**Summary Report and Next Steps**

**AUCH PPS Change in Scope (CiS) Sub-Group**

June 26, 2020

**Goals for the Day**

1. Review Impact Analyses
2. Review Structure Function of CiS per Impact Analysis
   1. Triggering Events
   2. Expenses Carved In/Out
   3. Timing
3. Review Concerns and Other Considerations
4. Identify Next Steps and Roles

**In Attendance**

Craig Hostetler, Curtis Degenfelder, Angela Chatman, Debbie Turner, Todd Bailey, Lori Wright, Jackie Choto, Darci Elmer

AUCH staff: Beth Fiorello, Natalie Stubbs, Zach Miller, Courtney Pariera Dinkins, Ambrish Sharma, Jenifer Lloyd, Kaitlynn Drollinger, Alan Pruhs

**Structure Function of CiS**

Curt Degenfelder presented:

* Reviewed PPS impact data and estimated impacts of PPS change in scope on Medicaid revenue for all participants. There was a brief conversation about the state’s primary care grant program and how it was very limited and not focused on helping FQHCs over any other type of provider. A CiS would positively impact all but Midtown.
  + Specific themes emerged:
    - Low Medicaid penetration at some HCs limits the impact of a CiS;
    - It is uncertain exactly how the CiS process would look at a HC with an APM – would those HCs have the option to stay the same?;
    - Consensus that undergoing a CiS must be optional (as at least one HC would be harmed); and
    - It would be very helpful to have good data from all the HCs so this could be reviewed for all.
  + Curt asked how Utah Medicaid’s audit process worked – Todd noted that there had been no auditors on site for over a decade and the audits are conducted through existing records only.
  + Another point to be clear on – a CiS is not the same as rebasing; Utah Medicaid’s director has mentioned being familiar with rebasing but not CiS.
  + Did AUCH decide how to address the tribal organizations? It’s a different conversation with AIR rates and will be addressed at a future time.
  + Curt asked how the APM process works. Todd replied that Medicaid pays HCs what they bill but at the end of the APM process, the APM rate is compared to PPS rate to make sure it’s comparable.
  + Curt then reviewed changes noted since HCs’ last PPS rate was set. Alan noted that 10/13 HCs are providing MAT. Curt requested that behavioral health integrated into primary care be added as a triggering event separate from mental health. Mental health section should also include medication management and/or psychiatrists and/or psychiatric MH NPs as separate triggering events.
  + Design of CiS:
    - Initial CiS’s would be significant for most since it has been a long time since rates were reset.
    - For the first CiS, it will be based on a cost report for most recent fiscal year but it will be looking at triggering events since last rate was set.
    - After initial rate change, CiS only happen upon the occurrence of a triggering event.
    - Definition of enabling services is needed.
    - Add to proposal: A CiS triggering event need not be tied to getting new billable visits.
    - Add to proposal: HRSA CiS requests for HCs should be considered separate from triggering events for a CiS with Medicaid.
    - Negative Triggering Events
      * There remains philosophical discussion about whether HCs should be able to use a CiS as a positive factor but not as a negative factor or to just keep the issues separate entirely.
      * Should removing a service or providing a less intense service be seen as a ‘negative’ triggering event? If you eliminate a service and your costs drop over 2.5%, would you then have to file a negative CiS application? Should there be a cap on how much a CiS could drop a HC’s rate?
    - Pharmacy: Agreement that adding a pharmacy does add additional administrative costs but may not be a triggering event. Offering clinical pharmacy services should be considered as a triggering event and this should be a separate line.
    - Better definitions of enabling services and SDOH are needed.
    - Does Chronic Pain Management mean new providers or new service? At Wayne CHC, there is a contract for services.
    - Telehealth
      * What about costs of telehealth?
      * Assumption is that it’s cheaper but not turning out to be so. Telehealth needs to be better defined.
    - Does service have to be Medicaid-covered to be included as triggering event?
      * Consensus was that it was not necessarily required; the service may be ‘incident to.’
    - Alternate therapies need to be defined.
    - New Site
      * Curt noted that a new site is not a change in scope for CiS purposes.
      * HCs may want to consider a triggering event for adding an additional site
    - Additional Physicians
      * The general consensus was that adding additional physicians could be considered a CiS event but other than that, no other changes would qualify.
    - Regulatory Compliance
      * What about regulatory compliance costs?
      * Definitions need to specify both federal and state.
    - Special Populations
      * Suggestion was made to expand special populations to include refugees or other special groups, not just homeless.
    - Teaching Health Centers
      * Suggestion was made to expand teaching health centers to education broadly – Alan mentioned involvement of HCs in other education efforts like NEPQR.
    - Discussion from June 5th:
      * Optional vs. Required. Decided on ‘Optional’
      * Total Cost Report (total allowable costs divided by total visits) vs. Incremental Cost Report. Decided on Total Cost Report
      * Develop a reasonable plan representing all costs to achieve the most appropriate PPS rate, and start negotiations with the Utah Division of Health Care Finance from that point
      * Submit a Medicaid cost report that includes:
        + Similar methodology to State APM Medicaid Cost Report with additions related to health center-identified triggering events
        + First cost report can include any scope-changing event(s) since the last rate setting.
        + After any PPS Rate adjustment from a CiS, health center would need to wait at least two years before filing another CiS
        + Threshold would be that the rate would change by at least 3%, not that the sum of additional costs need to be at least 3%
        + Submit the CiS and the cost report within 6 months of the end of its fiscal year.
        + Cost report would be retroactively effective to the first date of the fiscal year following the cost report year.

Scenario: Health center has a June 30 fiscal year end. Their rate was last changed 10 years ago. They added optometry on 4/1/18.  They file for a CiS, using optometry as the triggering event. They fill out a cost report for fiscal year 6/30/20, and submit that cost report on 12/8/20. The State audits it (potentially within a specified timeframe), and calculates a new rate for the health center on 2/15/21. Any claims paid on or after 2/15/21 would be paid at the higher rate.  In addition, the State will go back and reconcile all Medicaid claims paid between 7/1/20 and 2/14/20, paying the difference between the old rate (which could potentially include MEI) and the new CiS rate

* + - * Triggering Events/ Intensity, Duration, Amount/ and Other Considerations

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| **ADDITION AND DELETION OF THE FOLLOWING SERVICES THAT WOULD TRIGGER A CiS** | |
| Medical | Medical specialties (e.g., cardiology, derm, etc.) | | |
| Case management/care coordination for non-billable work | Yes | | |
| Dental | Either adding dental as a service, or enhancing a current dental program by Adding restorative, dental surgery, etc. | | |
| X-ray | Direct (Column I) (includes ultrasound), but not Column II or III | | |
| MAT | Yes | | |
| Mental Health | Both, mental and behavioral health (e.g., BH does not generate additional visit, but service), includes medication management, and/or psychiatrists, and/or psychiatric mental health nurse practitioners | | |
| Substance Use Disorder | Define beyond MAT | | |
| Lab | Beyond Rapid and CLIA-waived, but would include COVID rapid tests | | |
| OB/GYN | Yes | | |
| Social Determinants of Health (SDoH) interventions | Show distinct staff and services; Add to enabling sub-bullet | | |
| Enabling services | New service (e.g., interpretation, financial counseling, diabetes education, nutrition, etc.) | | |
| Optometry | Column I and II | | |
| Chronic pain management | New and/or Certified staff | | |
| Non-billable team member interactions | Include elsewhere; | | |
| Pharmacy | Outside of CiS triggering events, but included in Cost report; | | |
| Clinical Pharmacy |  | | |
| Chiropractic Care | Addition of; Column I or II | | |
| Physical Therapy | Optional service | | |
| Alternative Therapies | Yes, need to define; homeopathy/naturopathy, acupuncture, massage therapy, reflexology (further define) | | |
| **INTENSITY, AMOUNT, and DURATION OF THE FOLLOWING SERVICES THAT WOULD TRIGGER A CiS** | |
| Services provided (e.g., those listed in addition/deletion of new type of service) | Change in cost related to Services provided | | |
| Behavioral Health (e.g., DEFINE) |  | | |
| Technology (e.g., EMR, telemedicine) |  | | |
| Telemedicine (e.g., phone, video, e-visit, group visits, etc.) | Yes | | |
| Alternative Visits (e.g., patient portal interactions b/w patient provider) |  | | |
| EMR | No on change, yes on first time implementation; only cost report year costs | | |
| EMR Modules | Yes new modules | | |
| Remote Patient Monitoring (RPM) | Yes | | |
| Regulatory compliance | Yes for new federal and/or state rules (e.g., compliance officer) | | |
| Population (e.g., homeless, HIV/AIDS, other chronic diseases, elderly) | Yes | | |
| HRSA approved scope of project | Yes for new site paired with intensity and/or services changes; not required for PPS CiS | | |
| Provider mix (e.g., infectious disease, psychiatrist/psychologist to existing LCSW)) | Yes for change in intensity, duration or amount; do we need examples based on Todd’s question | | |
| Public Health Emergencies (e.g., COVID, Opioid, etc.) | Yes | | |
| **OTHER SERVICES THAT WOULD TRIGGER A CiS** | | |
| SDoH Services | New service | | |
| Changing capital costs from a remodel, relocation or establishing a new site | (Included elsewhere) | | |
| Technology (e.g., telemedicine) | New service | | |
| Costs associated with a teaching health center | Yes (e.g., residencies, rotations, education, etc.) | | |

**Next steps**

1. Craig and Curt will take this document and the notes, and combine this into a CiS proposal.
   1. Return to AUCH for Review by July 6th or 7th
   2. AUCH to submit to PRWG by July 8th
2. AUCH, Curt and Craig will follow-up with PITU and UNHS to better understand AIR (all inclusive rate) and impact
3. AUCH will continue to collect data