

**Health Resources and Services Administration
Bureau of Primary Health Care
Cooperative Agreement Quarterly Call
February 4, 2014 1 to 2 pm ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the Q and A session, you may press star 1 on your touch-tone phone if you would like to ask a question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I would like to turn the meeting over to Mr. Jim Macrae.

Jim Macrae: Hi. Thank you and welcome everyone in joining us today for our National Cooperative Agreement call. We're very excited to have you all be with us. I think we have all of our National Cooperative Agreement Partners.

We have our Primary Care Associations. I think we have our Primary Care Offices. I think we also have our Network Grantees on the call. So, welcome to everyone and for joining us. Thank you for being here.

We also, I think, most of you know have a call scheduled a little bit later for today at 2:30. It's our - it's the All Programs call. And what we want to do on this call is actually provide you some information that you're going to probably hear again at 2:30, but not a lot.

So, we really wanted to try to keep these as much as we could a little bit separate. But also on a couple of these items dig in a little bit deeper to allow you to ask questions or to get a little bit more in-depth than what we probably will be able to do on this All Programs call at 2:30.

So, if you can, please join us for both. That would be great. But if you cannot, hopefully we'll be able to address as many of your issues as we can today. So, just to begin, it's great that we are in 2014. That is my mantra going forward. 2013 was quite a year.

I'll just leave it at that. It was quite a year. A lot of things happened. And several of them were good. Several of them were not so good. And several of them were incredibly challenging. But we really are looking forward to 2014.

And really in particular I just wanted to begin by saying thank you for all that you did do in 2013. It made a tremendous difference in, all joking aside, what was really a challenging year. And really through the work that you all did at the national level, at the state level, regionally and, you know, in some cases all across the country, it did make a tremendous difference.

And I just - I can't personally thank you enough for all that you've done in the face of many, many challenges that we did face in 2013. With respect to 2014, we have some new challenges and new opportunities going forward.

I will go more in-depth on this on the call later today, but I did want to share a little bit about our budget. I know many folks have been very interested in what is going to happen with respect to the health center budget.

The good news is that we did receive almost a \$700 million dollar increase in 2014, which is great. But that's a lot of resources to be able to allocate and hopefully do it well. And so we are busily working on that.

As you know we actually have already made some investments against that \$700 million. We actually have awarded \$150 million for about 236 new access points. If you combine that with the 19 million that we did in 2013, I think it's a little over 260 new access points that we supported.

And I think what's even more important is that represents about - not quite a 100 but close to 100 new organizations have joined the family, which is great. But those folks, as we all know, typically need a little extra support in terms of the work that we've doing.

And I know many of you have been involved in providing that extra support for these organizations because - I won't say that sometimes they have signed up and then they are like, oh God, what did I really sign up for? But we all know that's the reality of what happens.

And so we've been working with many of you both again at the national level and at the state level to work through and work with these grantees to really bring them into the family and make sure that they meet what it is that they need to do to continue to be part of the family, and most importantly that they are providing good quality care to peoples in their communities.

So thank you for that. We're excited about it. But it is a lot of work both from where you sit as well as from where we sit. We also were able to give out 58 million in one-time outreach and enrollment supplements.

Jen Joseph, who I know many of you have heard from quite a bit in terms of this whole activity, will share more in terms of updates. The only thing that I will say is that we've had several big opportunities to do massive outreach and enrollment pushes. We're going to have another opportunity in March.

There's going to be a lot of interest in what we are doing. And I will share that we have shared a lot of the data that you all have provided to us, actually to the secretary, and there is enormous interest in just what health centers have been able to accomplish.

So, this effort will definitely continue into the future. And Jen will talk more about some of the, I think, real highlights of what folks have been able to accomplish to date. In addition, we actually just announced in the last, I guess, two business days.

Today is Tuesday, right? It is Tuesday. It's all sort of a blur. It is Tuesday. So, we've announced two new investments that we're proposing to make in health centers across the country. One is for - actually I'll do the one that was announced yesterday, and then I'll do the one that was announced Friday.

We announced yesterday \$35 million dollars being available for a Patient Centered Medical Home Capital Award. Basically these are one-time funds to support the construction or renovation at an existing health center site to support the transformation to a PCMH model of care.

Basically we have about, like I said, \$35 million dollars available to support some of these projects. We're hoping ultimately to award between 150 and 175 awards at up to \$250,000 to support our continuing efforts to get health centers to be recognized as patient centered medical homes.

Now folks are not required to actually be PCMH to be able to apply for this money, but they do have to show how these resources and this capital effort, either construction or renovation, is going to help people become recognized as patient centered medical homes.

There is a TA call. It's on February the 18th. And there is information about that on our Web site that folks can access but they will be more in-depth on that. And then on Friday this past week, we actually announced a \$50 million dollar mental health service expansion/behavioral health integration effort.

This was actually announced by the Vice President in December, and it's basically to provide up to \$50 million dollars to probably 200 health centers across the country to support both the expansion of behavioral health services as well as to really promote a more integrated primary care behavioral health model of care.

The thing that we wanted to do with this opportunity was not just add capacity because that's clearly something we would want. And actually at least one of the things we expect is folks will add at least one licensed behavioral health provider, but that they also demonstrate how they're trying to better integrate or incorporate behavioral health into their primary care workforce and how they actually deliver care.

So, the idea is that we don't want behavioral health to be something separate. We really want it to be something that people fold into their teams in terms of how they work and how they provide care in their particular centers.

So there will be, like I said, up to 200 awards. Folks can compete for up to \$250,000. And there will be a TA call on this also in February. It's actually

February the 10th. So, that one will be the sooner. And the other two pieces, which more details will follow, but I know folks are interested.

Our appropriations did include \$110 million dollars for base adjustments. And I know many health centers are very interested in that. That's one of our, I think, largest base adjustment amounts of funding that we've ever had before, which is great.

And we're still trying to work out exactly how we will allocate that money, but we are looking at trying to address what additional costs people have experienced over the last several years in terms of just what they've invested in their programs and to try to continue that.

So more to follow on that. But we do hope to get that out probably sometime in the summer because we would like to use the most recent data to be able to make some of those base adjustments.

And then finally the last one is - and we're still trying to figure out exactly what it is going to be but probably somewhere around \$300 million to support expanded services or potentially additional new access points.

We haven't made any decisions at this point in terms of what that mix will look like or in terms of whether we will do any new access points for 2014, but it is what the language is in the bill - I mean in the law actually now. I can't say bill.

And so we're trying to determine exactly what's the right approach. And we're having conversations right now with folks throughout the department to come to consensus about what the focus should be.

I think from where we sit, we definitely would like the expanded services to model what we've done in the past or the recent past in terms of how we approach this. We would really like to be able to do supplemental awards based on some formula amount that folks could have a target and then propose to us what they would do with respect to that money.

Clearly a portion of that would need to go towards expanded medical capacity to help deal with just, you know, what we anticipate being an increase in demand both from insured as well as uninsured patients in certain states as well as the option to provide oral health, behavioral health, pharmacy, and/or vision services at existing health center sites.

So, we're excited about that. I don't have anything beyond that. We have and are working on a guidance but nothing yet. So just stay tuned on that one. More to follow. So I'm sure a lot of folks will have a lot of questions about that. And you can ask those questions, and I'll be able to answer maybe some of them and we'll see what we do from there.

The other thing that I wanted to do just in terms of giving an update before I turn it over to Jen to give us a policy update, is just to share with you that we do continue our work on really trying to better clarify some of the policies out there.

Jen's going to talk in particular about our governance roll out, but we are continuing our work around the sliding fee discount PIN. We got a lot of good comments from folks about that. We really are trying to strike that right balance between making sure that people can access care and there are no barriers with the realities of, you know, wanting to keep people financially viable.

It's not an easy balance. It's not an easy balance from a policy perspective. It's not an easy balance from an operational perspective on the ground. In addition, we are working to finalize our total budget PIN.

I know we got a lot of feedback on that. We got some good feedback from a lot of folks on the phone about that. Appreciate it. We are hopeful to get that out and I think you will see some significant revisions to that PIN. I'm going to talk more about that on the All Programs call so I won't bore you with that on this call. That's a little teaser for you all to stay tuned for the 2:30 call.

And then finally the last thing that we're working on is really something that many of you have shared with us and then you'll see it through some of the other things that we're doing and going to give updates on today.

We have heard a lot of feedback about just how we can do what we do a little bit better in a number of different areas. And one of the big ones to be honest has been around how we do compliance reviews of our centers.

And really I think the issue has been some concerns about just the, I don't know what the right word is, maybe it's consistency of interpretation of what really is required from the 330 Program for different folks to be in compliance with the 19 Key Program Requirements that you all always hear about.

And there's been concerns raised both from our own staff in terms of having, you know, consistent definitions and ways of looking at it. We've definitely heard concerns from consultants as well as we've heard concerns from people on the receiving end of consultant reports about interpretations.

We've heard concerns from primary care associations or even concerns about what we hear from primary care associations about what they interpret the

requirements to be as well as from national cooperative agreements as well as from health centers themselves.

And so if there's that much noise going on and confusion to some extent, I think we've recognized that we need to do clearly a better job in terms of articulating what those requirements are.

So, we're working on this idea of creating a, for lack of a better word, a Program Requirements Manual where we basically would be clear about what the requirements are and in particular articulate beyond what we now have, which is about three pages of the 19 requirements.

But to basically articulate more clearly what are the core elements of each of those 19 requirements? What are the musts that people must do? So be very clear about what those things are.

And then take it a step further and say, and then what are those things that we actually need from health centers that will demonstrate that they actually are in compliance? And do that both from a paper review process. So what documentation do we need from an application?

What documentation do we just need to be able to make that determination? And then, what documentation would be need to actually see whether people did it if we were doing an on-site review?

And Tracey will talk about some of the steps that we're starting to take in that area already when we talk about our operational site visits. But what are those things that we would need to see if we were onsite to be able to say, yes, people are actually doing it, they're actually implementing the requirement in that full way?

And then the last piece, which is probably the most challenging, I would say both for us sometimes and probably for you all from where you sit because we - it's the yin and the yang, I think, of this program is, what are some areas where we think people really ought to be thinking about this particular requirement?

But ultimately it's their decision about how they approach it. So we haven't figured out what the right term, maybe serious considerations or whatever, what that looks like. But basically, hey, ultimately this is your decision.

But, hey, if you're really not thinking about this, you're in for a world of hurt if you don't think about it in the right way. But it's not our call. And I think you'll see that with the total budget. You know, I think ultimately we have this - how do I say this the right way?

We are on the receiving end sometimes of a lot of decisions that are made of health centers. And a lot of times we're asked to correct those decisions. And sometimes we can't do that. In fact, most of the time we can't we can't do that because this really is a community based program.

It's not a federally run program in the sense of us running the health centers. But we live in this world sometimes where we're treated like we really do run these programs and so it creates challenges in terms of just what people ask of us.

And I think where we've come out, and we've definitely heard it in the total budget concept and we've definitely heard it in other places, is that we need to be really clear about what our lane is and then we need to be really clear about what is it that health centers ultimately need to be responsible for.

And we can provide some guidance and support but ultimately it's their decision. And in turn they have to live with the consequences of those decisions. So, you know, in some cases that's going to be painful and we've dealt with some of that already.

You know, some health centers have made some very challenging decisions in terms of what they've done. But ultimately if we're doing what we're supposed to be doing, we're supposed to have them understand what it is that they're doing hopefully before they make that decision and then once they do make the decision live with the consequences.

And we at the same time need to hold folks accountable for the requirements in terms of what people are about. And ultimately we need to invest in those organizations that are doing the things that we want to see more of.

But we can't overstep and try to do their job just like we don't want to overstep and do your job as cooperative agreements. And finding that right balance and right line is really part of what we're trying to do with this Program Requirements Manual is to try to be clear.

These are the musts. These are things that we want to see. These are the things we have to see. And then these are the things that, hey, you know, yellow light, red light, take a look at, but ultimately you've got to make the decision about what's best for you and your community and your organization.

So it will be a shift for us in terms of this transition because, like I said, we're often asked to get into that last category and actually make decisions. And

what we're going to say both to ourselves and to outside partners is that that's really not our lane or our role.

And that's going to be a challenge. And in turn it's going to put more pressure, I think, in particular on you all as cooperative agreements to help these health centers make better decisions in some cases.

In a lot of cases and I would say the vast majority, they're making right decisions. But as you know, you have a few problems and it seems to just cast a pall over the entire thing. And so, really from where you sit, you're going to have more responsibility in terms of doing some of this.

And I don't think it is the wrong thing to do and I think, you know, it got reinforced with the all the comments we got on the total budget thing about what is our role? But it is a shift and I think you'll see it as we start to roll some of these things out in terms of just what is our appropriate role versus your role versus the health center's role?

And to the extent that we're all clear about it I think the better off we'll all be. So with that I will stop and turn it over to Jen to talk a little bit about the governance roll out, which of course we're extremely excited about. It's a long time coming and I'm really excited about this coming out. Jen?

Jennifer Joseph: All right. Thanks, Jim. Good morning and afternoon everyone. I'm happy to be with you. I'm just going to give you some high level overview of the governance PIN. There will be a call that will provide more detail on Wednesday, February 12th for health centers, consultants, and others.

So do note that there will be an opportunity to dig deeper and ask questions at that time. And certainly we welcome whatever ones come up today as well.

You know, Jim spoke to sort of these fundamental roles of HRSA health centers.

The fundamental underpinning of what we do and what you - what health centers do as community based organizations is really grounded in their governance. And so, we are really excited to be able to put this resource out for everyone.

It was posted on the Web site on January 28th. This PIN has been in development for many years and so staff that - who have been here much longer than I, have worked really hard to put together the centralized policy source that speaks to all of our Health Center Program governance issues and supersedes lots of the other separate PINS that provided this guidance.

And we very much hope that this will be both helpful to health centers and helpful to you in providing support to them as we move forward. Excuse me. The PIN mainly clarifies and pulls together all of our existing policy into this one document.

The major new policy in the PIN is that HRSA will no longer consider requests for waivers of the monthly meeting requirement. Folks internally have looked at the extent to which this is an issue for health centers and it looks like about 30 of our grantees have this approved monthly meeting waiver.

And we have developed a plan to support and monitor these organizations and their progress and have included times for education and communication between the PO and the health center, development and submission of plans to remedy any noncompliance, and provision of additional technical assistance as needed.

We will ultimately employ progressive action policies and processes only after health centers have the opportunity to demonstrate a plan to come into compliance. And we're thinking, you know, just in terms of timelines not necessarily getting to that point until November of 2014.

So we know that this is going to take a while for people to be able to absorb and think about. And that to actually remedy what some of these situations are that are creating what is now noncompliant governance structures or processes.

It will take some time. So we are committed to provide the support that's needed for people to come into compliance and hope that we can lean on you to provide some of that support as well. There are obvious connections between this PIN and other aspects of the program.

Tracey will talk next about the Site Visit Guide and the revisions that are being made to it to make it consistent with the PIN. So I mentioned the call on the 12th. If you have questions prior to the 12th, general policy questions should be sent to the mailbox that's indicated on the PIN cover page.

That's bphcpolicy@hrsa.gov. If individual health centers have questions about their individual circumstances, they should contact their project officer. So health centers to the project officer, general policy questions to that inbox on the cover page.

So that's the high level overview. I hope everybody, if you haven't already, dig in. It's great reading. There is a lot of - it's, I think really helpful to have all of this guidance in one location. So some of you are probably very tired of hearing me talk about outreach and enrollment.

Others of you I don't get to talk to very often so, again, just a really high level overview of where things are. Nationally I'm sure you have all seen some of the encouraging enrollment numbers, that more than 8 million people have signed up for private insurance through the Marketplace, have learned they're eligible for Medicaid, or have renewed their Medicaid coverage.

More than 2.1 million people have enrolled in private insurance through the Marketplace. And 6.3 million have learned they're eligible for Medicaid or have renewed their coverage. Jim spoke to the one-time funding that we released to support what we anticipated to be an increase in demand for enrollment assistance at the end of this year and in the coming months.

And we know from data, at least from December, that the state-based Marketplaces saw a threefold increase in demand for - or in plan selections in December. And the federally facilitated Marketplaces saw a sevenfold increase in plan selections for December, in December.

So certainly that is a product of both interest and system capabilities. But I think the message is that people are taking advantage of this opportunity. And we are playing a huge and really important role in supporting that.

So I thought I'd just - Jim also mentioned our data and for those of you who haven't actually seen what the numbers are I'll just speak really quickly to what those are. So we receive quarterly progress reports, for those of you who aren't aware, from all health centers who receive outreach and enrollment funding.

And our second quarterly progress report covered the period from October 1 through December 31, so from the start of the open enrollment period through

the end of the calendar year. And we can really start to see the significant impact that health centers are having.

So our cumulative numbers that also included the three months prior to that where health centers were assisting people currently eligible for Medicaid to enroll in Medicaid, they have trained almost 11,000 assistors.

So that is - that exceeds even health centers' own projections for what the number of people that would be prepared to assist people with enrollment and have assisted over 2 million people to learn more about their options, what it means for them.

These are sort of personal touches of how we've kind of defined it. It's a more complicated definition than that. But generally speaking that's what we're talking about. So that doesn't include, you know, a group event or a community event with multiple people.

So over two million touches. And then they've supported the submission of over 600,000 applications. So a big impact and we're expecting to see a lot more, I think, in our final quarterly progress report. And we're trying our best. And whatever you can do to shore this up as well as to keep that energy going, keep people excited about this, because really while it's starting to feel like there's a light at the end of the tunnel, this is really the time when most of the work is going to be happening.

And when we expect folks who have been sitting back and waiting to see how this whole thing works to get to a point where they're actually ready for assistance. And so I don't - I think, we're going to see an ongoing if not

increasing demand from now through the end of March and this has been a heavy lift for a lot of people.

So we're so appreciative of all of the work that the health centers are doing and all of the work that you've done to help them do their work and to make this really, really important contribution.

In terms of our kind of day-to-day operations around outreach and enrollment we are continuing to work with health centers and primary care associations to identify issues that we could potentially help to resolve at the federal level and to identify successes that really highlight the great work that people are doing.

We're aware of several of the issues that I'm sure many of you who we don't speak to more often are aware of was the Medicaid loopers are getting terminology for some of the common issues, issues with - some issues with the call centers, some issues with appeals.

And especially we're starting to hear some of the issues around the utilization of insurance. So both some of the challenges just technically and systemic challenges to people being able to access their - and use their insurance but even more so the whole next lift which is simultaneous now with the outreach and enrollment and I think will continue as a need for this next couple of years is really to educate newly insured people about what this means and how to be consumers, an insured consumer.

And where - we've been explaining what Advanced Premium Tax Credits are, which, you know, that in and of itself - if people have got that down that's a huge accomplishment. And now we're moving on to explaining, you know, what co-pays and deductibles are. What it means to be part of a provider network? How to access specialty care?

I know many of you are living and breathing and hearing about what some of these challenges are and know that the Primary Care Associations especially are thinking forward already about how they can support health centers in this next challenge and invite our other national cooperative agreements to think as well about the ways that you can provide those supports.

And if you have great ideas or are doing great things, we would love to hear about what they are because I think the more the better at this point. So, I guess I'll stop there.

Jim Macrae: I think we'll turn it over to Tracey.

((Crosstalk))

Jim Macrae: Do you want to take questions now? Or what do you want to do?

Tracey Orloff: Up to you. (Unintelligible). So me first?

Jennifer Jacobs: Why don't you go and then we'll do questions?

Woman: All right. Well, hello everybody. We're actually really excited about what Jim was talking about with the changes to the whole site visit process and the guide and the manual that is being worked on.

And so I was just going to take a few minutes to tell you a little bit about the changes to the Health Center Site Visit Guide and what you're going to start seeing in kind of the immediate near future.

In particular, you might have noticed that on January 29th that the Health Center Program Site Visit Guide was changed on the Web site. And so the new version is up there. That version will probably be implemented and start being used early - very early in March.

But we wanted to give people time to take a look at it, see what's there. And I'm going to kind of walk you through some of the changes in both the guide as well as the process and the impact on some of you on the call given you are our partners and technical assistants to the grantees.

So as you know beginning in 2012, we really made a commitment to try and make sure that we did review the grantees once every three years, aiming for that midpoint in those project periods. And it was - this was directly to kind of align us with the whole review process of the application then actually seeing something onsite and all that to make that make sense.

And what that means for us is that those regular operational site visits would extend not only to health centers but to existing look alike as well as we're using that same process for the pre-designation of look alike as well.

And then, of course, our newly funded grantees between that 10 and 14 mark month of their first initial project period, they'll also continue to get an LOC.

So what - the changes that we've made in our approach, as we said, aligns so that it's streamlined with the budget period progress report and we're really trying to balance both the burden on the health centers and BPHC while maintaining a meaningful and appropriate level of federal oversight and the integrity of the program.

And so we really took to heart a lot of the information we got from all of you. With the expansion of how we've been using the operational site visits just to give you an example, in 2013, we did about 400 operational site visits in calendar year.

And for calendar 2014, we'll be doing over probably a good 500 operational site visits. So it's pretty dramatic - a lot to do and then we'll have potentially other sites visits like we usually do that provides some technical assistance and other things that we need to do but just to handle the OSVs alone is pretty dramatic.

We - given the importance of the OSV and the rapidly increasing number of who we're trying to visit and making sure those visits are conducted consistently across all of them, we recognize that it's really very difficult to make sure that it's all done the exact same way from, yeah I'm going assessment review and that...

So we wanted to make sure that any revisions we did would impact all the site visit tools and processes that we have so it all together made a - kind of a complete package. So based on this, we based significant - we took significant input from BPHC survey results, individual health centers, and then of course we heard as Jim had said, a lot of feedback from the PCAs, NPAs and all of our partners.

And it was really critically important and there was a lot of convergence on what we were hearing, which really helped us fine tune and hone in on those things that might make the most impact. And so, let's see - so what we've done and what you'll see in the guide is some substantial steps to focus on some key priority areas to increasing the quality of the reviews and the reports themselves.

And so the OSVs and other site visits will provide consistent and comprehensive information that will benefit us in helping manage the programs. And so some of the specific things that we've changed in the guide as you - and I would encourage you to read it - is that you will see that the questions in the guide are used for assessing and documenting compliance.

They been clarified and streamlined for every single program requirement. And in addition, all the - as Jen had said - all the new governance requirements are in there as well.

And while we're aware that - of the need to put out additional expanded policy clarifications as Jim mentioned, which we will continue to work on, we did those things that could help most dramatically in the interim and provided those updates that we could get out and be very consistent with everybody that won't change.

In addition, you'll also see the other big change in the guide is that we've removed all the performance improvement questions in all the program requirement sections. And so that's been all pared down. In and based on the health center feedback and our experience, we've found that documenting those numerous performance improvement areas both =, you know, in some ways detracted from the components of the actual OSV.

And compliance was sometimes misconstrued as non-compliant findings, which they weren't or required actions for the health centers that they could choose to do, but again that was misunderstood and then, you know, really was of minimal value to us so we were really trying to clear things out to make it as consistent as possible.

But in addition, one critical thing is that consultants will continue to focus on performance improvement of clinical and financial performance and be looking at selected required performance measures. So they will get at that performance improvement that's really critical based on the outcomes for our grantees.

And so additional information and clarification have been added to the guide that will ensure that the process, how we conduct it, everything is done the same and in particular that the site visit reports will be tighter, more to the point, and streamlined to get at what's needed more quickly.

I do want to clarify that while the general performance improvement is no longer a focus of the OSV and won't be in the written report, we're going to highly encourage health centers and you'll hear this on the next call, to really take full advantage of the expertise and experience of that technical assistance capability of the consultants who are part of the site visit team.

They will learn a lot in terms of just normal discourse and dialog about how - if they're struggling with something and lots of different methods of how other people have done it and kind of share that good information. So that kind of expertise and experience won't be lost and it will still be of value to the grantees.

In addition to the onsite assistance, we will continue to encourage all health centers, of course, to take full advantage of our other types of technical assistance and other resources so including the support from the PCAs, like you on the call, as well as the NPAs and kind of the full range of types of technical assistance support that are available to the health centers. So please, you know, take full advantage of the experience and the tools available.

We're trying to get them to really realize this kind of codery (sic) of resources that we have for them. And for the PCAs on the call, just wanted to emphasize, if you were wondering, you'll still be an integral part of the OSV process both as observers doing the newly funded OSVs as well as as appropriate and depending on the situation, we leave it up to the project officer's discretion to - as to whether you are notified about the other site visits.

But we're trying to keep an open policy on that. And encourage folks to realize - the health centers to realize that you're there as a resource for them and encourage them to look to you for those resources.

We - the whole aspect of doing this interim step before we get to the manual stage of the policy manual and doing this Health Center Site Visit Guide revamp now is that we really want to get some immediate changes out on the ground.

And therefore, we're going to need your help to really get input and feedback on how it's working on the ground. And so whatever is bubbling up as we start implementing this in March, we want to hear that.

And so we need this to - this whole piece to be an ongoing quality assessment and improvement process. And so we'll keep kind of tweaking along the way to ensure what works and what doesn't and how to keep improving.

And so therefore, we're going to do that right now with the guide until we get to the future stage when it becomes a protocol. And so we want to keep improving and learning from, you know, these changed methodologies that we're trying out.

And so we will - you'll be seeing from us that we want to constantly evaluate. We're not going to wait. We're going to set up an email box to get people's input both from grantees, consultants, projects officers, everybody.

And so you can send those in at any point in time. Those questions will also - those feedback questions will also be part of the formal site visit evaluations that go out. So we'll have a lot of doors through which people can give us input on a regular basis as we're going through this together.

And so if you haven't already reviewed the updated guide, I really encourage you to do that. Read it thoroughly. And we're also going to be doing some back end processes that impact that as well both from the reporting end and thinking about, you know, feedback from the grantees and things like that.

So I do have a couple more updates, but I'm going to wait. This has been a lot that we've shared, so maybe we'll take some Q and As now and then I'll give you some more updates before turning it to Suma.

Jim Macrae: Okay. Great. All right, operator. I think we'll take some questions now.

Coordinator: Thank you. At this time, we will begin the question and answer session. To ask a question, you may press star 1 on your touch-tone phone. Please unmute your phone and be sure to speak your first and last name clearly when prompted.

To withdraw your question, you may press star 2. Once again, if you would like to ask a question, press star 1, unmute your phone, and record your line when prompted. One moment please. Our first call comes from Clifford Chang.

Clifford Chang: Hey, Jim. Hey, Tracey. Hey, everybody. Thanks so much for all your hard work. Really appreciate the new governance PIN coming out and the new site visit. Just a couple questions on the governance if it's okay.

Since all the Pacific Islands are as you know public entities, I number one appreciate that there's a section now specific to public entities, but I just wanted to clarify - so my understanding is 98-23 has been officially withdrawn. That was about a couple years ago. Is that correct? And then the PIN specific to the public entities, 99-09, is that also inactive?

Jim Macrae: Yes. So everything related to governance basically, Clifford, now is in the governance PIN so that is now the resource for superseding and, in fact, there's actually a list of things that have been superseded in the PIN itself in the very beginning that makes that clearer. So...

Clifford Chang: Oh, okay. All right. Well, thank you.

Jim Macrae: Sure.

Coordinator: Our next call comes from Jodi Samuels.

Jodi Samuels: Hi. Good morning. This is Jodi Samuels from the California Primary Care Association. And I just had a question sort of going back to some of the beginning information about the additional budget appropriations for base funding adjustments.

Obviously, of course, our health centers are going to ask us questions about that but I'm going to be a little bit selfish here and ask if there are going to be any base adjustments for the PCA funding as well.

Specifically here in California, we were extremely fortunate to get a number of new access points in the latest round of funding. So I think internally we're struggling a little bit with how do we support those new organizations especially as some of them are new to the family as Jim had said?

But if we as a PCA aren't given additional resources to do that, it really can cause a strain on some of our existing resources and staff. So I was just wondering if there had been any thought given to that aspect of the PCA base funding as well?

Jim Macrae: Great question. This is Jim. We have not gotten that far in terms of where we are with respect to the cooperative agreement funding. I think the good part that we were able to do this year so far was to actually roll that average center enrollment one-time funding that we gave to PCAs last year actually into your base.

And so we actually have been able to increase that. So I know right now that's really targeted around outreach and enrollment. Whether we can do anything beyond that is something that we're looking at. But no decisions at this point.

Jodi Samuels: Okay. Thank you. I was just putting a plug for looking at that and keeping it as a possibility because like I said because we obviously want to be able to support all the new organizations. But...

Jim Macrae: Sure.

Jodi Samuels: You know, when we have so many more new ones and we have to try to get our staff out there and do all of that, it does make it a little bit challenging sometimes.

Jim Macrae: Absolutely. I hear you.

Jodi Samuels: Thank you.

Jim Macrae: Sure.

Coordinator: Okay. Our next question comes from (Faline Jacobs).

(Faline Jacobs): Hi there. I have a question regarding what sort of duties the CAGs will be doing after March. I think all of us have an idea, but I'm really wondering if it would be possible for you all to have either a conference call or a Webinar based specifically around what comes after March 31st for those assistors.

Jennifer Jacobs: Thanks. That's a great question. We began this conversation with the Primary Care Association just to get a sense of what their plans were just last week. And we got a lot of great feedback from them about what they were thinking about.

And so what we've talked about internally about doing is to pull together like we have pulled together some of the promising and best practices for outreach strategies to also kind of pull together a list of the different ways that people are focusing time and energy based on needs post-March 31 and make that publicly available.

(Faline Jacobs): That would be great. Thank you.

Coordinator: Okay. Our next question comes from Lathran Woodard.

Lathran Woodard: Yes. Excuse me. Good morning - good afternoon, everyone. Two quick questions. Jim, Tracey, and I think it was Jen I heard. This is about the

governance PIN and I thought I heard that there would no longer be waivers on monthly meetings?

Jim Macrae: That's correct.

Lathran Woodard: Okay. And so that includes for like we have a migrant voucher program and we got a waiver because the PCA Board is the one that oversees that with the Migrant Advisor Council. And I was trying to see whether that would apply to voucher programs as well.

Jim Macrae: It does. It applies to all of the programs. We just, you know, based on the feedback as - to be honest, based on the realities of what folks are having to deal with, especially given the healthcare environment, we just felt it was essential that folks meet at least once a month in terms of just managing the programs.

And the realities with now technology being such that people can do it, you know, in some cases virtually or at least over the phone, we just felt like it was absolutely essential that folks have this.

And we understand that it is going to be a change for some programs. I think it's a total of - I think a little over 35 that actually don't currently do monthly meetings, but in the scheme of things we just felt, you know, given again all the accountability, all of the responsibilities now, that it just made sense. So, yes. It would apply - short answer, Lathran.

Lathran Woodard: We just got ours approved in 2013, so I was just making sure. And I'll talk to my project officer first of how we - an effective date and how we transition.

Jim Macrae: Sure.

Lathran Woodard: But the last question if I can, the - I heard you talking about the \$700 million more we got and how you split it up in terms of what you're looking at, base adjustments and all. Would there be any consideration or are you thinking about having any new opportunities for health center control networks?

Jim Macrae: I've been asked that question a couple of different times so it's definitely something that we are looking at. It really depends on just how much resources we ultimately have available. But it's definitely something that I've been asked, Lathran, and it's something we're looking at.

Lathran Woodard: Okay. Thank you.

Jim Macrae: Sure.

Coordinator: Okay. Our next question is from (Robert Cue).

(Robert Cue): Good afternoon, Jim and everybody. How are you all doing? Jim, question about the OME March rollout. You mentioned that there would be another round. And question is whether or not that would be ongoing, rolled into base, or one-time preparing for the next outreach enrollment period?

Jim Macrae: I think you're speaking in particular for the Primary Care Associations in terms of the funding?

(Robert Cue): And, or CHCs, yes.

Jim Macrae: Well, for the CHCs, we did roll, for lack of a better word, their 2013 outreach and enrollment into their 2014 base. And so that money is ongoing. And people should be receiving it as their continuation applications are approved.

So folks will have that just be part of their ongoing base in terms of their operations.

We actually have done the same thing with Primary Care Associations. So the money that you received in FY 2013 will be rolled into your base going forward. The one piece of money that will not be ongoing is the \$58 million that we awarded just in December in FY 2014. That really is just for one-time activities.

(Robert Cue): Okay. So that - maybe I misunderstood, but I thought I heard you say there would be another round of OME in March.

Jim Macrae: No. I - more I was just saying that that's going to be the big push in terms of doing enrollment. I mean we had a big push when October 1st first started, of course, as most folks know had clearly some difficulties with that.

It was clearly a big push at the end of December in terms of getting people enrolled. And then as I think both Jen and I mentioned, there was clearly going to be a huge push for getting folks who really for insurance - it's never something they've actually ever utilized to really get them to think about enrolling. So that's what I meant in terms of push. Not money, but effort.

(Robert Cue): That clarifies it. Thank you.

Jim Macrae: Sure. And I think, operator, at this point just for the sake of time, we're going to ask just to hold the rest of the questions until we get the final part of our presentation done. And then we'll open it up. So, Tracey?

Tracey Orloff: Okay. So a few quick things and then I'll toss it to Suma. Just wanted to let everybody know that a lot of the NTAs have been putting events on our TA calendar on our Web site.

And so now we're going to make sure that those NTA events are now published on the BPHC TA calendar so they'll all be together with the things that we're doing so that should make it easier for people to look across the board and see the range of opportunities that come from us and our NTAs.

So take a look at that and look at that on our Web site. And then in addition, I also just wanted to give another plug, and this was in the digest last week, that we're really trying to work on improving the Health Center Program Web site.

And - but we need further feedback on how to make it better to understand both what you do and what you look for in our Web site. And if we understand that better, we'll be able to make the Web site better.

So if you could just take a minute and go on our home page, there is a little button called Be Heard. And that way you can give your input in saying what kind of things do you want to use the Web site for. So I'd encourage you to do that. And then I will turn it to Suma.

Suma Nair: Great. Thanks, Tracey. Hello, everyone. I'm pleased to join you to give you a couple of updates and heads up around some of our quality and data activities to support you and supporting the health centers with all of the upcoming activities and timelines we have.

So a quick update on UDS, FTCA, and some technical assistance that we have available and then where we are around patient centered medical homes

activities. So first and foremost, our most upcoming deadline looms with UDS submissions.

The UDS submissions are due in EHP by February 15th - so here very soon. Again just encourage grantees to make sure they submit in time for that deadline and that all of the resources that have always been available including the UDS help line, the BPHC help line are all available to support them as they get to the end of this submission period.

Quick note on timeline so you have a sense for your own planning, as soon as the grantees submit their data, they can get a copy of what they submitted through the electronic handbook so they have that for their reference.

When it will be finally all 1200 plus grantees in, validated, and cleansed and when people will have access to all of the reports will be in July. And then in August, we anticipate having all of those 2013 data updated on our Web site.

So please look for that. And that's the timeline. Quick note about the 2014 reporting - so we'll start reporting on this data in 2015. The PAL was finalized with the updated measures and changes that we'll be making.

We will be hosting some training early this spring to go over those new metrics that we have and provide all of the assistance needed in that vein. While we're on the topic of data and UDS, to the PCAs we are working on an update to your condition reports.

Sometime this week you should get the next update on the conditions report that you've been historically receiving semiannually. We're hoping to move that up to a more frequent basis. So the email will talk about how to access this information.

And then we'll host a subsequent call with all the PCAs and their data folks to talk about some of the feedback we received from focus groups and questions that you may have on data access and how to use the data, etcetera.

So please look out for a save the date for a TA call around that. In terms of FTCA, just a quick, you know, heads up because you've often helped the health centers with their work around the FTCA deeming process for 2015 deeming.

We anticipate the EHB module that holds the deeming application will be open early April. And it will close about 45 to 60 days later at the end of May. We don't anticipate any significant changes in the application.

The PAL with all the information should be out very shortly so health centers can pull that down and look at any changes or updates. But again there's no significant changes, just mostly dates and such.

Technical Assistance are planned since this will be available - the module will be open early in April. Mid-March we will be making available some office hours for specific questions grantees may have as well as many Webinars to go through some of the elements and sections of the application and talk about the requirements as well as samples and resources that would be helpful for grantees in completing that application.

And again just a high level timeframe - upon receipt of a complete application with all of the requirements and all of the information there, we're usually able to turnaround deeming determinations within 30 days, again contingent on receiving a complete application.

One more note related to technical assistance on FTCA. I think you all are aware of the wonderful accomplishments that we have in the Health Center Program. Among them, you know, we provide care for over 500,000 prenatal patients a year and have delivered over - almost 175,000 babies in 2012 alone.

So we look forward to seeing what 2013 has. But as you guys know in medical malpractice, one of the high explosion risk areas is in OB/GYN care. And so to really support health centers, particularly those who have a large volume of prenatal care and on deliveries, we're focusing on a new Webinar - a new educational series we have, Optimal Outcomes.

It's electronic fetal monitoring and it's a nine hour or nine credit continuing medical education opportunity to support health centers with some of the best practices and how to provide this care to promote best outcomes for our patients and really mitigate risks.

So we're excited about that opportunity. We sent out a couple notices. Please sign up. We don't have capacity for everyone to come on. So if you're really interested, we encourage you to let us know as soon as possible.

While we're talking about technical assistance and communication, we had our first Clinician Leadership Forum at the end of last year. And it was very well received. We had about 500 people, clinical leadership all across the health centers on the call, representation from all 50 states and Puerto Rico.

More than 95% of the participants said that it was excellent or very good. So we're going to continue that. Our next one is on February 20th from 2:00 to 3:00 pm and the topic will be the Change In Scope Process in Consideration for Clinical Leadership in Health Centers.

And future calls will also be focused on the clinical considerations for various program requirements. So something that your folks would probably be interested in. And so, save the date. And finally to round out my updates, with patient centered medical homes.

I'm happy to share that we are at 40% of health centers being recognized as patient centered medical homes. Thank you all for all of your efforts to help our health centers in making that transformation in the way they deliver care.

A couple of quick updates around that. We know that there's still a bit of a backlog with NCQA. They've made some good progress. But we know that there's still some surveys in-house of NCQA that they're reviewing.

We're working with them on that. If you have any issues around that, please do let me know and we'll make sure that we do our best to work through all of those. And then finally the last note around patient centered medical home activities.

We continue to work with our colleagues at CMS on the Advanced Primary Care Demonstration Project. And the goal, remember, is - this year finally is it. That was a quick three years. October of 2014, we have to have all of our 500 sites achieve Level 3 recognition.

Currently we're about 25% of the way towards our goal. So we have a big push. Together I know many of the coaches on the PCA have been working very aggressively on this, gotten the training and supporting the health centers.

So as you work through that, I just encourage you all to have an open communication channel to myself and the team I have in my office so that we

can support whether it's, you know, a contractual recognition process issue or if there are other issues that we can work together to support our health centers to having a really great outcome with this important demonstration project. So I think that's it.

Jim Macrae: And then the last thing, we just wanted to give folks a heads up on the 340B Program. The recertification process, I think most of you are aware, is open at this point. Actually, no. It starts on February the 10th.

The recertification will begin February the 10th and end on 3-14. There was a Webinar that was presented on January 22nd and a recording can be found on the front of the 340B database. For those who are very interested, it's <http://opanel.hrsa.gov/opa>. Just type Office of Pharmacy Affairs 340B and you'll find it on the HRSA the Website.

That's easier for me than writing all that stuff down. So the biggest thing is just encourage people to submit it. If they don't submit and aren't recertified then it can actually mean they're removed from the 340B Program.

And I think most of you are very aware that the 340B Program is just undergoing a lot of scrutiny and a lot of accountability and so there is definitely much more of a desire and interest to do what needs to be done.

So please encourage health centers to recertify as quickly as they can. And with that, we will close it. I think we'll take - why don't we take two questions. And then we'll wrap it up because we know folks got to go to their All Programs call. Yes. At 2:30. So this was a very content-dense call.

And we apologize but it's been a while since we've had one of these and we just have a lot to share with you. So hopefully it was helpful. We apologize

that it may be wasn't as fun as some of the other ones that we've had. But we had a lot of, I think, rich content to share with you today. So, operator, a couple of questions and then we'll end the call.

Coordinator: Okay. We do have a question from Neal Colburn.

Jim Macrae: Okay.

Neal Colburn: Yes, Jim. Thank you for all the work you've done.

Jim Macrae: Sure.

Neal Colburn: As far as expanded services...

Jim Macrae: Yes.

Neal Colburn: And expanded medical capacity is concerned...

Jim Macrae: Yes.

Neal Colburn: My concern is this - we have a lot of centers that are sort of cramped in their facilities and their - if they go for an ES or an EMC...

Jim Macrae: Sure.

Neal Colburn: Their space, you know, is going to be very inefficient. You know, they'll probably have to cram it in if they can do it at all or be discouraged. And I wondered, policy-wise, rather than them doing that and then waiting a while and filing for a change in scope, if there's a way to include in the plan a pending change in scope or intention to file a change in scope?

And let's say they have a dental unit or a behavior health unit, etcetera, allow them to build that or renovate space for it within their existing service area so they can do that in a more efficient way rather than in effect pile things in and then do a change in scope later?

Jim Macrae: I mean it's definitely something that a few folks have shared with us just in terms of all this, so that's actually really helpful to get that kind of feedback. And it's definitely something that we will consider. The other thing that folks have asked about, you know, just related to this is well, if we can't, you know, of course, have more space, can we expand our hours as part of this?

And I think that's something we would definitely look at, you know, in terms of giving people the option to, you know, physical space is limited but maybe number of hours could be expanded and could resources be used to support something like that? And I think that's something we're definitely open to. But we'll definitely, Neal, take your suggestion under consideration.

Neal Colburn: Thank you very much.

Jim Macrae: Sure. Operator, next question.

Coordinator: Okay. We don't have any further questions in the queue at this time.

Jim Macrae: All right. Okay. Well thanks everybody so much for participating today. Really appreciate it. Again, big thanks for all of your work in 2013. We definitely will need you in 2014 because a lot is going to happen. And hopefully many of you can join us for our 2:30 call with all the health centers and all the programs in the Bureau of Primary Healthcare. So thanks everybody and Happy New Year.

Coordinator: Okay. Thank you for joining us and we ask that all participants please disconnect your lines. If the speakers will stay on briefly and I will send you a message regarding the call.

Jim Macrae: Will do.

END