Recent Changes at the Federal Level

Community Clinic Association of Los Angeles County

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Agenda

- Recent activity in 330 funding/regulations
- Recent activity in CHIP funding
- What does a government shutdown mean to CHCs?
- Medicaid waiver activity
- Compliance Manual and OSV Protocol

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Recent Activity in 330 Funding

330 Funding Basics

- The health center program is authorized under Section 330 of the Public Health Service Act
- Authorized means the program can be given funding, but it does not permit the government to cut a check or enter a contract. It is designed to set parameters for the government
- The 330 program is then funded through two streams:
  - Health center fund (mandatory)
  - Annual appropriation (discretionary)

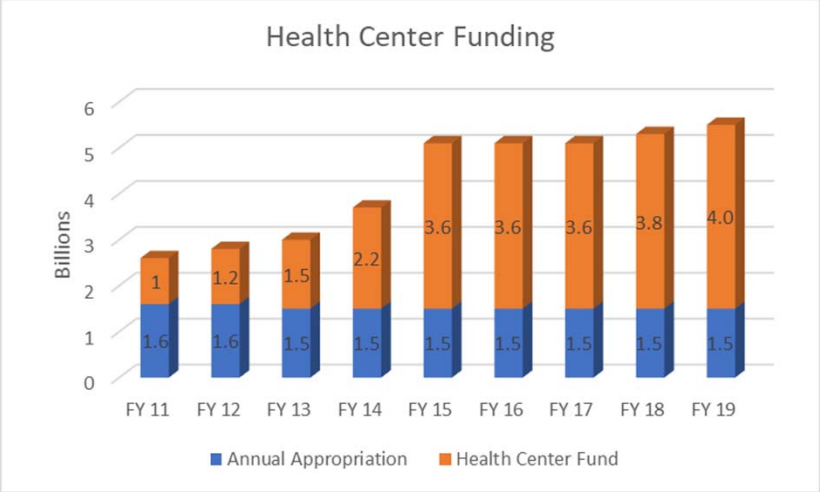
330 Funding Basics

- Once a health center has an NOA, they are entitled to the funds, which cannot be taken away
- In event of 330 funding issues, impact on health center may be dependent on grant year

330 Funding

Health Center Fund	Annual Appropriation
Mandatory	Discretionary
Required spending	Annual, up to Congress to determine amount
Special 5 year trust fund created in PPACA in 2010 to increase health center capacity	Prior to PPACA, only CHC funding
Extended by Congress in 2015 for two years via MACRA	Cut several times, backfilled with mandatory funds
$3.6 billion in FFY 2017	$1.5 billion in FFY 2017
9/30/19 - $3.6 billion each for FFY 2018 & 2019 + $600 million for health center operations + $60 million for CHCs impacted by natural disasters (not 330 funds)	
CHIME Act seeks 5 year funding	

330 Funding Timeline



Partial List of Other Changes to 330

- Requires applicants to demonstrate that thy "consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site"
- Permits HRSA to give priority on Expanded Services grants to applications that address emerging public health and behavioral health issues, including substance use disorders
- Requires health centers to directly employ CEO
- Requires health center to have written p&ps to ensure that all Federal funds are being used in a manner that complies with federal rules

Partial List of Other Changes to 330

- Reduces project period from two to one year for new awardees who do not meet certain 330 requirements
- Limit training and TA to 3% of total 330 funding
- Limit waiver or audit requirements to one year
- Report additional data to Congress, including rural/urban funding breakdown
- Allows HRSA to consider a health center's sustainability plans when making supplemental quality awards
- Allows HRSA to give grants for innovative programs to serve homeless veterans
- $25 million for NIH Precision Medicine Initiative

CHIP Funding

- On January 22, 2018 funding was extended from FFY 2018 to FFY 2023
- On February 9, 2018 funding was extended through FFY 2027
- Covers up to 300% of FPL
- In some states, rolled into Medicaid program, so exact count of CHIP eligible is impossible

Government Shutdown

Shutdown Basics

- A shutdown occurs when the federal government is not funded, either through a budget or continuing resolution
- Every shutdown is different. The federal government is not shut down, only partially shut down. The Executive Branch has some discretion (national parks)
- Federal government activities are divided into two categories:
  - Essential (not impacted by shutdown)
  - Non-essential (potentially impacted by shutdown)

How Does a Shutdown Impact CHC Grants?

- For health centers with an NOA with no conditions, and approved funds, all dollars available for drawdown
- Certain HRSA and other federal employees could be furloughed (not paid, and not permitted to come to work)
- IT support for eHB not furloughed
- Health centers with drawdown restrictions may take longer to get approval

How Does a Shutdown Impact CHC Billing?

- Funds for payment of Medicare claims are mandatory, and not impacted by a shutdown
- MAC contract paid with appropriations, and may be impacted by shutdown. Administration may try to minimize impact by fully funding MACs (as they did in last shutdown)
- Funds for payment of Medicaid claims are mandatory and not impacted by a shutdown
- Administrative portion of Medicaid comes from State budget
- Note that a delay in a state budget could impact Medicaid payments
- Potential for delay in VA payments

Medicaid Waivers

- As of 2/8/18, there were 24 pending waivers, in 12 states to modify Medicaid to include*:
  - Work requirements (8 states)
  - Eligibility and enrollment restrictions (9 states)
  - Benefits restrictions, copays, healthy behaviors (7 states)
- Partially driven by the growth of the Medicaid enrollees (in both expansion and non-expansion states). Medicaid enrollment nationwide is at an all-time high, and is a large part of the state budget

Source: Kaiser Family Foundation

Medicaid Waiver Sample – Indiana HIP Copays

FPL	Monthly Income, Single Individual	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	Less than $221.10	$1.00	$1.00
23-50%	$221.11 to $502.50	$5.00	$2.50
51-75%	$502.51 to $753.75	$10.00	$5.00
76-100%	$753.76 to $1,005.00	$15.00	$7.50
101-138%	$1,005.01 to $1,403.48	$20.00	$10.00

Medicaid Waiver Sample – Indiana HIP Tobacco Surcharge

FPL	Monthly Income, Single Individual	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	Less than $221.10	$1.00	$1.00
23-50%	$221.11 to $502.50	$5.00	$2.50
51-75%	$502.51 to $753.75	$10.00	$5.00
76-100%	$753.76 to $1,005.00	$15.00	$7.50
101-138%	$1,005.01 to $1,403.48	$20.00	$10.00

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Medicaid Waiver Sample – Wisconsin Badger Care Reform 1115 Waiver for Childless Adults

1. Impose premium (can be paid by a third party)
2. Lower premiums for those engaged in health behaviors
3. Health risk assessment (can the health center perform it?) to get into Medicaid
4. Eligibility limit – 48 months on, 6 months off (clock stops if working or in school)
5. Drug screening (does SBIRT count?) & testing
6. Residential treatment coverage (not previously covered, need waiver for Feds to pay for it)

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Finance/Operational Changes To OSV Protocol

OSV Protocol – Sliding Fee

a) Applicability to all in-scope services
b) Sliding fee discount program policies
c) Sliding fee for Column 1 services
d) Multiple sliding fee discount schedules
e) Incorporation of current Federal Poverty Guidelines
f) Procedures for assessing income and family size
g) Assessing and documenting income and family

OSV Protocol – Sliding Fee

h) Sliding fee for Column II services
i) Sliding fee for Column III services – note that sliding fee patients must "receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule"
j) Applicability to patients with third party coverage
k) Evaluation of sliding fee discount program – "the setting of a flat nominal charge(s) would be nominal from the perspective of the patient" (Compliance Manual – Page 38)

Compliance Manual – Sliding Fee

"Build in cost of living considerations when calculating income" (Page 41)

"The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process)"

OSV Protocol – Finance

a) Financial management & internal controls
b) Documenting use of federal funds
c) Drawdown, disbursement & expenditure procedures
d) Submitting audits and responding to findings
e) Documenting use of non-grant funds

OSV Protocol – Specific Questions

Site Visit Team Methodology

Have CFO or other financial staff walk through the last quarter's use of Federal Health Center Program award funds starting from drawdown to obligation to payment, etc…
Review sample of source documentation to support expenditures made under the Federal Health Center Program award for the last quarter.

Site Visit Findings

Based on the sample, does the health center have a financial management system that is able to account for the Health Center Program Federal award and related expenditures (e.g., in chart of accounts) made under the award? Specifically, do the health center's financial records contain relevant information and related source documentation?

OSV Protocol – Specific Questions

Does the health center have written procedures for utilizing the Federal Payment Management System that, at a minimum, require that the drawdown of funds is completed in a manner that minimizes the time elapsed between the transfer of the Federal award funds from HRSA and the disbursement of these funds?

Do the health center's written procedures contain provisions for ensuring that all expenditures of Federal award funds are allowable in accordance with:

- The terms and conditions of the Federal award, including those that limit the use of Federal award funds?
- The Federal Cost Principles in 45 CFR Part 75 Subpart E?

OSV Protocol – Specific Questions

In the last complete fiscal year, did the health center generate revenue from health center activities that was then utilized for activities outside the scope of the project?
If Yes: Was the health center able to document that these funds were used:

- To support activities that benefit the current patient population?
- For purposes that are not specifically prohibited by the Health Center Program?

OSV Protocol – Billing & Collection

a) Fee schedule for in-scope services
b) Basis for fee schedule
c) Participation in insurance programs
d) Systems & procedures
e) Procedures for additional billing or payment options
f) Timely and accurate third party billing
g) Accurate patient billing (reasonable efforts)
h) Policies or procedures for waiving or reducing fees
i) Billing for supplies or equipment
j) Refusal to pay policy

Bonus Material!
Comments on Proposed SPA

Thoughts on SPA

- Retroactive to 1/1/18
- Codifies intermittent clinic from 20 hours to 30 hours
- Productivity standards – 3,200 for physician, 2,600 for midlevel. Generous definition of admin FTE
- Not a great understanding of HRSA – NOA, Forms 5A, 5B & 5C
- Troubling changes to the PPS Change In Scope:
  - Rate has to wait a year (need a full fiscal year of the service)
  - Seem to be required CIS (for example, allowing a community agency to use your space)
  - Envisions 2 annual cost reports
  - Extends current cost narrowness creep, i.e. thresholds for increase in certain cost, even though a whole-site cost report is required

Thoughts on SPA

- Many items on “four walls”
  - Uses terms like “home”, “residence” and “temporary and intermittent” in an unclear context
  - Envisions services outsides of four walls when these services cannot be delivered in health center
  - Mixes mental health concepts like monthly treatment plans with all services, including primary care
  - Some insight on what patients served by FQHC providers can be paid at PPS rate
  - Seems to allow for payment for assigned MCO payments, whether or not the FQHC has seen them
  - Uses term “continuing treatment of an illness or injury”
  - Changes to mobile van rate setting

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