Department of Health Care Service (DHCS) Tribal and Designees of Indian Health Programs Meeting
May 28, 2020 - 11 a.m. to 1 p.m.
Summary & Questions

Meeting Summary:

The DHCS hosted a Tribal and Designees of Indian Health Programs meeting on May 28, 2020 from 11:00 a.m. to 1:00 p.m. via WebEx. The meeting materials have been distributed can be found posted on the DHCS website.

Attendees included representatives from the following Tribes, Tribal Health Programs (THPs), and Urban Indian Health Organizations:

- American Indian Health and Services
- Central Valley Indian Health
- Chapa-De Indian Health
- Colusa Indian Health Clinic
- Consolidated Tribal Health Project
- Feather River Tribal Health
- Greenville Rancheria
- Indian Health Center of Santa Clara Valley
- Indian Health Council
- K'ima:w Medical Center
- Karuk Tribe
- Lassen Indian Health Center
- Lake County Tribal Health
- MACT Health Board
- Northern Valley Indian Health
- Phoenix Area Indian Health Services
- Phoenix Indian Medical Center
- Pit River Health Services
- Pit River Health Board
- Quartz Valley Indian Reservation/Anav Tribal Health Clinic
- Riverside-San Bernardino County Indian Health Program
- Rolling Hills Clinic
- Sacramento Native American Health Center, Inc.
- Santa Ynez Tribal Health Clinic
- Scotts Valley Band of Pomo Indians
- Shingle Springs Health and Wellness
- Sonoma County Indian Health Project
- Southern Indian Health Council
- Strong Family Health Center
- Toiyabe Indian Health Project
- Tule River Indian Health Center
- United Indian Health Services
- United Indian Health Services Health Board
- Washoe Tribal Health Center
- Washoe Tribe of Nevada and California

Others:

- California Rural Indian Health Board (CRIHB)
- California Consortium for Urban Indian Health (CCUIH)
- California Health and Human Services (CHHS)
- Center for Medicare and Medicaid Services (CMS)
- Health Net
- Department of Health Care Services (DHCS)
- Indian Health Services (IHS)

Tribal and Designees of Indian Health Programs Meeting
Summary & Questions

Items Reviewed:

- Introduction to Dr. Bradley Gilbert, DHCS' New Director (Slide 3)
- May Revision – State Budget (Slide 4)
- Brief Status Updates on:
    - CalAIM (Slide 5)
    - Medi-Cal RX (Slides 6-8)
    - COVID-19 Flexibilities (Slides 9-26)
    - Development of Tribal FQHC Provider Type (Slide 27)

For details on the items discussed during the meeting please refer to the presentation slides indicated above and other meeting materials available on the DHCS website.

Questions and Responses

Budget

1. **Question:** Are Tribal and urban programs going to be considered Federally Qualified Health Centers (FQHCs) for purposes of the optional benefit reductions?

   DHCS Response: For providers currently enrolled in the program as FQHCs, they will still have the Optional Benefit Exclusion (OBE) that were eliminated. As what happened with elimination in 2008-09, Tribal IHS/MOA clinics, did not have that same ability to provide OBEs and DHCS subsequently created the tribal uncompensated care pool through the bridge to reform waiver. That will be something for DHCSs to consider when looking at the 1115 waiver and the work DHCS is looking to do with the Center for Medicaid and Medical Services (CMS) for an extension.

2. **Question:** Will IHS/MOAs continue the ability to bill for pharmacy separately from the All Inclusive Rate (AIR)?

   DHCS Response: Yes, provided the tribal health program has a separately enrolled Medi-Cal retail pharmacy.

3. **Question:** When will the Optional Benefit changes go into effect?

   DHCS Response: No sooner than 7/1/2020, but there is a process for approval by CMS. DHCS will continue with the process of obtaining CMS approval on State Plan Amendments (SPAs) and negotiations continue for the budget with legislature. DHCS will keep you informed in the process.

4. **Question:** Both Urban and Tribal Health Clinic Programs are statutorily FQHCs, can you confirm the ITU will treated as such with regard to the optional benefit reductions.

   DHCS Response: To the extent clinics are enrolled in Medi-Cal as FQHCs, FQHC/RHC services are mandatory benefits under the Medicaid program. To the extent that the benefits are limited, there are certain requirements in terms of services that FQHCs/RHCs have to provide, such as podiatry that would continue to be made available to FHCs/RHCs, Those clinics will continue to receive those reimbursements. During the first benefit elimination that policy was not fully executed and there was subsequent litigation. That litigation did affirm the obligation of the state to help ensure those services are provided. So, for FQHC/RHC providers who participate in our program, for purposes of the OBE, they would still have that ability to provide those services, to the extent they are services covered by Medi-Cal.

5. **Question:** What about clinics enrolled as MOAs, then they would not receive reimbursement?

   DHCS Response: Correct, if they are not enrolled in Medi-Cal as a FQHC and they are enrolled as an IHS/MOA clinic then they would not receive reimbursement for the proposed eliminated OBEs. Similarly to what DHCS had to do with the Medi-Cal 2020 waiver. DHCS had created the Bridge to Reform (name previous to Medi-Cal 2020 waiver) which includes the uncompensated care pool. So, it would be through this that the reductions are being proposed. As DHCS is looking to continue that waiver this would be one of the component parts to include for continuation. Those specifics have to be worked out with CMS. Until such time that the waiver is no longer in place and depending on the outcome of the budget discussions that are in process is complete and the legislature accepts the budget eliminations then, as they are today, those services will be available to through that uncompensated care pool for the IHS/MOA clinics.

6. **Question:** How are benefit reductions/cuts being prioritized from being rolled back from the current budget proposal if/when the state receives federal funding?

   DHCS Response: There is what is called trigger language within the proposals and the proposed trailer bill language that the cuts would only come effective to the extent that they are approved by the federal government. It then it doesn't have an impact on the state's ability to receive the enhanced federal funding that has been made available as a result of the public health emergency.

7. **Question**: What date are the Optional Benefits being eliminated for the IHS/MOA clinics and will CRIHB or the state manage the uncompensated care pool?

DHCS Response: The proposal is that they would be eliminated no sooner than July 1, 2020, but this requires legislative action as well as federal review and approval. In the interim, DHCS still has the tribal uncompensated care pool. Today that pool remains operational and the budget did not propose any changes to it. As an example, chiropractic services were one of the original benefits that were eliminated with the 08-09 reductions. If was never restored, but IHS/MOA clinics, through the uncompensated care pool using CRIHB as the intermediary, still have the ability to bill for chiropractic services. DHCS will have to look to the future in terms of financing but the capacity is there today to provide the services.

8. **Question: Can** clinics elect to sign up as a Tribal FQHC (TFQHC) between now and July to continue to bill for Optional Benefits?

   DHCS Response: The TFQHC would be operational January 1, 2021. In the interim, DHCS does not have the ability to have the TFQHC provider type in place. Clinics always have the option of enrolling in the Medi-Cal program as a FQHC. In doing that it will have an impact on the clinics reimbursement rate in terms of it being the Prospective Payment Services (PPS) rate in place of the All Inclusive Rate (AIR). For the TFQHC, the state is looking to use/leverage in accordance with CMS guidance the ability to maintain the AIR rate as a TFQHC provider.

9. **Question:** Will the state have a process in place to allow cross border tribes to claim for uncompensated care? As you are aware, the tribal LGA has refused the Washoe tribe a contract for CRIHB options. The state intervened and concluded that the Washoe tribe would be able to have a contract with the tribal LGA however CRIHB stated that they preferred to not contract with us. Will the state implement a process specifically for cross border tribes located in Nevada and Arizona to bill for uncompensated care?

   DHCS Response: DHCS requests additional information on this matter to ensure understanding of the concerns and questions raised previously. Please forward information to Andrea Zubiate via email at andrea.zubiate@dhcs.ca.gov.

10. **Question**: Please elaborate on the previous question around the trigger language and how benefits will be prioritized when the state receives federal funding?

    DHCS Response: The way the trigger language is written, there's not a different priority set to the benefits so the benefits as a whole are being identified for elimination. The state is not prioritizing on any specific benefit verses another, it's the collect set that would be subject to the trigger language.

11. **Question:** What is the status of TMAA reimbursement for the period reimbursement that was not received?

    DHCS Response: The final batch of invoices were sent to DHCS' accounting office to process on April 28, 2020.

12. **Question:** With the loss of the optional benefits how much time will it take to continue the CRIHB uncompensated care program?

    DHCS Response: DHCS is looking to extend the 1115 Waiver for one year and are not proposing any major changes to the construct of that waiver. DHCS will have to go through CMS for approvals.

13. **Question:** Does DHCS have a plan for uncompensated care that expire on 1/1/2021?

    DHCS Response: The uncompensated care pool is under the 1115 waiver and DHCS is looking to extend that waiver for one year beyond the expiration date of 12/31/2020.

14. **Question:** Do the optional benefits rolled into the TFQHCs reflect what other state's TFQHC are getting? What about acupuncture, physical therapy, etc., they are not listed.

    DHCS Response: With the OBEs, if you are a TFQHC you can still provide those services that you are otherwise providing in your clinic and still be reimbursed at your PPS. For the IHS/MOA clinics, you're only able to bill for those services that are currently covered under our state plan. IHS/MOA clinics are able to get benefits through the uncompensated care pool and the state is looking to the extent the waiver this is part of. For FQHCs, to the extent an optional benefit you cover is eliminated, DHCS has an obligation under federal Medicaid law and cannot cut these services. FQHCs define doctor of podiatry, optometry, chiropractic, etc., as physician services. If the service performed is a service included in the FQHC PPS rate, the service is covered.

Medi-Cal Rx

15. **Question:** Has there been considerations of the impact to tribal pharmacies and regards to a process to assist us in expanding the number of prescriptions in one Treatment Authorization Request (TAR) to better accommodate us at the local level. The impact of the state transitioning to Medi-Cal Rx for brand name medications, many of our clinics operate off the generic formulary which includes mostly generic medications.

DHCS Response: That question has come up in terms of the way Fee-For-Service (FFS) pharmacists are using contract vs non-contract drugs. In terms of TAR requirements, they're asking for the number of prescriptions per TAR. Please contact the Medi-Cal Rx inbox at RxCarveOut@dhcs.ca.gov .

DHCS will take your question back to make sure it is fully understood in terms of what your ask is regarding TAR requests.

Because of the way DHCS does rebates, state general funds savings is not generated. The state has use of brand names and all drugs on the Federal Drug Administration (FDA) approved list of drugs are covered. Drugs not on the contract drug list are subject to prior authorization requirements. With the transition to Medi-Cal Rx from the managed care plans DHCS is not requiring prior authorization (PA) for existing prescriptions that did not require a PA prior to Medi-Cal Rx. PAs will also not be in place for the first 120 days, with a few exceptions, and there will be no impact to dispensing or payments. Part of this plan will be for the state to message back to pharmacy providers the need for future forward prior authorizations that require in accordance with the state's policies today.

DHCS has not identified a particular provider type as saying that there will be different treatment for prior authorization recognizing what the state's policies are. DHCS is looking to make sure that beneficiaries have access to the covered benefit and making sure that the state is working closely with partners in the pharmacy space on this and understanding what the polices are when moving on to Medi-Rx.

DHCS is recognizing that this is a big shift moving from managed care to the FFS delivery system. Those policies are outlined in the transition plan developed which is available on the DHCS website.

16. **Question:** I'm concerned about the administrative process. Will there be impact on the tribal workflow?

DHCS Response: DHCS recognizes there has been differences between the managed care plans at large and the state in what is covered. There has been some drugs on the contract drug list that are generic drugs require no prior authorization. DHCS looks at cost benefit to the state when looking at drugs to cover because it's cheaper at times when looking at the difference between the rebates that able to be collected vs. not and the cost of drug. There are times that even with the rebate it's difficult for to cover the generic drug and then those generic drugs are added to the contract drugs. DHCS is looking at the formularies that have been used historically by the managed care plans and what DHCS has in Medi-Cal FFS to help inform future policy discussions.

17. **Question:** Is there an update on the 340B Program?

    DHCS Response: With the budget, given the current fiscal challenges, the proposal for a 340 B supplemental payment pool has been rescinded. DHCS is open to have discussion with legislators in term so funding for the clinics that are impacted by the move of the pharmacy benefit and it being carved out of managed care and moving to FFS.

Public Health Emergency

18. **Question:** Is the expiration date (Public Health Emergency (PHE), set by the state or federal government?

    DHCS Response: These dates are set by the Federal government. The start period of the various policies are set by the federal government. The state does not yet have an expiration date. The policies are all premised on when PHE will no longer exist. When declared, the expiration date should be the last day of the month the PHE is determined to end.

19. **Question:** There is a lot of uncertainty about how COVID-19 will play out and unfortunately COVID-19 has been politicized. CCUIH is concerned the PHE may be relieved under political consideration and not public health considerations.

    DHCS Response: Unfortunately, that's not something the state has control over but does hear and understand your concerns. With these flexibilities there are certain things that DHCS can do at the state level, in terms of payment options and covered services came about due to national public health decisions. So, to the extent that the PHE stops, there are many funding opportunities due to PHE, funding to tribes, funds to cover uninsured populations for COVID-19 related treatment, etc., when declaration is made that PHE has ended, what happens to the funds already appropriated and not used. Recognizing that the state at that point may still be under PHE and still have a need for these services. It's a problem that has to be address addressed at both a state and a federal level.

Tribal FQHC

20. **Question:** The proposed TFQHC SPA is not acceptable, DHCS did not take into considerations feedback received from us regarding lab, pharmacy, imaging or X-ray? Tribal Technical Advisory Group has requested a one year extension for the TFQHC from CMS. We request a meeting to meet specifically on TFQHC.

    DHCS Response: Thank you, DHCS understands your concerns and is happy to/are planning to meet on TFQHC. In terms of costs/visits, DHCS believes this does move the needle in meeting needs and making accomplishments in the current budget state. In recognizing labs and X-rays, one thing that is helpful to

hear is about face-to-face visits with providers and people who are coming in for just a lab or X-ray. DHCS can only go by the current data that is available and look forward to ongoing discussion regarding the TFQHC.

CMS has indicated that there is no change in the required implementation date.

21. **Question:** Will certified Public Health Nurses (CPHN) be billable for services outside the clinic?

    DHCS Response: Yes, as a TFQHC, services for CPHNs are billable inside or outside of the clinic.

22. **Question:** Will the TFQHC allow two medical visits in one day or will there still be the requirement for a combination?

    DHCS Response: Yes, the TFQHC will allow two medical visits in one day. The allowed visits can be in any combination in one day.

23. **Question:** Can the next meeting focus entirely on the TFQHC SPA?

    DHCS Response: Yes, DHCS will work to get a meeting set up to specifically talk about this. Please give your feedback on today's webinar to the Primary, Rural, and Indian Health division representatives as it's helpful to know if you feel webinars will work in place of face-to-face meetings, especially now due to the PHE.

Next Steps:

- DHCS will conduct meetings with Tribal and IHP representatives to continue discussions on the Tribal FQHC provider type. Upcoming tentative meeting dates are July 2020 and October 2020.