

Memorandum

ATTORNEY-CLIENT PRIVILEGE AND ATTORNEY WORK PRODUCT

TO: Andie Patterson & Ginger Smith

FROM: Kathryn E. Doi

DATE: January 3, 2019 [DRAFT 12/21/18]

RE: *American Indian Health & Services v. Kent* – Retrospective Claims Litigation Update

I. INTRODUCTION

This memorandum provides an overview of the status of outstanding issues arising out of the *American Indian Health & Services v. Kent* matter following the June 2018 Court of Appeal decision upholding the Superior Court's ruling that the Department of Health Care Services wrongfully refused to reimburse FQHCs and RHCs for the adult dental, podiatry, and chiropractic services provided to eligible Medi-Cal beneficiaries during the period July 1, 2009 to September 26, 2013.

Following the Court of Appeal's decision, the Department agreed to meet with us to discuss the process for the submission of claims. The Department issued instructions for the Petitioners who brought the lawsuit to submit claims for processing and payment, but told us that it would not accept, process, or pay claims of FQHCs or RHCs that were not parties to the lawsuit.

This memorandum reports on the status of the claims submission by the Petitioners, as well as a motion brought by the Petitioners asking the Superior Court to require the Department to process and pay the claims of any FQHCs or RHCs pursuant to the writ granted by the Court, and a motion brought by Petitioners requesting the payment of their attorney's fees.

II. STATUS OF CLAIMS SUBMISSION

The Superior Court's order directed the Department to follow its regulations to process and pay the health centers' claims. The Department interpreted its regulations to allow for the filing of claims within a 60-day window, which opened on October 18, 2018, the date that the California Supreme Court issued a remittitur declining to consider the merits of the case on its own motion. In subsequent communications, the Department's fiscal intermediary Conduent indicated it would not begin to process and pay any claims until the 60-day window closed. The 60-day window closed on Monday, December 17. To date, we are not aware that any claims have been processed.

Memorandum To:

Andie Patterson & Ginger Smith

January 3, 2019 [DRAFT 12/21/18]

Page 2

III. MOTION TO CONFIRM RULING APPLIES TO ALL FQHCS/RHCS

On November 13, 2018, Petitioners filed a motion with the Superior Court seeking to enforce compliance with the writ. Specifically, Petitioners argued that the Court's writ ordered the Department "to process and pay for adult dental, chiropractor, and podiatric services provided by Federally-qualified health centers and rural health clinics between July 1, 2009 and September 26, 2013, following the Department of Health Care Services' existing regulations regarding late claims" and that the Department's refusal to process and pay for services provided by FQHCs and RHCs that were not parties to the action was in violation of the Court's order.

The Department opposed the motion. The judge's tentative ruling, issued on December 19, would have denied the motion on the grounds that since the writ language did not address non-Petitioner health centers' claims one way or another, the non-Petitioner health centers' claims were not included. The tentative ruling would have required the non-Petitioner health centers to attempt to submit claims, have them rejected, and then file their own lawsuit.

We requested oral argument to raise our concerns with the tentative ruling and a hearing was held on December 20. Following oral argument, the judge took the matter under submission, so the tentative ruling did not become the final ruling at that time and the matter is still pending. The judge has 90 days to issue a ruling, but we anticipate the judge will issue his ruling in January 2019.

IV. MOTION FOR ATTORNEYS' FEES

On November 26, 2018, Petitioners filed a motion with the Superior Court seeking their attorneys' fees relating to the litigation before the Superior Court, Court of Appeal, and California Supreme Court¹ in this matter. The motion seeks \$378,328.00 in attorneys' fees dating back to November 11, 2014, when this state court action was filed. The hearing on this motion is set for February 4, 2019.

KED:KQD

¹ The Department had made a request to the California Supreme Court to depublish the Court of Appeal decision. We opposed this request, which the Supreme Court denied.