

**Health Resources and Services Administration
Bureau of Primary Health Care
BPHC Cooperative Agreement Quarterly Update Call
January 6, 2015, 1 to 2:30 p.m. ET**

Coordinator: Thank you for standing by. At this time, all lines are in a listen only mode. During the question and answer session, you may press star 1 on your touchtone 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. I would now like to turn the meeting over to Mr. Jim Macrae; Mr. Macrae you may begin.

Jim Macrae: Great, thank you, and welcome everybody. Happy 2015; Happy New Year! Hope everybody has had a great holiday season and now is prepared to jump into 2015 with a lot of gusto and verve and other things. It's been a little exciting here today in Washington.

We got an unexpected bigger snowstorm than we anticipated. We were told initially, although in Washington we always over prepare for snow, that we would get 1 to maybe 2 inches of snow and so it wouldn't be too bad a dusting; I think that was the way it was described. Well, it turned into 4 to 6 inches; well, that completely threw everything into chaos here. So, as you can imagine we are not snow experts.

So, many of us are now participating via phone, which was the smart thing to do; because for those of us who chose to drive in, it took anywhere from an hour, to an hour and a half, to 2 hours, to two and a half hours, to actually get in because of all of the traffic and chaos that ensues as soon as it snows here.

So, anyway, hopefully you all are not experiencing that; although I know many of you are in a cold, cold area right now.

It's also an exciting time because we have a new Congress that actually began today. So, there's a lot of activity associated with a new Congress as you can imagine, a lot of interest in terms of what's going on, a lot of interest in particular around the Health Center Program and everything that we're doing.

For today's call, we're going to do a number of different things. We're very excited about having some very special guests with us. We also have some important updates that we want to share.

And we also wanted to take some time to follow up on some items that we had a chance to just begin to discuss a little bit at the annual PCA network meeting that was held in November of last year. During that annual meeting, the PCAs and the networks were actually broken into different workgroups to identify a set of questions that they wanted to share with BPHC leadership. And so myself, Tonya Bowers, and many of our senior leaders were up on a panel answering a variety of different questions. And we got through a number of those questions but we didn't, weren't able to finish. So, what we wanted to do today was actually share answers to those questions so that everybody could benefit from it, and most importantly, get to some of those questions that we weren't able to address in November. So, we will spend most of the next hour talking about those things, but we did want to provide just a couple of updates.

And in terms of updates, I know everybody's probably, in particular, interested about the budget situation. I'm going to talk about the 2015 budget first, and then in some of the Qs and As, I know people will ask about the cliffs; so we will address that as we go through the Qs and As. In terms of the

new budget, we were very pleased to receive our budget. We actually got it earlier than we have in many past years, so that actually is very helpful. We're in the process right now of developing a spend plan for 2015; that ultimately has to be finished and finalized by the end of this month. We hope to actually be able to do it a little bit sooner than that. But I can share just a little bit in terms of some of the parameters that we're going to be operating under with respect to that new spending plan and budget.

First and I think this is really important, is that we're going to be spending a minimum of \$350 million to support both new access points and expanded service applications—that's between the two of them. At least \$350 million must be available to support new access points and/or expanded service grants. So, we're very excited about that opportunity; that's a significant investment in health centers across the country.

In addition, \$165 million is allocated for base adjustments and again that's also a minimum of \$165 million for base adjustments.

And then finally, up to \$150 million will be available for construction or capital improvement projects. As I mentioned, we're still in the process of finalizing the spend plan in particular how to determine how to use the remaining funds.

We are looking at, I know many of you have been interested, in particular on the cooperative agreement side, if there are any adjustments that we can make there. We are looking at some potential options there to see if that's a possibility.

We also are looking at what we're proposing to do with respect to networks; and we're thinking not just to be honest for '15, but also into '16, because we

know those grants come open in December of 2015. So, that's actually coming up shortly. So, we're beginning the process to look at the guidance and new activities in that whole area; so, very excited about all of that. As I mentioned, we will hopefully finalize that, at the latest, at the end of this month. We will, of course, share that information with you all as soon as it is finalized.

But it is a great opportunity to continue some of the work that we've been doing and really in some critical areas with respect to new access points, expanded service, with respect to construction; and then with respect to base adjustments, which have been really instrumental in terms of helping health centers with some of the ongoing costs of care but, have also supported some of the quality improvement activities that we know health centers are engaged in across the country. So, that's the update on the budget.

In addition, I just wanted to mention to you all something that came out, I think, from our grants shop; and it came out through EHB which relates to disclaimer language on publications and other things that are supported through grants from the Federal government. There's a level of specificity in the disclaimer language that several of you have expressed some concerns about. We have always had the standard disclaimer language about that things supported with the cooperative agreement do not necessarily reflect the views of the Federal government, or the agency, or department. But the disclaimer language that was sent out just recently went to a greater level of specificity and many of you have expressed concerns about your (1) ability to be able to do it and then [2] what does that actually mean.

So, we've had some follow up conversations with our grants office and we'll be getting out more guidance to you all in terms of what that looks like but, for the time being, you can continue to use the standard disclaimer language

that we've been asking you to use for any kind of publications or activities that you all are doing. So don't worry about it, is what we're saying for right now, and we'll get you more information soon with a little bit more specificity about what the actual requirements will be going into the future. So, that's it in terms of quick updates from me.

I'm going to turn it over to Jen Joseph to talk about some updates in the policy realm; and then we're going to turn it over to Suma Nair to give us some updates on the quality realm; and then we'll go through the Qs and As; and then we'll wrap it up with Marquita to share some information from the Office of National Assistance and Special Populations; and then I'm very excited to have Gina Capra, a former BPHC employee, share some updates about what's going on with the Veterans Administration and some of their activities to support the use of health centers in providing care to veterans in our country. So we're very excited about having Gina here so we're going to spend, like I said, about the first hour on BPHC stuff; and then at about two o'clock, we're going to turn it over to Gina to share some information about veterans. So with that I'm going to turn it over to Jen.

Jen Joseph: Okay, thanks Jim. Greetings, everyone. I'm happy to be with you. I'm going to go through several updates with gusto and verve in the theme of our call today and we've a lot to cover.

So I just wanted to quickly touch base on outreach and enrollment. Congratulate you and your support of our health centers in this 2015 year list and for all the progress that's been made there. Encourage you to do all that you can to push that continued effort through February 15th, and likewise encourage health centers to submit their QPRs, or quarterly progress reports. Those are due on Monday, January 12th.

And just as a quick reminder with respect to that data, which of course is really one of the primary ways that we're able to show our impact and the impact of the resources we've invested in this effort, that we have asked health centers to, for this first quarter, count as trained the assistants that may have been trained in a previous quarter but were trained to prepare them for this year. So, as we've talked I think before, we're resetting our numbers at zero; and it's really important that we capture what the effort is in this quarter for supporting outreach and enrollment across the country.

And then just as another reminder, for you to impart to health centers that those who are unable to get their reports into us we will put them on drawdown restriction. So that's the stick, but we haven't actually had to use that and we're hoping to have that same situation for this reporting period.

And a few, just reminders for you, none of this, I think, is new information; but I thought it was important to point out some other ACA-related opportunities for comment. So, the draft non-exhaustive HHS list of ECPs is available for comment; those comments are due this Friday, January 9th. Likewise, the draft Letter to Issuers for the Federally-facilitated Marketplaces for 2016, which includes the evaluation of network adequacy that CMS will be doing, which I know is an issue near and dear to many of your hearts and the hearts of health centers, is available for comment. Those comments are due January 12th, and I encourage you to weigh in there. And just as an FYI that the related 2016 Payment Notice Proposed Rule that includes additional proposed requirements was published on November 26, that comment period has closed.

And then just one final touch on ACA-related activities; ASPE, the Assistant Secretary for Planning and Evaluation, is doing an evaluation of the impact of the ACA on several HHS programs, including the Health Center Program.

They're working with the Rand Corporation and NORC at the University of Chicago; and they will be reaching out to many of you, in particular, to some PCAs and to health centers; and they're doing a combination of phone discussions and site visits, and these will be occurring between February and April 2015. They'll be looking at questions such as the impact of the ACA on coverage expansion, on payer mixes, client volumes, workforce challenges, delivery system reforms, etc. So, if you hear from them, if you please, be on the alert for hearing from them, and if you are, we encourage you to participate. And if you have any questions that you want to send our way, in relation to that activity, you can feel free to send those to me at jjoseph@hrsa.gov .

So, moving on to some other policy and program development updates, I know we've talked about this and will continue to over time, the Program Requirements Manual, we know that everyone is anticipating seeing what that looks like and we hope to release that for comment in the first quarter of 2015. We anticipate providing 90 days for public comments; and folks are working hard now, on developing an online system for submission of comments to make that process easier for you and, frankly, easier for us on the backend and 'easier for us' means a quicker turnaround time on our end, too. So, we're very much looking forward to getting that out and to getting feedback from you.

I know in Dallas some of the, many questions came up around sliding fee; those frequently asked questions are available and were promoted, I think, in our BPHC Digest, and are also available on a link, or through a link, on the sliding fee policy thing part of the Web page where you access the policy itself. And likewise, within the policy, and on that page, you can also submit additional questions to BPHCPolicy@hrsa.gov . And as we collect those questions and identify issues that are applicable to health centers overall, as

opposed to very particular situations, we will update that sliding fee FAQ document to address those frequently asked questions; so, please, please do send your questions there.

Likewise, as just a quick follow-up because I think this issue came at Dallas, in Dallas, too, around mergers and acquisitions, that we are working on a technical assistance tool that's still in progress, and will outline general areas for consideration, and provide some key actions steps from a HRSA grants management perspective.

Another sort of progress update on scope alignment, folks are in the final stages of making updates to some of the individual Form 5B comments that were provided in the SAV process. Health centers have been notified individually that these things were, are taking place and they will be notified once these minor corrections are complete. These are minor corrections that were asked of us to do for health centers. And, other than that, all of HRSA's follow-up has been completed, has been summarized on the scope alignment validation Web page; so, you can see that there. Likewise, on BPHC's Scope of Project Web page, there is a resource that should address many of the questions that health centers might have about any follow-up actions that might be needed from them at this point in time.

Just another quick follow-up on some issues that have been raised in the past, around patient numbers, and service area competition, and funding reductions, just wanted to give you an update on where we are in terms of what this SAC cohort has fallen in terms of their reductions in funding and reductions in patient projections. So, at this point in time, it looks like only about 4% of the SAC applicants in this cycle ended up with funding reductions based on their reduction in patient projections; and just as a reminder, the maximum reduction, which would have been for a reduction of up to 75%, was a

reduction of 2% in funding. And then, there were about fewer than 5, about 6%, of folks that reduced their patient projections by less than 5%, and those reductions do not result in any corollary funding reduction. So, I know there was some interest in the, how many health centers were in this situation, so I thought that might be helpful.

And then, many of you may be interested to know that we're, for the new access point competition, we're nearing the end of our CME(?) period; so, some of you may be hearing from the few applicants that may be deemed ineligible later this month. So, just know that that's sort of where we are in the process and you might be hearing from folks on that. And that's, that's all I've got.

Jim Macrae: Great; thanks, Jen. I think in particular the piece with respect to the essential community provider list is really important. There is information that's come out from CMS. We will be sending something out either later today or tomorrow to just reinforce that. But just for people to make sure that their list is up to date as possible; it was pulled from our scope repository which you heard from Jen. We've spent a lot of time working with health centers over the last year to update. As I mentioned at the PCA network meeting, it did have an impact in terms of some sites ultimately being determined not to be in scope, which was really helpful, but it was a significant number. And so just that continued effort to encourage health centers to keep their scope of project up to date is really important, and we're looking at different ways to support that.

Right now, we're going to turn it over to Suma to give you a quality update; and then we'll begin the effort to go through the questions that we weren't able to address in that November meeting. So, Suma?

Suma Nair: Great; thanks, Jim. Good morning, good afternoon, everyone. Just a couple of quick updates; you know, it's the beginning of the new year, which means it's the beginning of reporting in UDS, so wanted to provide a quick update on the 2014 reporting period. Just recall that the deadline is February 15th, for 2014 UDS reporting and by now you all understand the importance of the UDS data, not only for talking about the value and impact of the Health Center Program, but it really drives a lot of the funding that we then put out including our quality improvement awards, etc. So, really important that grantees submit by the deadline and give us the data so we can talk about the great achievements of the Health Center Program.

In addition, moving from 2014 UDS to look to 2015 UDS we did post a PAL in December that identifies the proposed changes to the 2015 UDS. They are relatively minor. We're having three main changes. One, we're adding in a line in Table 4 for counting dual eligibles beneficiaries. We're also aligning our diabetes measure with the NQF measure that really more focuses on the over 9%, and finally, we're so pleased to be able to add a new dental measure. We've been talking with many of you all about including measures on behavioral health and oral health; and those are the two areas that we were lagging, and we finally have an opportunity to add a dental measure that is NQF endorsed and aligns with the Medicaid Meaningful Use program. So, more information and details on the measures and the changes can be accessed through our website and by accessing the 2015 PAL.

The next update that I will go through is the PCMH. I know many of our health centers were getting close to 60% of health centers being recognized. And so, part of that is, we grew from less than 1% in 2010 and we had a kind of paper process using a spreadsheet; and as we've grown and experienced huge growth in the program, we also want to make sure that we're revising our processes to accommodate that growth. So, in the spirit of increased

transparency and accountability, we're proposing later this year to come out with a new NOI process so that we have a better opportunity to manage the data and information, and report out on PCMH recognition, but also to support you guys when you're putting this in, especially some of the PCMH is done at site level. Each time an NOI has gone in, we can really track the timing where it is in the process to just support that piece as well. So, more information to come; just wanted to give you a heads up that we're making some tweaks to hopefully, make it a better experience for all of our health centers and easier for us to track and report out on the benefits and progress health centers have made around PCMH.

Another important update around PCMH, we've been mentioning to you all that the 2011 NCQA tools that have been issued to date; if, they have to be submitted by March of this year. If they're not, they're no longer valid; and health centers must come in using the new 2014 standards. So, one last push and reminder for any health centers who have 2011 tools to go ahead and make sure that they get them in by the March deadline, and then moving forward all health centers that come in for recognition will come in under the 2014 standards. Again, par for the course, we will have training through NCQA around the 2014 standards that people can access on demand; and I think there are monthly webinars as well to provide support through those.

And then finally, again we anticipate the PCMH base adjustment awards like we did last year; and we probably would use a similar timeframe like early in the summer. We would look at everyone who is recognized and then, they would get rewards related to that. We anticipate using a similar process by hosting a listing on a website and encouraging all health centers to look at it and make sure we have all of their right information around the number of sites that have been recognized and then we would make the awards. So, look out for that this summer.

And then finally, last update is around the QI awards. In case you missed it, in early December, we released our quality improvement awards and we conducted a technical assistance call in mid-December. During that call, we went through the different criteria for the four categories of awards, and we talked about the different rationale of how we came up with the different categories, and we also pointed to the release Web page which had the listing of all of the health centers that fell under each category. Subsequently, we've received about 50 or so inquiries from individual health centers about their award calculations. If you're receiving any inquiries, please have them sent forward to us and we'd be happy to walk the grantee through how the award was calculated. We also anticipate shortly to have a Web page up that also links to all of the listing of each health center by category and additional TA resources, such as the archived TA call, the PowerPoint slides, and information on the adjusting process that we use for the clinical quality measures, etc. So, hopefully that spurred some interest and excitement around quality improvement. Again, our goal is to have another round of QIA awards moving forward so, that interest will hopefully encourage health centers to continue to work on clinical quality improvement and make sure that they're able to access those awards in the future as well. So, those are the key updates that I wanted to provide. I can turn it back to Jim.

Jim Macrae: Thanks, Suma. You know, I think in particular the quality improvement awards really have made a significant difference in the impact. We've gotten a lot of feedback both from health centers, PCAs, and to be honest, internally, just in terms of moving in this direction to recognizing the performance of health centers. In fact, there's a meeting tomorrow with the Secretary where we've been asked to provide a little bit more in-depth presentation on what we've been able to accomplish with those quality improvement awards. And as you all know, it's not a lot of money, and it's one time, but I think it's the

recognition that's the most important. It actually got picked up in a number of different news publications across the country.

And I think, most importantly, it reflects two, I think, really important things for the Health Center Program: one, is that we are willing, and able, and capable of sharing our data and sharing it publicly, so that we are transparent in terms of our performance; and the second thing, which I think is even more important, is that health centers are actually doing incredibly well, in terms of their quality performance—either improving, or actually hitting, national standards and benchmarks, or just providing care to populations that need it the most and providing that care in the highest quality manner. So, I think that's been a really positive thing; that is something that we plan to continue. We do plan to do a similar thing with the 2014 data; and if that's not enough of a plug, please encourage health centers to get that 2014 data in—make sure it is as accurate as possible. There is an enormous amount of interest from a variety of different places in terms of that data, both from the quality standpoint that we just talked about, but also, and you all know it, from the impact of the ACA; and really being able to show what the impact is in different states and even in different health centers across the country. So, please whatever you can do to help support us in that that would be great.

At this point, I'm going to go through the set of questions that came up, and then I'm going to turn it over to Marquita in terms of giving us an update on ONASP, and then we're going to have Gina come in and talk about the veterans' piece.

So, I'm going to address the questions and I've asked my partner here, Tonya Bowers, to be the reader and, sometimes, answerer of questions,

Tonya Bowers: interpreter,

Jim Macrae: along with Suma and Jen, and then anybody else who wants to help answer questions is more than welcome to do that. I've also given them the power to say, 'What are you saying Jim? That's a crazy answer. Let me correct you.' So, Suma since you're not here in the room, you can do that; feel free to interrupt me if I say something wrong.

Tonya Bowers: Good afternoon, good morning, everyone. So, I'm going to read through a series of questions and hopefully, as Jim said, we will have some answers for you. So, the first question is—how does the BPHC restructuring impact regional offices and their responsibilities?

Jim Macrae: Well, because we have a total of 64 questions some of my answers are going to be incredibly brief. So, in terms of the answer to that question, it has no impact on the regional offices or responsibilities.

Tonya Bowers: Terrific; second question; (laughter) this isn't so well (laughter), well organized.

Jim Macrae: But I will tell you, it will have no impact on what OPR, or what the Office of Regional Operations, does. We do anticipate, however, that more BPHC staff that we bring on board may be located out in the regional offices. That is the one impact that we do see, is that there will be more opportunities for both more staff coming into our bureau, but also more of those staff being out stationed in our regional offices.

Tonya Bowers: Thank you. In terms of the next question—what's, what are the expectations, or what's the story behind, having questions in the operational site visits regarding 340B and 340B participation?

Jim Macrae: Yeah, we've added, I think, it's four to five questions to our own operational site visit guide that deal with the 340B program. This is to basically acknowledge that 340B has a huge impact on our program; and it's also a request from our colleagues in the 340B program that we help them in terms of identifying any potential issues that may arise. So, those questions are fairly basic in terms of what they are asking; and all they are doing is to prompt if there's additional follow-up that our colleagues in the 340B program need to follow up with a particular health center on. So, this is not a full blown 340B review. These are simply questions that may identify some potential concerns about what health centers may or may not be doing, with respect to the program that may ultimately get them into some issues or difficulties in terms of complying fully with the program. So, we've told people, just relax, just answer the questions truthfully; and then either technical assistance will be provided, or more support in terms of being able, to address those questions.

Tonya Bowers: So, the next question is, I know it's come up a couple of times and I think we've addressed it in some forms—but it's regarding the availability of technical assistance and TA for PCAs and others that are expected to help in preparing grant applications regarding data, targets, those things that are included there; and what's the role of the PCAs and expectations there?

Jim Macrae: Jen mentioned this just a couple of minutes ago in terms of the impact. For this year's service area competition application, we did share back with individuals their own targets that they had set in terms of what they wanted to see in terms of number of patients. So, either from their previous SAC applications, and any additional funding that they received either through a new access point or an expanded service grant, their targets were raised to reflect that.

If, for whatever reason, they could not hit those targets, in previous years, they were actually deemed ineligible. And we felt like that was too draconian; and so what we did this year, was actually create the opportunity for people to be able to say they couldn't meet those targets—or they wouldn't potentially meet those targets in 3 years—and that's important. It's that it's not that they're going to meet it in the next year, but they actually have the full 3 years of their SAC to be able to reach those targets that they had set on their own for what they want to achieve. And that's, I think, really important.

But, if for whatever reason they're not able to address it, they would receive a slight reduction based on the new projection of number of patients. So, as Jen said, if people are proposing to reduce by 5%, there actually is no impact on the grant. But if it goes beyond 5%, up to 25%, there would be a small reduction in terms of their grant funding; and what it allows people to do is one, be eligible for applications where they previously have not, but also to right size their applications. And why that's so critically important is that people, we want to create the, the reality of people to put in more realistic projections in terms of their number of patients. So that, when they're submitting, in particular, competitive applications, they're not just promising the moon, and the sun, and the stars; but they really are providing realistic projections.

We asked you to help them with those projections and we apologize for not sharing that beforehand with you all. We just knew you could do it. But as we said at the PCA meeting, just looking at what current grant costs are per patient (both nationally, which is about \$125, and also within your state) is a good proxy for people to be able to judge what projections should be in the future.

Tonya Bowers: So, I'm going to combine a couple of questions,

Jim Macrae: sure,

Tonya Bowers: just for brevity or for expediency here. That, and a lot of it's regarding continued or different support for PCAs going forward; so, a couple of questions related to performance bonus payments for PCAs, or, also around base adjustments to, you know, regarding shifting focus from looking at core compliance to looking more at quality initiatives, and finally any additional funding related to some ongoing initiatives out in the field, like ACOs, quality initiatives, those kinds of things.

Jim Macrae: Yeah, the idea of performance bonuses for PCAs is a new one. It was shared at that meeting. I think it's something we would definitely be interested potentially in working in. Basically, the idea, I think, I, as I heard it—was potentially giving PCAs some bonuses if they work with a set of health centers to actually improve their performance—interesting idea. I think we'd have to think a little bit more about it, but definitely open to that.

I think, in terms of resources, Suma will talk about this a little bit more, but we definitely see, and I think this is even one of the questions that comes up later, we are gonna begin to ask PCAs, and our cooperative agreement partners, and basically all of the folks that are on this phone, to begin to work with our centers in less of a compliance focus, and more of a quality improvement focus. It doesn't mean that it goes away completely, but it means in terms of where we want people to focus. We've spent a lot of time and energy asking you all to do compliance, which, to be honest, in some cases has been a square peg in a round hole, and we, now, with part of this restructuring, are building up our staff capacity to be able to do more in this area. But, where we realize we need your expertise, and really, I think, incredible training and TA that you provide, is really around that quality

improvement part; 'cause while we've made some progress, there's clearly more progress to be made.

The last thing is, we are absolutely looking at PCA funding. In particular, the area that has come up, I think, repeatedly has been around the whole issue of data, and just the need to have that kind of data and information be available—whether that's to support quality improvement activities, ultimately to support health centers as they're dealing with the new marketplace and arena, so, we're definitely are looking at something potentially in that area. We've also heard it on the network side that, that's clearly an issue, and so we are looking at that in terms of the guidance. And then, I think, even one of the other questions was related to, some sort of national effort around a data strategy; and so we are looking at all of those different pieces to support both PCAs, networks, and our national cooperative agreement partners.

Tonya Bowers: Thank you. I think there's several questions that relate to the future of network funding.

Jim Macrae: Uh, huh

Tonya Bowers: You touched on that briefly, looking at '15, the spend plan for '15 and '16, but really looking a little bit more about, there's specific questions about, whether or not look-alikes can be counted towards network membership in future fundings as we continue to expand that program. Looking also around, I'm skimming forward, just about the process for, or thinking about what that might look like into the future in terms of network aligned, and PCA and NCA alignment.

Jim Macrae: So, we definitely agree with health center controlled networks that it has been an important investment; we do plan to continue that. Those awards do come up, as I mentioned, December 1st, 2015, as it's etched in my brain. We are beginning to work on the guidance related to that; Suma may want to provide a little bit more details. We definitely are looking at what's the next phase in terms of how we approach this, in terms of what is it that we are looking for, but I think, in particular, some of the core principles around, you know, how do you use data, how do you use it to do quality improvement, and how do we engage as many health centers as possible in these network arrangements, I think, really are some of our key goals.

I like the idea of including look-alikes; I think that makes a lot of sense. It isn't been something we've done previously, but we really are trying to move in that direction overall so, I think it makes a lot sense from where I sit.

And, I think, in terms of just the future, stay tuned. We do hope to have a guidance out relatively soon, sometime out in the spring because if awards are to be made in December, we will, of course, like to get something out in the spring to be able to do that. So, I don't know if Suma, you want to add anything with respect to the network piece?

Suma Nair: Yeah, sure, I think, you know, it's going to be building upon what we've done already. Health centers have had great success in adoption and implementation of electronic health records, and it's now really using our health center controlled networks to switch towards Meaningful Use stage 2 and 3, and really, with the focus on interoperability, as well. So, you know, the health centers themselves having the data in the system and using it for quality improvement, but then able to exchange data in the broader health care system to improve the quality of care. So, you'll see a focus on that really

aligned with the Federal Strategic HIT Plan and the ONC Interoperability Plan.

Jim Macrae: All right. Tonya, do you want to jump to the next one?

Tonya Bowers: Sure; there, there's two questions that are kind of similar related to the role of primary care associations. I guess, pretty much all of our cooperative agreements, around guidance whether it's pre-application or subsequent of funding related to mergers and acquisitions; and what is the role and what support is available for, to support mergers, acquisitions, and other types of realignment out in the field, either before the applications are submitted or subsequent to funding?

Jim Macrae: So, that's a great question. We, one of the pieces to that is, are we working on any kind of guidance to provide to health centers as they're potentially thinking about it? The answer to that question is yes, we are, developing some guidance to help health centers, as they think through whether they want to potentially merge—what the steps are that would be required to be able to do that.

We, from where we sit, are agnostic about whether health centers should merge or not. That really is a role ultimately for PCAs, I think, to engage with their members on, and to potentially help members think through, what is in some cases, a very difficult and sometimes painful decision about whether organizations need to either stay separate or potentially merge to be able to survive and thrive in the future.

But what we know we need to do, from where we sit, is be able to clearly articulate what are the steps that are needed to actually make something like that happen. What are the potential, if there are any, risks in terms of all of

that? And what do people need to do as they're thinking about it, both from the very beginning planning phases all the way through? So, we definitely think it's something that PCAs can do. It's not a requirement, per se; but it is something that we know many PCAs are involved in, and they are challenging conversations to have, but we will be getting guidance out on mergers soon.

Tonya Bowers: Similar to that question, and this has come up in a couple of questions, more recently, is around expectations, or, or sort of conversions, of different funding, different types of organizations that are considering coming in for now funding or look-alikes—what's the expectation for supporting those organizations in converting to the FQHC model and, even going a little bit further, that a little bit more related to, the expectation for comprehensive primary care service as the main focus for most of these applications?

Jim Macrae: So, a couple of different things in there, so, the first one, one of the questions that we're getting asked a lot about, and you've probably seen articles about it in the press, that there are many local, in particular, rural hospitals that are beginning to close their doors. Many of them are critical access hospitals or other entities and, you know, one of the questions of course that's coming up is—well, what are the options for that community going forward? And one of the things that we've started to see a little bit in the Health Center Program is that some critical access hospitals are actually becoming FQHCs (phone ringing). In fact, we have three of those that are actually out there right now (phone ringing). Hello,

Tonya Bowers: Hello.

Jim Macrae: We actually have three out there that have basically converted from being a critical access hospital to becoming an FQHC. They've retained some aspects of the critical access hospital operations, but they have basically made the

transition to become that community-based board, that govern piece by the FQHC itself. And we're actually gonna have those three entities come out in the spring time, and share their story with us in terms of just what do they need to do. The key piece to all of this is that we don't see this as a panacea for saving hospitals across the country, number one.

Number two, it's not something you just do turn-key, that just happens; you actually have to do a lot of strategic planning—a lot of effort to make that change because it is a significant change for a critical access hospital to potentially do. But, if the community, if all of the participants, and ultimately, if, you know, the people that are involved in the operations of these things, are willing to do it, it can be a successful model. It does take some work; it is challenging, but we are open to doing that. So, we're gonna be looking at that and potentially, supporting some additional entities that are interested in making that transition and, I think, that's important because we have a lot of entities out there that want to become FQHCs that, again, don't necessarily want to go through all of the steps.

In fact, we're dealing with one today, that has been very much on us because we are saying, 'No, you actually have to have a governing board that meets all these things. No, you can't retain these certain authorities.' and they're upset with us. And what we've said, 'No, those are the requirements. Now, there are ways to do it, but you've got to work through it.' and we're seeing that with behavioral health entities, we're seeing it with hospitals, we're seeing it with a variety of different folks but, to the extent that we can all together provide what those requirements are, it's important.

The second part of your question was comprehensive services versus new access points. This is something, that I just shared, that one of the concerns that I have is that there are health centers that (and understandably, because

that's a lot of the way our money has been done) is that there's been pressure to add more sites, rather than to expand the current level of service that's provided in their current communities, or even to expand that range of services that are in their current communities. And what we're seeing is that, in some cases, health centers are becoming extremely large, and are beginning, I won't say, to lose, but you worry about whether they're losing some of that community-based-ness that they really are driven.

The other thing is that in terms of need, or addressing need at a certain level now, in more communities, but we're not digging down deep to get at more need within the high-need communities that we already are in, and we recognize that we're part of that issue. Part of that will be addressed, I think, with our budget in terms of how we move forward with the distribution between the \$350 million for new access points versus expanded service, but part of it is just an orientation to, in terms of really trying, to encourage people to look at what they're currently doing for their current patients and can they do more there, before they begin to think of going into new communities. So, it's more of a philosophical thing rather than a specific thing, but it will come out in terms of some of our decisions around budget, definitely, will, I think, be part of your conversations as people are talking about expansion planning and other activities going forward.

Tonya Bowers: Thank you. So, a couple of questions related to our operational site visits, so, around the timeliness of the visits, the timeliness of the information getting back out—

Jim Macrae: (noise) Sorry.

Tonya Bowers: sort of, role of our partners in the field regarding that feedback. Also, a couple of questions related to how we establish priorities, our priorities for

operational site visits, given the cycles that have been put in place and the urgency that sometimes appears for some visits.

Jim Macrae: Okay, so, I'm going to turn to Suma for a couple of these; and I might even add a couple more pieces to that 'cause, I know, there were some specific things related to PCAs that people were asking about. So, in terms of the site visits, we are looking at how to improve that process. We actually did some internal PDSA'ing in terms of our process; so, we've actually been able to reduce the cycle time for our site visit reports by almost 50%, which, I think, has been great to really try to reduce that time. Our goal is to get the site visit reports completed within 45 days as of the end of the site visit, and we're making real progress to do that.

At the same time, we're trying to reduce the amount of information that's in the report, and really have it focus, primarily, on compliance issues and take out a lot of that performance improvement piece that really confused people.

The third aspect that we're doing (and is really going to be the effort going into the spring, after we get out our Program Requirements Manual for public comment) is to try to better align what we're doing with respect to really knowing what compliance looks like and ultimately, we're going to evolve this guide into more of a protocol. So, the site visit guide is actually gonna become a protocol that people will need to follow. So, when they go out on site, they'll have the 19 requirements and then, there'll be specific things that they need to look at to determine whether somebody is in, or out of, compliance. So, we really are making a number of steps to try to do that and make it better.

In terms of prioritizing, we try to hit everybody as best we can in the middle of their project period; in the middle of a 3-year project period is the ultimate

goal. But, we do prioritize, sometimes, those centers that are having difficulties or issues that have been brought to our attention—sometimes from you all, (noise) or sometimes from the press, or sometimes from other people—to go out and do those visits. So, if you have some concerns about it, or really think we should prioritize some, please contact us; contact your project officer to just encourage us to think about what do we do.

Now, one of the questions—

Tonya Bowers: Right.

Jim Macrae: relates to PCA participation—

Tonya Bowers: Yes.

Jim Macrae: and sort of differences of opinion, sometimes, can the PCA team, team attend? All those kind of questions, do you want to try to take that, Suma?

Suma Nair: Yeah, absolutely. So, I think that we continue to strongly encourage all health centers to invite their state PCA to be an observer as a part of the operational site visit. If the PCA can't attend the whole operational site visit, it's so helpful for them to be at that opening and closing session—so that they hear kind of what there is to begin with, and then what were the findings, or concerns, or just positive findings even at the end. So, if there is any questions about that, please know that we do encourage that; but it is ultimately up to the health center to invite, invite the PCA.

There was another question around our consistency, and Jim alluded to this, since March of 2014, we've undergone a, you know, quality improvement process with our site visits and even our consultant reviewer quality oversight

process. And so, we've made a lot of really great progress and changes, but that's really contingent upon the feedback that we get from grantees. And so, whatever you can do to encourage health centers to complete their OSV feedback forms, immediately following the site visit, that's going to be really helpful to us to have timely information and insightful feedback, so that we can continue to improve our process. Now, if something comes back, and we're starting to see a pattern or something isn't working out with a specific reviewer, we can start to deal with those in a more timely manner rather than waiting until the end of the year to, you know, identify all of these concerns. So, I think the progress that has been made to date has been based upon your feedback and health center feedback, and we're going to continue to need that, as we move forward, to really get to an ideal state.

Jim Macrae: Great; thanks, Suma. A few more questions, Tonya, and then we actually will open it up for other questions, but we're going to try to get through as many of these as we can.

Tonya Bowers: So, one of the questions, and it's an important one, is around any impact that we see based on differences in states with or without Medicaid expansion, so, the impact of that in terms of how we operate.

Jim Macrae: Yeah, there's been a lot of interest in potentially, you know, what do we do with respect to states that may do things differently and the impact on health centers; and we have, I think, always, and from where I sit, would like to continue not to make decisions based on what states are doing with respect to our program. I really do believe it's important not to, to do things just based on what's happening at the state level, per se, because number one, that can change. We've had circumstances where, you know, I think, we're talking primarily now about Medicaid, where either a state has expanded Medicaid significantly, and then made a decision to cut back or, in some cases, has

decided not to expand, but then decides to expand. If you make funding decisions based on that, then what do you do going forward as that, those things are changed? It would cause incredible disruption. So, what we attempt to do is not make decisions about funding, or different aspects of what we do, based on what states do; we do it more based on what the local health center's experiencing.

So, you know, a lot of what we've done with base adjustments, expanded services, look at the number of patients that are served, and then looking also at the number of uninsured patients, because even if you're in a state where you've expanded Medicaid, you still may be, as an organization, seeing a lot of uninsured patients. If you're in a state that maybe hasn't expanded Medicaid, there are circumstances where the health center is still not seeing a lot of uninsured patients even though that's the circumstance. So, we really have attempted to look at that, and sort of get at the impact of what states are doing based on what the actual reality is on the ground with the individual health center because we feel like that's the best way to approach the program. It also reflects, I think, the best data we have in terms of what's happening and it doesn't have us completely change things from year to year, or whatever in terms of what's going on with the state. Because what happens with the state, (sneeze in the background) as we know now, can actually be very different because of the marketplaces that are now having big, big impacts on health centers.

And, I think, that's one of the next questions, which relates to contracting, and any advice about that in terms of what are the requirements around contracting and different issues. And I'm going to start it, and then I'm going to turn it over to Jen to speak to a little bit of this. We have consciously, from where we have sat, stayed out of the contracting realm. We do provide guidance in terms of what people need to look at with respect to contracts. But, in terms of the

individual decisions, we believe that it's ultimately up to the health center, and their local board, and their CEO, to make those decisions about who they ultimately contract with. And we believe that's the best position to be in; because, while we've had some pressure from different folks for us to get involved, if we began to get involved number one, we would begin to own the decisions, which I don't think is appropriate, as a Federal entity because this isn't, per se, a Federal program. It really is community based. It does get Federal grants but number two, I'm not sure we would make the best decisions, and we ultimately want to leave that up to the board. Now, they need to make those decisions and ultimately live with the consequences of them which sometimes is challenging. But I do think ultimately, it's up to the health centers to make those decisions because again this is a community-based program. We are not the ones providing the care; the health centers are. And so, from where I sit I think, we can provide basic guidance, basic information; but to tell people who to individually contract with or who not to, I, I really, I don't believe that's our role. And we've had that confirmed in our conversations with our lawyers in terms of all of that. With respect to just the whole issue of contracting, network adequacy, the ECP list, Jen has been working, and will with this reorg, actually work to develop more capacity to work with CMS on some of these issues, but if you want to speak that just a little bit.

Jen Joseph:

Sure; you know, I, certainly, you have your opportunity to comment directly but also, you know we, we do have a relationship with CMS and have a limited capacity to engage with them on what we're hearing from you. And as we move forward in this new structure, we're very much expecting to enhance our capacity and to strengthen that relationship with CMS even more. That doesn't, that means that we have a voice that gets factored into what are obviously, a variety of competing priorities that they, they have to balance. But certainly, if the more we hear from you and the more feedback we get

from you, about what those issues are and what the impacts are on health centers in your states and across the country, the better positioned we are to speak to the, these issues and to respond to questions when asked, and to actually be at tables prospectively as this planning goes forward. So, encourage you, to the extent possible to, to share some of that real life and even story-based experience with us both directly, and also through these other opportunities that I mentioned. You know as, as ASPE's going out in the field, this is exactly the kind of thing that they're looking to capture from you (through interviews and actually going on site), and PCAs, and health centers. So, there are multiple places to bring these concerns, but to the extent that you want us to relay them, I would welcome the feedback and welcome additional feedback in terms of how we can maybe, more systematically, collect that feedback from you.

Jim Macrae: No, that's great; and I think that segues to really the last of the questions that we wanted to talk, and these are primarily, we're going to focus to Suma which relates to the reorg. Do you want to talk about that, in particular, where the new location is for PCAs, PCOs, and networks, and some of the vision around that? Do you want to just share what some of those questions were?

Tonya Bowers: Sure; some of the questions are related to how PCAs are going to, well where they fit within the reorganization and clarifications for them regarding that. Whether or not there's a different role for them in terms, going forward, in terms of looking at quality versus looking at (and Jim touched on this a little bit earlier) versus that focus on compliance; and then there's a couple more just related to the role of the, the project officers and their relationships with the PCAs, and also just the connection between the project officers working with health centers and their, their primary care associations in state, just sort of general questions.

Suma Nair: Sure; so, you know, we're really excited in the new structure to have the Strategic Partnerships Division that will bring all of our technical assistance partners together, to really have an aligned focused effort around our technical assistance with health centers. Part of that will include, under that division, includes our health center controlled networks, our national cooperative agreements, and our primary care associations; so, PCAs will be housed within these different partners. We also will have a very close connect to our technical assistance contracts that we have through our quality areas, as well as the MSCG contracts, that we use for our technical assistance site visits. So, the goal is, by bringing all of these different resources together, we can align them and make sure information is being shared across. The other nice part of being, well housed within the Office of Quality Improvement is that you'll be closely linked to the Data and Evaluation shop, so that we can be sure that our technical assistance efforts are really grounded in data and that we're focused on quality improvement.

You know, what it means for PCAs, we're slowly, we'll be working together to really leverage your strengths. As Jim mentioned, compliance is helpful and you've done a lot of work, but it may not be the natural fit with what the PCAs do best. Your focus is statewide—looking at the policy arenas, looking at convening people at a state level. We found great success in the PCMH arena; having primary care associations partner with national cooperative agreements, and with their individual health centers, to really have quick transformation in, in a very short period of time and, and really challenging transformation that we've been able to go. So, looking at that model, we feel that if we align all of our resources, and provide resources at each level on the ground, at the state level, and the national level, we can get a lot more traction in terms of quality improvement and transformation.

So, the goal is to have PCAs really focused more and more increasingly on both, in quality improvement broadly, both clinical and operational. Traditionally, we focused more on clinical quality improvement. We'd really like to open that up to think more broadly about the operational quality improvement elements as well, because we all know what's so important in terms of helping health centers be successful—it's not only the clinical part, but it's also the operational effectiveness of the organization. They go hand in hand to get the best outcome for the health center and the patients.

So, we're excited about this opportunity that there'll be more linkages and stronger relationships between our national cooperative agreements (who are subject matter experts, content developers, policy experts in their respective domains) to work hand in hand with the primary care associations to be the folks who then, take that national information, tailor it to the state level, and then implement it; and work on a more routine basis with the health centers in their state to really develop improvement; and then also partnering with the health center controlled networks in the areas that they're most effective in (systems, technology, data), to have everyone work together to get to improvement. So, we think that, that will be really good; so we're broadening the expectation of the, our definition around quality be both clinical and operational. And we think by bringing all of these partners together, we've already seen a couple of areas where this has been successful. And we're hoping to extend it beyond PCMH, to all of the other quality improvement areas that we're focused on. I think that, and I know we're running out of time, but that hits it very broadly in terms of the benefits of having all of these folks together.

There was a subsequent question around special populations and helping them with certain quality improvement activities, and I think, this kind of connects with it. By having all of our technical assistance partners together, including

those focusing on our special populations, and with our senior advisors for special population health, we're going to be able to elevate those issues, and make sure that we're taking into consideration of their issues and the special types of nuances or technical assistance that individuals may need, and making sure that we're building that in as well. I think, in addition to aligning and strengthening our technical assistance, by bringing everyone together, we're able to elevate the policy issues in a way that we haven't been able to do before.

There was a question around project officers. Currently, we have more than 40 project officers who are serving as project officers for primary care associations; so, they have both PCAs, as well as health centers, in their portfolio. And so, by bringing these 40, into, you know, 5 or 6, project officers that serve all PCAs, we feel that we'll be able to elevate the policy issues, and then, as Jen was mentioning, bring them to the table to CMS, or ONC, or other folks to get some traction around those more quickly. So, we think it'll strengthen not only our TA, but the policy feedback that you all are able to produce; and we'll have greater outcomes in those arenas as well.

Jim Macrae: No, that's great Suma; and I think we see the real possibility, and opportunity with all of this, but again, throughout all of this, we definitely want your feedback. We know we've taken a lot of time today to actually answer questions, and we haven't opened it up for questions; so, we apologize for that, but hopefully, we've been able to address a number of the questions that have been on your mind in terms of just what we're doing.

We are continuing with our reorg plan. We do anticipate it becoming live, sometime in late February, early March, in terms of this real restructuring, and, I think, throughout the whole process, we want to continue to work with you to continue to move forward.

One of the areas we definitely want to work with you all on, it's one of the questions we weren't able to get to, but I really think it makes sense not to get to yet, is—what is our strategy around struggling health centers? How do we go about working with them, supporting them, both from where we sit, from where you sit, and really, what should we be doing going forward? Because it is an issue and, I think, with health care reform it, and you all have heard me say it, it has definitely put a spotlight, and sort of a heat lamp, on health centers across the country. I think, to be honest, it's put a heat lamp on all of us. So, if you weren't maybe doing so well before, it's gonna make it worse. If you're doing great, boy, you can really rise to the occasion and even do greater things. But, it definitely has put a spotlight on, and—

Tracey Orloff: What?

Jim Macrae: something of a heat lamp, on us all, in terms of what's going on, so that's clearly something we want to do.

The last question we weren't able to get to is actually related to the VA, which we're so glad to have Gina and Lelia be a part of that.

But before we jump to them, I actually want to turn it over to Marquita Cullom-Stott, who's our Acting Director of the Office of National Assistance and Special Pops, to tell you about a couple of things that we know are of most interest to you all. One is, one of (noise) these opportunities to get health centers together to work together to improve, and one of them deals with operational site visits and actually for PCAs. So, Marquita, I'll turn it over to you, and then we'll turn it over to Gina; and thanks, again, everybody for participating today.

Marquita Cullom-Stott: Thank you, Jim. Good afternoon, everybody. To start, I'd like to highlight some collaborations. We have a few, new peer learning teams that I wanted to note. We have a new, small rural health community health centers peer-to-peer learning team, which was established just in November; and the, this peer-to-peer learning team is to address the unique challenges facing rural and underserved communities. It's really an opportunity for health centers to support each other, learn from each other, and share information. But, we're very excited about the establishment of this particular peer-to-peer learning team.

In addition to that, there's a national cooperative agreement peer learning team, the NCA peer learning team just recently hosted a face-to-face meeting here in our area; and a major focus of that meeting was to explore how NCAs can continue to work individually, as well as collectively, in providing a data-driven, cutting edge, and cost efficient training and technical assistance to health centers.

In terms of upcoming activities that we have, you know, you've heard a lot about the PCA site visit protocol, and so I wanted to provide you an update on that. Over the next several months, BPHC will be pilot testing the new PCA site visit protocol and we're going to be working with a small cohort of PCAs. The results of this pilot will help to shape how, how we'll conduct the site visits for the PCAs in the future. Because this is in the pilot stage, you know, we're still working through it; there'll be more to come on that.

Another item that I wanted to highlight is the Bureau of Primary Health Care special and vulnerable population's yearlong enrichment series. The enrichment series that we have been having was well received; and we're going to continue to have the enrichment series and expand it through 2015. We will be hosting the upcoming enrichment webinars that will consist of a

‘Governance Series: Understanding Board and CEO Roles and Responsibilities;’ and that actually is gonna be scheduled for January the 22nd, from 1 to 2:30, if you were not aware of when it was gonna be. And then, ‘Expanding Service Delivery Through the National Health Service Corps’ will, will be on February 3rd, 2015, that’s going to be from 1:30 to 3 p.m. Eastern Time as well. Again, these are opportunities that we’re taking to highlight our collaboration and coordinated efforts. We’ll be launching a series on improving quality health care access for migrant and seasonal agricultural workers and their family members; and that’s actually gonna be scheduled for some time in February.

And then lastly, I just wanted to remind everyone that on December the 8th, BPHC released the 2014 Workforce Recruitment Survey; and the survey is still out and it’s still, you’re still able to have health, encourage health centers to complete the survey. But, it’s a very brief, five-question survey; and it’s really out to update us on health centers’ hiring efforts and the efforts we’re looking at is since October 27. The data collection will enable us to provide training and technical assistance to support health centers and efforts to recruit and retain both civilians and veterans. And the survey is voluntary, but we really encourage all health centers to participate; so, if you are, have an opportunity to encourage we would, we would like to, for you to do that. (5-second silence) So, those are the updates that I have.

So, at this time, I’m going to transition to Gina Capra. As Jim mentioned, Gina is from Department of Veterans Affairs; and she’s going to be talking to us about Veterans Choice Program.

Gina Capra: Marquita, thank you so much. Good afternoon and good morning, everyone. To colleagues at the Bureau of Primary Health Care, and to cooperative agreement colleagues (faint music in the background) around the country, it’s

a pleasure to have this opportunity to speak with you. It's been about a year and a half, (faint music in the background) as I transitioned over to VA; and I'm currently the Director of the Office of Rural Health.

And so, it's with vigor and verve, I think that's the theme today, that I'm, I'm pleased to walk through with everyone an exciting new opportunity that VA now has to engage with community health centers and other Medicare providers across the country, as a result of some landmark legislation that was passed in August of 2014. I do want to mention, before we get started, that I'm joined by my colleague, Lelia Jackson, who's the Acting Director of VA's Office of Community Engagement. Lelia and I work within the Veterans Health Administration and are part of this new engagement effort with non-VA community providers across the country.

You may be aware, based on the 2013 UDS data, that approximately 85% of community health centers report serving veterans. This is according to the demographic data that's available; and it appears that rural community health centers, in particular, appear to be serving the highest percentage of veterans. And so, we know that many community health centers, with the support of primary care associations across the country, have pursued relationships with the VA over time; and we know that these relationships have ranged from 'not very successful' to 'very successful.' And so, we're encouraging all community health centers and primary care associations to feel reinvigorated with attempting to work with the VA before. I think there's a new attitude and a new atmosphere here in which VA is putting its best foot forward to expand access to care in collaboration with community providers.

Did you know that there are 22 million veterans in the United States today? And of those 22 million, about 24% are from rural communities; and so, there really is an emphasis now, to look at how we can ensure consistent, high

quality access to care for all veterans. Of the 22 million veterans in the United States, about 40% of them are enrolled in the VA's health care system, or 9 million. And the VA health care system has gotten a lot of attention this last year, due to some unfortunate, unfortunate findings about delayed entry to care. And we know that you can relate to this, when we think about service capacity and the ability to accommodate patients most in need.

And so, back in August, Congress passed the Veterans Accountability Choice and Access Act, and we call it the Choice Act for short. In a lot of ways, it's reminiscent of when ACA came down for HHS. The VA has an amazing opportunity through, specifically, this temporary program again, called the Veterans Choice Program. This provides veterans the ability to receive medical care within their own community under two circumstances. One, that the VA in which they're already enrolled cannot schedule an appointment within 30 days for that veteran, or, if that veteran resides more than 40 miles from the closest VA medical facility. So, the Choice Program, when it was authorized, (sneeze in background) it provided with it \$10 billion for what's called 'temporary emergency care'; and so, this program is considered temporary, and will supposedly expire no later than August 7th, 2017. And so, we really want to maximize the available benefits under it, while it is in existence, and with an eye to how this shapes the future of health care delivery and collaboration between the VA and community providers for years to come.

So, what veterans received these Choice Program cards? It's not all 22 million veterans in the United States. And as a matter of fact, it didn't even start with all 9 million of our enrolled veterans in the United States. The first group of veterans who received a Choice Program card are those that we call the 40+ mile group; and in the first week of November, veterans who live more than 40 miles from a VA medical facility received their Choice card. The next

group, or second group, of Choice card recipients were mailed out the week of November 17th, to those veterans who are located in specific service areas or markets who are waiting for a VA appointment longer than 30 days. And so, this was our second cohort focused on, again, these highly congested areas where the local VA medical center could not accommodate appointments for care in a timely manner. And then the third, and final, group actually are all the other remaining veterans enrolled in the health care system here at VA. And the reason for that is that Congress wanted to be sure that if that veteran moves on to another geographic area for their residence, or a service area where that, that market might be crunched for primary care access that, that veteran can then activate their card, if you will, to see a community provider. So, that's a little bit of the background of the Veterans Choice Program.

So, how is VA implementing the Choice Program? Well, you may have heard that VA is utilizing two, third-party administrators to implement the Choice Program. And it did this because we had about 90 days to stand up this program; and so, VA looked at its existing relationships, specifically, existing contracts with two organizations—one, Health Net Federal Services and two, TriWest Healthcare Alliance (paper rustling in the background). Existing contracts that VA had with those two organizations were modified to allow them to serve as the third-party administrators for the Choice Program.

These two third-party administrators were already in place in administering what the VA called, Patient-Centered Community Care contracts; I'll be referring to that as PC3, for short, for the remainder of this presentation, and PC3 (alert sound in the background) is a VA, nationwide program. Again, it was established in 2013, prior to the passage of the August Veterans Choice Program; and it provides (it being PC3), provides eligible veterans access to certain medical care when the closest, or most local, VA medical facility (cough in the background) cannot readily provide that care, whether due to

lack of specialists, long wait times, geographic inaccessibility, or other factors. And this PC3 vehicle had been the VA's preferred method of purchasing care in the community. So, it was this vehicle that was expanded to include primary care, again, prior to Veterans Choice. And then, when Veterans Choice hit in August of 2014, these third-party administrators agreed to develop what we've called 'provider agreement, agreements.' And overall, these provider agreements between the third-party administrator and the community provider group (it could be a community health center, it could be a solo doctor in a rural area), overall, this agreement is intended to provide veterans more flexibility in their choice to receive care in the community or through the VA.

Now, we already know that many veterans are dually receiving care. They're receiving care from their VA specialists, or from their VA primary care doc, or from the VA pharmacy. But, we also know that many are receiving care from community providers—whether it's a community health center, a solo practice doc, a Medicare provider. And so, I think, what the Choice Program does is, it really pushes for better care coordination and collaboration in a way that didn't exist before; and it also cuts down some of the challenging contracting requirements that also previously existed, let's say through a contracted community-based outpatient clinic, which some community health centers have administered on behalf of the VA for many years. So, this really reflects a new opportunity for engagement.

You may be wondering—what services are covered under the Choice Program? So, let me run through that quickly. For medical care, I wanna note that pre-authorization is required for every episode of medical care covered under the Choice Program. The authorization lasts for 60 days from the date of the first appointment with the provider. Emergency care is not covered under the Choice Program, although VA can make payment or reimbursement

for non-VA emergency care through other mechanisms that have always been in place here at the VA.

With regards to clinical information, it's these third-party administrators, (Health Net or TriWest) that will provide the veteran's clinical information to the community provider when that appointment is set with the veteran. And then after the veteran's visit is completed, the community (rustling noise in the background) provider submits their clinical documentation back to the third-party administrator; and they'll be the ones responsible for integrating that back into the VA health care system. (rustling noise in the background)

As for pharmacy benefits or prescriptions, prescriptions written under the Choice Program must adhere to the VA national formulary, which is pretty comprehensive. And it's important to note that, at this time, all, non-urgent prescriptions must be filled by the VA; and I know this has been something that's been raised as a bit of a challenge. So many of our community health centers have robust pharmacy programs right in the community where the veteran lives; and so, I think, this is an item that'll be, continued to be raised, however, under the parameters of the Choice Program, non-urgent prescriptions must be filled by the VA. Urgent prescriptions can be filled by a local non-VA pharmacy for up to a 14-day supply.

So, what's required of community providers interested in joining what I'll call 'the VA network'? Well, first if you, if a CHC has already signed up as part of PC3 over the last couple of years, they're automatically eligible to participate in the Choice Program. They're there with TriWest or Health Net. They've agreed to a reimbursement rate and so, essentially, they're all set. However, if a provider is interested in joining, specifically, the Choice Program, they can establish a provider agreement with the third-party administrator. The providers will be paid by the third-party administrator, who's paid by the VA;

and for the Choice Program, there's an important nuance to note—payment for medical care and services will generally be made at the applicable medical rate. However, it is possible to negotiate a rate that is more than Medicare for highly rural areas; and for federally qualified health centers, there is reimbursement up to the Medicare PPS rate. That's a distinction from PC3, in which the reimbursement rate is often less than that. So, these are important questions that health centers should be asking the third-party administrator if they want to engage.

And I would like to say, additionally that, you know, despite all these details that we're talking about here, there are Federal resources set aside for veterans already enrolled at the VA health care system. So, if a community health center is using their section 330 grants to subsidize the care for a veteran, who already has Federal resources set aside for them in the VA, I can see there being some real benefit worth considering, from a financial perspective, for health centers who may want to engage in this financial arrangement with the VA. Perhaps, it will allow some additional resource room as they think about their section 330 rate.

So, that's a little bit about the Veterans Choice Program. I'm going to ask Lelia Jackson, again, from the Office of Community Engagement, to tell you a little bit more, but before I do, I would invite anyone to be in touch with me at Gina.Capra@va.gov . Lelia?

Lelia Jackson: Good afternoon. I would just like to share with you how a community provider can find more, find out more information about the Veterans Choice Program. There's a couple easy ways. One, you can call our VA Choice Program Call Center; the number is 866-606-8198, again that's 866-606-8198.

But we've also, our office has created a fact sheet that we hope will be helpful for community health centers who are interested in joining the, signing up for the Veterans Choice Program. We specifically tailored it to, with questions that would be unique to health centers with a, and so that fact sheet has been shared with Stephanie and she's going to make it accessible through your portal, and you can also email Gina Capra (paper rustling in the background); and Gina will be happy to share it with you as well. And so, that is a very important point that we wanted to make with you, and to share with you the, the Health Net Web address. It'll have the, also TriWest information. It'll have the email addresses, the websites, key information that Gina pointed out earlier. And then, just, so that, that was the main thing I wanted to share was about our fact sheet and how to contact our VA Choice Program Call Center.

And we definitely, wanna leave time for questions and answers, but I wanted to just make a point to thank you so much, to the Bureau of Primary Health Care and all of you who participated on this call, and for all of your long standing service to our nation's veterans who live right in your communities. We really appreciate your service to our veterans; and we'd like to ask you to consider partnering with us as we care for our nation's veterans. Thank you so much.

Stephanie Crist: Wonderful; thank you, Gina. Thank you, Lelia. This is Stephanie from the Bureau of Primary Health Care. So, in the interest of time, at this point, we're going to close out the call. Thank you to everyone for listening today; and as Lelia and Gina had said before, there'll be an opportunity for you all to have one of their resources describing the program. So, that's all for today; thank you, again, everyone, and we'll see you for the next cooperative agreement quarterly call. Take care.

Coordinator: Thank you for joining. This concludes the conference call; all participants may disconnect at this time.

END