May 28, 2025

Department of Health Care Services

1501 Capitol Avenue

Sacramento, CA 95814

Re: PAHCA-SAC Input on Proposition 35 Fund Allocation

Dear Lindy Harrington,

Thank you for the opportunity to provide comments in my role as a member of the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC). I am writing on behalf of dental providers to express strong opposition to the proposal to divert a significant portion of Proposition 35 funding to backfill the state's Medi-Cal budget deficit.

Proposition 35, as approved by California voters, was designed with a clear and explicit mandate: to increase provider reimbursement rates and improve access to care—especially for underserved and low-income communities. The Department's proposal, as outlined during the May 19th meeting, to redirect $2 billion this year and next to support the non-federal share of Medi-Cal rates, is not only inconsistent with that mandate but fundamentally undermines the will of the voters.

Using Prop 35 funds to cover general budget shortfalls sets a dangerous precedent that opens the door for future reallocation of voter-approved funds based on administrative convenience rather than legislative or public accountability. Moreover, this move raises serious legal and ethical concerns regarding the misuse of restricted funds and may invite judicial scrutiny.

From the dental provider perspective, the consequences of this diversion are significant. Dental practices, many of which operate on thin margins while serving a high volume of Medi-Cal patients, depend on the rate increases promised through Prop 35 to maintain operations and expand services. Undermining this funding threatens patient access to timely and essential oral health care—particularly for children, seniors, and individuals in rural and underserved communities.

Furthermore, the uncertainty surrounding future dental rate increases, particularly those expected in 2027, creates instability for providers and disincentivizes participation in Medi-Cal at a time when we should be strengthening our provider network.

I strongly urge the Department and Advisory Committee to honor the intent of Proposition 35 and reject any proposal that diverts its funds away from their original purpose. We must uphold the integrity of voter-approved initiatives and prioritize access to care for California's most vulnerable residents.

Thank you for your thoughtful consideration of these comments. Please feel free to contact me at aterlet@aol.com or (510) 207-1471 if you have any questions or would like to discuss these concerns further.

Sincerely,

Dr. Ariane Terlet, DDS

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May 30, 2025

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Submitted electronically via: dhcspahca@dhcs.ca.gov

RE: PAHCA-SAC - DHCS Proposition 35 Spending Plan – 2025 & 2026

Dear Ms. Harrington:

On behalf of our 750,000 members and their families, **Service Employees International Union (SEIU) California** writes today in response to the DHCS Proposition 35 Spending Plan Overview published on May 14, 2025 and discussed in the PAHCA-SAC meeting held on May 19, 2025. Given these comments are being submitted as the Legislature and advocates react to the May Revision, it is impossible to separate this body of work from broader conversations and their clear implications to Medi-Cal enrollees and the workforce at the heart of their care.

As the May Revision and FY 25-26 California budget deliberations reminds us, even absent the federal actions that threaten California's Medi-Cal funding, revenue shortfalls and public funding instabilities from within make it more important than ever that we are making sure that there is financial transparency and public accountability for every public dollar—including these new funds. In this environment, it is also critically important that we get it right. **As we look across all domains and spending plan buckets, DHCS must seek opportunities to prioritize patient care and improve working conditions for frontline health care workers.**

In the comments below, we offer specific comments to the proposed spending plan, including Services and Supports for Primary Care; Graduate Medical Education; and Medi-Cal Workforce domains as well as PACHA-SAC process feedback.

SPENDING PLAN REACTION

SERVICES AND SUPPORTS FOR PRIMARY CARE ($50M)

SEIU CA is opposed to utilizing $50M in proposition funding annually (CY 2025 and CY 2026) to support the growth and expansion of the Community Clinic Directed Payment CCDP) program as presented.[1] As noted in our prior April 29, 2025 letter to DHCS, this bucket affords DHCS greater flexibility than this proposal suggests and presents an opportunity to create deep, publicly accountable, investments in quality care. These funds must be utilized to recenter care on the mission of clinics, a commitment to their patients and their workforce. These funds, regardless of the final mechanism of distribution, must have a significant and enforceable transparency and accountability mechanism that ensures enhanced funding is being reinvested in patient care and support services, something that the current CCDP is wholly lacking. Further, we must guarantee that the methodology ensures that funds do not go to clinics that mistreat health care workers and fail to put patients first.

Today's CCDP Falls Short and Must Recommit to Patients and Workforce

As noted previously, the predecessor program on which the CCDP is built (non-hospital clinic 340B supplemental payment program)[2] failed to publicly demonstrate a reinvestment in care coordination, and other patient care needs. Targeting 90% of funding based on highest utilization is no longer appropriate. A lone quality metric of simply seeing an assigned patient is not sufficient either. **For CCDP to be considered as a framework for this funding, at least 90% of funds must be committed to the core mission of clinics to guarantee funds are used for quality improvement, workforce stability, or patient access—priority areas for SEIU CA.**

If DHCS moves forward with the Community Clinic Directed Payment program expansion, it must be transformed so that payments are quality performance based,

[1] DHCS PAHCA-SAC Meeting Slides (04-14-25) 04-14-25 PAHCA-SAC Meeting Deck

[2] SPA 21-0015 Public Notice
https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0015-Public-Notice.pdf

similar to the Skilled Nursing Facility Workforce and Quality Incentive Payment Program.[3] It is imperative that quality measures include workforce and equity measures, not just clinical process metrics. Additionally, it is important that workforce measures are weighted at least equally to clinical measures as, without a commitment to workforce, one can not achieve the high standards of care our Medi-Cal population deserves.

Examples of quality metrics to consider include, but are not limited to:

- Workforce centric measures:
    - Percent of staff retention
    - Staffing metrics
    - Participation in a labor management committee
    - Providing enhanced wages and benefits
    - Providing training and workforce development opportunities above minimum credentialing/licensing requirements
    - Participation in high road training partnership or training trust fund
- Clinical measures:
    - Including care coordination, access to care, prevention, chronic care, etc. Clinical measures can be based on those used in the FQHC APM program[4] or other reported measures to HRSA[5] or other agencies.
- Equity measures:
    - Medi-Cal disproportionate share
    - Medi-Cal special or historic populations served, including commitment to UIS population
    - Racial, ethnic, income, and language data completeness
- Mission Spend Measure
    - Annual spending of 90% of total revenue on patient care and support services. Using HCAI AUR or IRS 990 forms to calculate, DHCS can determine and incentivize mission focused spending.

Requirement on How New Dollars are Spent

Furthermore, it is important that clinics are required to spend at least 90% of any new Proposition 35 funding, including potential directed payment funding, on patient care

[3] DHCS SNF WQIP website: https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx
[4] https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-Program-Guide.pdf
[5] HRSA Uniform Data System Clinical Quality Measures for 2024: https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-clinical-measures-handout.pdf

and support services, not administrative and management expenses or profits. Clinics must publicly report how they spend new Proposition 35 funding to ensure they comply with the 90% spending requirement.

Increased Public Transparency

Additionally, we can not endorse any funding methodology absent clear transparency and accountability. SEIU CA not only called for transparency upon the creation of the predecessor supplemental payment program, but has continued to call for greater transparency for non-profit, community clinics in other ways too (ex. SB 779[6] and AB1113).[7] As Congress threatens cuts to Medicaid funding,[8] and as other proposed state Medi-Cal changes, could lead to significant changes to provider funding, we must be even more vigilant with how limited public dollars are spent. This need for vigilance is not without reason. Recent actions of certain clinic CEOs and executives are irresponsibly spending precious clinic resources on unrelated expenditures.[9] Several community clinics have been mired in scandals over allegations of false reporting and fraudulent claims,[10] [11] [12] [13] and across the state, many clinic workers report chronic understaffing, high workloads, staffing turnover, and long wait times for patients.[14] These conditions only add to our trepidation to see new funds move without better systems in place.

If the CCDP proposal moves forward, DHCS must publicly post the performance of all eligible clinics on each metric and detail the directed payment amount that each clinic receives per patient visit along with the total amount received from all managed

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[6] Bill Text - SB-779 Primary Care Clinic Data Modernization Act. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB779

[7] Bill Text - AB-1113 Federally qualified health centers: mission spend ratio.

[8] Putting $880 Billion in Potential Federal Medicaid Cuts in Context of State Budgets and Coverage | KFF

[9] LM-10 report shows $577,145 in payments from Innercare to East Coast Labor Relations during June and July 2024 https://olmsapps.dol.gov/query/orgReport.do?rptId=901371&rptForm=LM10Form

[10] Clinica Sierra Vista - OAG Press Release, February 2, 2023, "Attorney General Bonta and U.S. Attorney Talbert Announce a Nearly $26 Million Settlement with Medical Provider in the Central Valley"

[11] Borrego Health, which is now part of DAP Health, San Diego Union Tribune, August 2, 2023, To resolve $110 million in Borrego Health debt, state regulators agree to accept $20 million

[12] Community Health Centers of Central Coast -US Attorney's Office, Central District of California, Press Release, June 29, 2023 Central Coast County Organized Health System, Three Health Care Providers Agree to Pay $68M for Alleged False Claims to Medi-Cal

[13] Clínicas del Camino Real - OAG Press Release, August 18, 2022. Attorney General Bonta, U.S. Department of Justice Secure $70.7 Million in Settlements Against a Southern California County Organized Health System and Three Healthcare Providers for Violations of the False Claims Act

[14] SEIU Community Clinic Workers United (CCWU) interviews with workers.

care plans for each calendar year. By having accountability mechanisms such as minimum spending requirements and reporting, it will help encourage low quality performers to use this funding to help improve their quality performance, and that other clinics maintain or improve their quality performance.

Additionally, having oversight on how these dollars are spent is important since, according to IRS 990 filings and other public documents, there are clear and troubling signs that several clinics are spending a significant amount of their revenue on non-program related expenses, from excessive overhead costs and executive compensation, to retaining large profit amounts. The top 10 highest paid community clinic executives were paid a collective $12.9 million in 2023.[15] The highest paid executive that year was paid more than $2.77 million in compensation[16] and the second highest was paid more than $1.9 million.[17] Some clinics claim to be financially struggling, yet clinics statewide had a net worth of $7.5 billion, according to submitted IRS 990 forms.[18] With public dollars on the verge of becoming more scarce, DHCS must ensure that any additional resources given to clinics are dedicated to patient care, not profits.

Expanding eligibility pool for Services and Supports for Primary Care funding
We appreciate DHCS' request at the May 19, 2025 meeting for feedback on which entities should be eligible for these funds. We continue to believe that DHCS is more narrowly defining the eligible entities for this bucket as a whole. Consistent with this, we are open to this bucket being eligible to entities beyond those that participate in the 340B program. That being said, under no circumstances can Proposition 35 funding go to clinics that receive any citations or administrative penalties from CDPH through the Community Clinic Directed Payment Program funds or for any other funding mechanism utilized. Data from the State Enforcement Actions Dashboard can be utilized to determine disqualification.[19] Additionally, DHCS must consider recent labor

[15] SEIU analysis of non-tribal FQHC and FQHC Look-Alike clinics submitted IRS 990 forms, Schedule J, with fiscal year end dates in 2023.
[16]Community Health Centers of the Central Coast Inc submitted IRS 990 form, Schedule J, access at: https://projects.propublica.org/nonprofits/organizations/953253302/202421349349306462/full
[17] Altamed Health Services Corp submitted IRS 990 form, Schedule J, accessed at: https://projects.propublica.org/nonprofits/organizations/952810095/202403209349325780/full
[18] SEIU analysis of non-tribal FQHC and FQHC Look-Alike clinics submitted IRS 990 forms with fiscal year end dates in 2023. This is a sum of net assets.
[19] CDPH State Enforcement Dashboard can be accessed at: *https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/StateEnforcementActionsDashboard.aspx*

violations, wage violations, and other ongoing disputes that indicated an entity might not be meeting the high standards we expect of our Medi-cal providers before allocating funding. Sadly, in recent years, certain clinics have had to pay multi-million dollar settlements related to allegations of labor violations. These settlements include class action lawsuits alleging wage theft and failure to provide meal and rest breaks.[20] [21] [22] These violations can not be ignored.

PRIMARY CARE AND SPECIALTY CARE SERVICE PAYMENTS AND FQHCs

We are aware that some clinic industry representatives have requested that additional Proposition 35 service payments be directed towards them in CY 2025 and CY 2026 through Managed Care uniform dollar increase (UDI) SDPs. We appreciate, and agree with, DHCS in their proposal not to make FQHCs/RHCs eligible for the UDI, as they are reimbursed under a Prospective Payment System per-visit reimbursement model. As DHCS note in their May 19, 2025 presentation, unlike other providers, FQHCs and RHCs receive annual cost-of-living increases under state and federal law.

GRADUATE MEDICAL EDUCATION ($75M)

SEIU CA is in agreement with the proposed allocation of $75 million annually (CY 2025 and CY 2026) to expand graduate medical education. As shared in our prior letter, regrettably, the very same hospital and health systems at greatest risk of being financially destabilized by threatened federal funding actions are also the site of much of California's physician training. For these reasons, SEIU encourages continued investment in, and the stabilization and expansion of, current programs over investments in new program sites. Through the CalMed Force program, the University of California is well-positioned with experience to provide funding to GME programs, and **we are supportive of Proposition 35 funding being distributed in a similar fashion to increase the number of primary care and specialty care physicians training in California.**

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[20] Bay Area Community Health (BACH) and Foothill Community Health, which merged into BACH (Alameda and Santa Clara Counties), agreed to pay at least $4.85 million in 2022 to settle a lawsuit alleging several claims, including unpaid minimum wages and overtime . See the case files here: https://drive.google.com/drive/folders/1Pfs5M0QJmUmy5KB1i67yXuZyX39tgzVm

[21] El Proyecto Del Barrio (Los Angeles County) settled a lawsuit for $2,150,000 in 2022 over allegations of wage and hour violations https://drive.google.com/file/d/1kPN47bgDPfmZXS76EGu6XhkSpvn-V0oD/view?usp=drive_link

[22] In October 2023, Innercare (Imperial and Riverside Counties) agreed to pay $1.78 million to settle allegations including failure to pay all overtime and minimum wages, failure to provide meal and rest periods, failure to provide timely wages, and failing to reimburse business expenses https://www.cptgroupcaseinfo.com/GarciaClinicasDeLaSalud/ClinicasDeLaSaludDelPueblo_ClassNotice(v1).pdf

WORKFORCE ($75M)

SEIU CA is deeply supportive of the $75 million annual investments to Medi-Cal Workforce in CY 2025 and CY 2026. As stated in our prior letter, once established, the Medi-Cal Workforce Pool has the potential to further address the pipeline, recruitment, and retention challenges plaguing California's health care delivery system. **This funding should be solely utilized for industry-led partnerships through Labor Management Cooperation Committees, like the SEIU Clinic LMCC, that lift the quality of care through shared strategies that meet the unique workforce needs of the health care sector.** This funding builds from strategic investments made by the State of California since 2020 through Labor Management Workforce High Road Training Partnerships (HRTP) in Healthcare. These initial HRTP investments have delivered measurable results, such as increased earnings for training participants and critical roles filled in nursing, behavioral and community health among other essential allied health positions.[23] Importantly, the HRTP health care programs have resulted in partnerships between employers, unions, the State and community colleges that have been extended to reach the state's health care industry more broadly, with recent HRTP expansions to county and community health center sectors which serve a large share of California's Medi-Cal population.[24] The Medi-Cal Workforce Pool, implemented as intended, will provide a reliable source of funding that can help further expand this successful HRTP approach through HCAI as the coordinating agency for State investments in the health care workforce. Fully implementing this allocation will provide essential funding to help meet the needs of our most underserved communities, provide training that lead to high quality jobs and career advancement, while building a talent pipeline for critically important health care roles.

PAHCA-SAC PROCESS RECOMMENDATION

We appreciate the difficult balance DHCS must find as they seek to drive forward Proposition 35 implementation while balancing a challenging federal regulatory environment, congressional reconciliation actions, and a state budget environment that has placed drastic Medi-Cal changes on the table. However, that work does not

[23] The Education Fund Annual Report: https://theedfund.org/the-education-fund-annual-report/; UCLA Labor Center, The Road to Economic Prosperity: https://labor.ucla.edu/wp-content/uploads/2021/05/Eval_FINAL-REPORT-2.pdf

[24] California Workforce Development Board, High Road Training Partnership awarded projects: https://cwdb.ca.gov/initiatives/high-road-training-partnerships/#hrtpprojects

preclude the need for a robust and transparent public process. It has come to our attention that not all comment letters relevant to this committee's work and to the implementation of Proposition 35 are being made public through the committee's website. In keeping with the Bagley-Keene Open Meeting Act Requirements, this committee must operate with transparency and accountability, including with regards to public comment. To allow stakeholders and committee members to fully engage in the process, all stakeholder letters regarding Proposition 35 implementation should be provided to members of the committee and made public on the committee's website.

In conclusion, as we review fixed spending allocations for CY 2025 and CY 2026, the specific payment methodologies matter. Those chosen today will not only influence how funding moves during a critical two year period that may be marked by deep federal Medicaid destabilization, but will lay the groundwork for how specific, percentage-driven structures move in CY 2027 and beyond. We hope this feedback, once implemented, further guarantees that new funding best supports DHCS' aim to design federally approvable payment proposals that advance the Medi-Cal program's goals for quality, access, and fiscal sustainability. We appreciate your thoughtful review of the feedback we offer today and your continued engagement with us as we, together, commit to strengthening Medi-Cal, improving access to care, and supporting the providers who serve more than 14 million Californians. If you have any questions, or would like to dialog further, on any of the matters contained within this letter, please do not hesitate to contact Beth Malinowski at bmalinowski@seiucal.org.

Sincerely,

Beth Malinowski
Government Relations Advocate
SEIU California

CC: Rafael Davtian, Deputy Director, Health Care Financing, DHCS
Alek Klimek, Assistant Deputy Director, Health Care Financing Department, DHCS

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May 30, 2025

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SUBJECT: Written Input re: the May 19, 2025, PAHCA-SAC Meeting and Materials

Dear Directors Harrington and Davtian,

I appreciate the opportunity to provide input on Proposition 35 (Prop 35) in response to the presentations and discussions and meeting materials that were presented at the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC) meeting held on May 19, 2025. I first want to express my appreciation for the work of the California Department of Health Care Services (DHCS) and the men and women who work as appointed leaders as well those who are career staff. Their passion for serving California's most vulnerable communities is evident every day.

Primary and Specialty Care Rates

As a long-standing agency, DHCS has inherited what could be termed as bureaucratic silos that at times impede the partnership role that DHCS could and should play with its health plans, hospitals, physicians and other providers.

For example, in the past twenty years DHCS has been faced with cyclical funding challenges and each time it reacts with the power of the payer with limited engagement of those affected:

1. Without much discourse, over the past 20 years DHCS has historically underpaid independent primary care and specialty care physicians, resulting in California consistently near the bottom (48th) among states in terms of physicians reimbursement rates, particularly for treating Medi-Cal patients. This low reimbursement has been a long-standing issue, with physicians frequently citing it as a barrier to participating in the program. This results in limited access to care for Medi-Cal beneficiaries. It not only affects the patients' wellbeing, but it leads to avoidable emergency room visits, hospitalizations, and expensive treatments.

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2. Despite that, in 2011 the DHCS cut physician pay by another 10% without meaningful engagement of physicians. Fortunately, many Medi-Cal health plans absorbed the 10% cut rather than risk losing physicians from their network.
3. When the Affordable Care Act was implemented, there was a provision to increase Medi-Cal payment for primary care physicians to 100% of Medicare for two years. DHCS was delayed in its implementation and eligible physicians were faced with a confusing response as to who among health plans, Independent Practice Associations (aka IPAs), or Management Services Organizations (MSOs) would be responsible for payment. To this day, many primary care physicians have said they never got paid the additional money.
4. Similarly, the implementation of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) was equally disruptive despite physician efforts to use the lessons of the past to improve the payment process. This caused many physicians to spend time and money chasing payments they were entitled to, and it led many of them threaten lawsuits in order to get paid. Recently, many physicians have said they have not been paid what they were due under Proposition 56.
5. Currently, we are facing similar challenges and uncertainty in the implementation of the MCO Tax pursuant to the Protect Access to Health Care Act of 2024 (PAHCA). While there have been global discussions between DHCS and the provider trade groups, there has been very little clarity as to when and how dollars will find their way to the providers who earned that payment. Even the flow of funding to the health plans and how that gets translated by IPAs and MSOs is not widely understood by physicians.
6. The electorate overwhelmingly approved Proposition 35 and we must be diligent in our duty to follow the will of the people.
7. Other institutionalized policies affect health plans and hospitals as well. For example, each year, health plans and pharmacies are wary of unilateral “clawbacks” in payments from DHCS which may have a ripple effect on other providers.
8. Many providers in service delivery are of the impression that Medi-Cal capitation rates are not actuarially sound. This forces stakeholders to campaign for direct and indirect subsidies that often end up increasing costs rather than streamlining the program.
9. Health equity begins with patients, but equity should also include equitable payment for all providers.
10. The CalAIM program and Equity and Practice Transformation (EPT) would have been better served if health plans and providers had been engaged early on.

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11. The total expenditures on Medi-Cal, including federal match, have exceeded $120 billion per year, yet there are plenty of examples where patients benefit very little from this program.

I want to emphasize that listening to primary care and specialty care physicians and building trust with them through multidirectional communication is of critical importance.

As a PAHCA-SAC member deeply committed to advancing health/mental health equity, I strongly encourage DHCS to support primary and specialty care for underserved communities through provider rate increases. I want to emphasize critical challenges that demand immediate action.

The DHCS proposal does not include any provider rate increases in 2025 for primary care or specialty care despite the significant dollars allocated under Proposition 35 for exactly those purposes. These are the very doctors that underserved communities struggle to access. It is important that the specific dollar amounts in Proposition 35 for calendar year 2025 be utilized as intended for provider rate increases in 2025 in order to increase access to care. To that end, in addition to the uniform dollar rate increases for Emergency Department physicians that are included in the current DHCS proposal with an effective date of July 1, 2025, there should also be rate increases for primary care and specialty care providers effective July 1, 2025.

Critical Timeline for 2026 Resident Match

Communities of color already face enormous access issues leading to disparities in health outcomes. About 11.4 million Californians reside in federally designated Health Professional Shortage Areas (HPSAs), where physician-to-patient ratios fall critically below the threshold needed to meet basic health care demands. About two-thirds of them are African American, Latino or Native American. Graduate Medical Education (GME) programs serve as a vital pipeline for addressing these shortages by strategically deploying physician trainees directly into areas where underserved communities reside. The impact is substantial: a single physician resident typically provides care for 535 direct patient care visits per year, offering immediate relief to strained health care systems while gaining essential clinical experience in high-need areas.

The administration of GME grant programs requires extensive lead time to ensure successful implementation and meaningful impact on California's health care workforce. Medical residency programs must make commitments and allocate resources well in advance of the National Resident Matching Program cycle. For the 2026 resident match, programs need confirmed funding commitments ***this fall*** to effectively recruit residents and plan program expansions.

The University of California (UC), which is tasked with administering the programs, needs these funds right away so it can open applications to prospective GME programs and GME-naïve health systems looking to establish new GME programs in underserved

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communities. The application process, which is competitive and requires multiple rounds of review and evaluation, cannot take place overnight. UC needs several months to update grant applications and guidelines, promote the availability of these new funds, open the application and provide sufficient time for programs to compile and submit the necessary documents, and review, score and determine awards for GME programs.

Without prompt release of Prop 35 GME funds, California risks losing a full academic year of potential resident training positions. This delay would have cascading effects on our state's physician workforce capacity and deployment, particularly in underserved communities that depend on these training programs to develop culturally and linguistically competent providers who understand and serve diverse populations. What's more, this delay would come at a time when cuts affecting these very populations are on the horizon from both the state and federal levels.

And, beyond the long-term implications of these delays, a delay in funding residency slots this year could result in as many as 120,000 forgone patient visits in the communities that need care most.

Urgent Action Required

The convergence of GME program timelines and health equity imperatives demands immediate action from DHCS. Every month of delay in releasing Prop 35 GME funds reduces our ability to maximize their impact on California's health care workforce and health equity goals. I urge you to expedite the fund release process so that grant programs can be launched, applications processed, and funding commitments made in time for the 2026 resident match cycle.

California's communities – particularly those that have historically faced the greatest barriers to health care access – are counting on these investments to expand and diversify our physician workforce. The time to act is now.

Leveraging GME for Health Equity

California's GME investments represent a unique opportunity to advance health equity through strategic workforce development. Research consistently demonstrates that physicians who train in diverse, community-based settings are more likely to practice in underserved areas and provide culturally responsive care. By prioritizing GME programs that emphasize health equity training, meaningful community engagement, and service to vulnerable populations, we can create lasting improvements in health care access, service utilization, and outcomes.

Prop 35 funds should be used to support programs that specifically address health disparities through innovative training models, community partnerships, and curricula that prepare residents to serve California's increasingly diverse population. This approach aligns with PAHCA-SAC's commitment to ensuring that health care workforce development advances equity rather than perpetuating existing disparities.

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Formation of a Health Equity Subcommittee

Health equity must be a foundational principle in the implementation of Prop 35. The formation of a Health Equity Subcommittee ensures that systemic disparities in access to care and health outcomes are addressed through focused, informed, and sustained attention. An equity-centered approach ensures that the benefits of Prop 35 are not distributed evenly, but rather **equitably**, directed where the need is greatest to correct long-standing imbalances in care and represent community voices.

Prop 35 implementation must include listening attentively to diversity of voices to advance health equity. The Prop 35 implementation process must ensure resources can be strategically directed towards supporting a diverse healthcare workforce that matches the diversity of our state. Additionally, one of the factors that most significantly increases quality of care is culturally competent and linguistically appropriate services. To achieve this, organizations that represent diverse populations and diverse healthcare workers must be at the table. Thus, as the PAHCA-SAC proceeds with guiding the implementation process of Prop 35, I urge forming a Health Equity Subcommittee to include additional voices and stakeholders at the table to advance health outcomes and protect our communities and our healthcare workforce.

Because the health equity goals supported by voters through the passage of Prop 35 remain central to PAHCA-SAC's work and recommendations, I strongly urge the establishment of a dedicated Health Equity Subcommittee within our PAHCA-SAC structure. This subcommittee would provide focused expertise and guidance on how all Prop 35 initiatives – including provider rate adjustments and other access improvements – can advance health equity goals.

A Health Equity Subcommittee would enable the PAHCA-SAC to systematically evaluate proposals through an equity lens, ensuring that investments in California's health care system reduce rather than exacerbate disparities. This subcommittee could listen and take input from diverse voices from communities most affected by health inequities, academic researchers specializing in health disparities, and health care providers with demonstrated experience serving historically underserved and hardly reached populations.

The subcommittee's scope would encompass reviewing funding priorities, developing equity-focused metrics for program evaluation, and providing ongoing guidance to ensure that PAHCA-SAC recommendations align with California's broader health equity objectives. This structured approach would strengthen the PAHCA-SAC's ability to fulfill its advisory role while advancing the state's commitment to health/mental health equity.

Recommendations:

1. DHCS should be more proactive in engaging health plans and providers, including the PAHCA-SAC and other affected parties when new opportunities

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arise. This work should proceed with transparency except where legal or regulatory guidelines prohibit it.

2. DHCS and providers, including the PAHCA-SAC and other stakeholders should work on modernizing Medi-Cal. Medi-Cal currently covers about 38% of the state's population and as such it should be a marquee program for California rather than the current narrative that it is an expensive program for the poor, subject to political decisions, and budget constraints.
3. Immediately release the $75 million allocated by Proposition 35 for Graduate Medical Education (GME) in 2025.
4. I urge the formation of a Health Equity Subcommittee to include and listen to additional voices and stakeholders in order to advance health outcomes and protect our communities and our healthcare workforce.
5. Please, make the PAHCA-SAC materials available to our SAC with more time to be able to review the multiple documents before the meeting. For the Monday, May 19th meeting, we received the link to the materials on Friday, May 16th at bit after 5:00 pm (I was out of town then and returned on the night of the 18th to join the May 19th meeting in person). I recommend to send the materials at least a week ahead.

Thank you for your serious consideration of the comments and recommendations included in this letter. I'm committed to partnering with DHCS and the members of the PAHCA-SAC on the sound and timely implementation of Prop 35 and serve better our Medi-Cal population.

Sincerely,

Sergio Aguilar-Gaxiola, MD, PhD, MS
Professor of Clinical Internal Medicine
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Cc: Michelle Baass, Director, California Department of Health Care Services
Tyler Sadwith, State Medicaid Director
Alek Klimek, Assistant Deputy Director, Health Care Financing
Aditya Voleti, Chief, Fee-For-Service Rates Development Division
Linnea Koopmans, CEO, Local Health Plans of California and Chair, PAHCA-SAC

Sent via E-mail dhcspahca@dhcs.ca.gov

May 30, 2025

California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

To whom it may concern:

I submit this comment in response to the proposal by the Department of Health Care Services ("DHCS") to improperly and illegal transfer $27 million in funding earmarked by Proposition 35 for private ground emergency medical transportation ("GEMT") providers to increase Medi-Cal managed care capitation rates for calendar years ("CY") 2025 and 2026.

For CYs 2025 and 2026, Proposition 35 appropriates $50 million "for ground emergency medical transportation." (Welfare & Institutions Code § 14199.108.3.) The proposed diversion of over half of this amount from private GEMT providers to managed care plans is a blatant violation of DHCS' ministerial duties.

On May 19, 2025, during a meeting with the Proposition 35 Stakeholder Advisory Committee, DHCS attempted to justify this illegal diversion by claiming that the capitation rate increases reflect increases in level of utilization or level of payment and that Proposition 35 does not guarantee that any provider will receive an increase in reimbursement rates. According to DHCS, the additional payments to managed care plans comport with Proposition 35 because they are "in addition to managed care payments rates that existed as of January 1, 2024" and, therefore, the payments "expand[ ] healthcare benefits, healthcare services, healthcare workforce, and payment rates above and beyond those already in effect or in existence as of January 1, 2024."

Not so. By review of the Medi-Cal May 2025 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26, DHCS does not estimate significant increases for either the PP-

GEMT IGT program from 2024-25 (total expenditure $374,588,000) to 2025-26 ($366,984,000) or the GEMT QAF program from 2024-25 ($166,862,000) to 2025-26 ($166,237,000). The data show that DHCS does not anticipate any increased utilization of GEMT services to justify the $27 million increase in capitation rates. *Increasing capitation rates by $27 million will not expand GEMT benefits, services, workforce, or payment rates.* Thus, the transfer will violate Welfare & Institutions Code sec. 14199.107(a)(1), which requires that Proposition 35 monies be used only to "expand the health care benefits, health care services, health care workforce, and payment rates above and beyond those already in effect or in existence as of January 1, 2024."

The decision by DHCS to transfer Proposition 35 monies from private GEMT providers to Medi-Cal managed care plans also conflicts with the stated purpose of Proposition 35: to increase rates paid to providers. (*See* Welfare & Institutions Code §§ 141199.101(j), (m); 14199.102(a).) The proposal from DHCS includes no reference to any mandate to health plans to pass through to GEMT providers any of the $27 million in payments they receive.

In addition, I continue to oppose any allocation of Proposition 35 revenue to public GEMT providers. DHCS must direct these limited funds to private ambulance providers furnishing emergency services in response to 911 calls, and only 911 calls for service.[1] Proposition 35 funding is limited to private ground emergency medical transportation providers, consistent with Welfare and Institutions Code section 14199.115.

Nothing in the proposition nor its legislative history authorize the use of the MCO Tax proceeds for public emergency medical transportation providers. The purpose of this limitation was to correct chronic underfunding of private GEMT providers, who are excluded from the Public Provider Ground Emergency Medical Transport ("PP-GEMT") program. Private providers have not received a base rate increase in over two decades, and the GEMT QAF add-on amount has remained unchanged since the

[1] Generally speaking, only HCPCS codes A0427, A0429, and A0433 derive from 911 call centers, although in some rare cases, a hospital may call 911 for an interfacility transport billed using A0225 or A0434.

program's inception in 2018. This results in a per-transport rate of **$339** for private providers, well-below cost.

In contrast, public providers may access the PP-GEMT program, which reimburses at significantly higher levels. Last year, the PP-GEMT program provided a per-transport add-on of $1,049.98 to public providers, resulting in total Medi-Cal payment of **$1,168.18**. Pending SPA 25-0002 proposes a dramatic increase of the add-on to $1,478.68 per transport, which would raise the total Medi-Cal payment to **$1,596.88** per emergency transport, likely the highest in the nation.

Private ambulance providers remain entirely ineligible for any portion of this add-on, and the disparity that the PP-GEMT creates between public and private providers is displacing private ambulance operators in favor of more expensive publicly run ambulance systems that drive up costs for taxpayers, commercially insured patients, and the state's Medi-Cal program. In fact, it was recently reported that the City of San Diego generated "so much money in profits" ($17 million) after taking over the ambulance service 19 months ago from a private provider, that it intended to use these profits, which include PP-GEMT Medi-Cal funds, to cover other city department budget shortfalls.

DHCS's decision to divert Proposition 35 funding will only accelerate the displacement of private providers that have reliably delivered over 70% of California's emergency ambulance services for more than five decades. If this displacement continues unchecked, it could increase the state's Medi-Cal emergency ambulance transport costs by more than $1 billion—an amount that far exceeds the $50 million in funding private providers are requesting under Proposition 35. Rather than supporting the backbone of California's emergency medical infrastructure, this reallocation of Proposition 35 funding would undermine its efficiency and cost-effectiveness.

Allocating Proposition 35 funding away from private providers is not only arbitrary and capricious but also fails to address the most urgent and unsustainable disparities in the system. Relief must be targeted where the need is greatest and where the investment will have the greatest impact. Supporting private ambulance providers—who already

carry the majority of the emergency response burden—aligns with the intent of Proposition 35 and serves the best interests of California's patients and taxpayers.

I call on DHCS to comply with the voters' mandate in Proposition 35 by committing $50 million in 2025, and $50 million in 2026 to increase payments to private providers of ground emergency medical transports.

Sincerely,

Jason Sorrick

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May 30, 2025

Michelle Baass
Director, California Department of Health Care Services
Via email: DHCSPAHCA@dhcs.ca.gov

SUBJECT: Proposition 35 GME funds

Dear Director Baass,

On behalf of the University of California (UC) and as a member of the Protect Access to Health Care Act Stakeholder Advisory Committee, I am writing in support of the Governor's May Revision proposal and the provision in the Department of Health Care Services' (DHCS) Proposition 35 spending plan that proposes to allocate $75 million for graduate medical education (GME) for calendar years 2025 and 2026 to UC.

Proposition 35 provides $75 million in each of calendar years 2025 and 2026 to create new GME programs and expand current GME programs in California. These funds will support medical resident and fellowship positions across the state, as well as planning grants and direct technical assistance to GME-naïve health systems.

Due to timelines associated with the national "Match" process, along with the time needed to announce the program, score applications, and make award decisions, **funding must be allocated to UC as soon as possible, and no later than July 1, 2025**. See my letter dated April 23, 2025, for more detail on these timing considerations.

The UC is eager to continue this important work to increase the size of the physician workforce, particularly in areas facing physician shortages. Thank you for your consideration.

Sincerely,

Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs

UNIVERSITY OF CALIFORNIA HEALTH

University of California Health
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Oakland, CA 94607

universityofcalifornia.health

May 30, 2025

Michelle Baass
Director, California Department of Health Care Services
Via email: DHCSPAHCA@dhcs.ca.gov

SUBJECT: Proposition 35 Hospital Investments

Dear Director Baass,

On behalf of the University of California Health (UC Health) and as a member of the Protect Access to Health Care Act Stakeholder Advisory Committee, I am writing to provide input concerning the materials presented to the Committee on May 19, 2025. Specifically, this letter offers feedback for the proposed allocation of Proposition 35 funds for designated public hospitals (DPHs), hospital outpatient services, emergency department facility services, and behavioral health facility throughput.

UC Health's six academic health centers are an essential part of California's health care safety net system. As designated public hospitals (DPHs), UC's academic health centers provide high quality care to those in need regardless of their insurance status or ability to pay, helping to create a more equitable and person-centered network of care for all Californians. UC Davis Health, UC Irvine Health, UCLA Health, UC San Diego Health, and UCSF Health own and operate hospitals. UC Riverside Health provides clinical care through community facilities, along with owned and operated clinics. Together, UC Health locations are the second largest provider of inpatient services to Medi-Cal enrollees, despite having only seven percent of all hospital beds in California.

First of all, I would like to express support for the proposed allocation of $150 million in 2025 and 2026 to support the non-federal share of a portion of special-funded hospital directed payments. This approach is consistent with the intent of Proposition 35 and will help to reduce the non-federal share burden that has historically been placed on DPHs.

I am concerned with three other aspects of the administration's proposed Proposition 35 spending plan.

- First, the proposal to redirect $1.6 billion of Proposition 35 funding from provider reimbursement to reduce state General Fund costs in Medi-Cal is not aligned with Proposition 35's goal to improve Medi-Cal members' access to care.

- Second, with regards to Proposition 35 funds for emergency department facilities and physicians, while I am supportive of the proposed use of $255 million to support the non-federal share of existing hospital directed payments in 2026, I am concerned that the DHCS's approach for payments in 2025 may add undue complications for programs that have either already received or are awaiting federal approval. I'd like to reiterate the suggestion provided in my April 25, 2025, letter regarding state-only grants in 2025 to expedite funds to a broader number of providers more quickly.
- Lastly, I urge DHCS to reconsider the proposed use of $300 million for behavioral health throughput in each of 2025 and 2026 and instead prioritize the support of direct patient care and growth in behavioral health capacity.

In summary, while I am pleased to support the proposed use of funding for DPHs, I respectfully request that: (1) Proposition 35 funding be fully utilized for provider payments in excess of preexisting reimbursement levels, (2) DHCS prioritize timeliness and ease of federal approval as it continues to implement Proposition 35, and (3) behavioral health throughput dollars be used to invest in services.

I understand that organizations representing hospitals continue to submit input concerning the allocation of these funds, and I urge DHCS to continue working closely with these affected stakeholders to expend Proposition 35 funds in alignment with our collective suggested approach.

Sincerely,

Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs

Clinica Sierra Vista

Lindy Harrington, Assistant State Medicaid Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS
Department of Health Care Services, PAHCA- SAC Team

Re: Written feedback following the May 19, 2025, Protect Access to Health Care Advisory Committee.

Thank you for giving me the opportunity to provide written feedback regarding the proposed payment methodologies presented at the May 19th meeting.

Proposed Payment Methodologies related to Primary Care and Specialty Care

It is concerning that the Department of Health Care Services (DHCS) considers excluding Community Health Centers (CHCs) from eligibility for the primary and specialty care funding domains under the Prop 35 spending plan proposals. Reducing investments in primary care does not save money; it shifts costs downstream because of worse health care outcomes and increased Emergency Department utilization. At least since 2019, over 40% of all primary care visits were delivered by CHCs, making CHC sustainability a priority for public health.

In a recent article written by Basu et al, the loss of Community Health Center sites was associated with an increase in mortality in the years following the loss. Preserving CHC access is important to maintain population health.

If the DHCS continues with the Targeted Rate Increase proposal for Primary and Specialty Care, DHCS should include Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) as eligible providers and seek federal authority to create an Alternative Payment Methodology (APM) that allows for clinics to retain the differential between the APM rates and the PPS rates.

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Community Clinic Payment Direct Program (CCDP)

This quality-based incentive program not subject to reconciliation is an adequate proposal for CHCs. It will be crucial for DHCS and the committee to identify a meaningful metric that aims to improve initiation and continuity of care. A CMS metric currently under review, percentage of primary care visits with a member's assigned primary care provider in the past 12 months, could be a meaningful metric that promotes continuity of care. Continuity of care has the potential to lead to improved access, better health care outcomes, and lower healthcare costs.

Uniform Dollar Increase

Federally Qualified Health Centers (FQHCs)/ Rural Health Clinics (RHCs) should be eligible for the Uniform Dollar increase non subject to reconciliation. As Prop 35 envisioned, medical stakeholders should be able to obtain compensation reflecting the increasing costs of California. Even though FQHCs' PPS rates receive annual cost of living increases already, the yearly adjustment is around 3% and it does not accurately reflect the rising costs of California. A recent example is how AB 525 (Durazo) abruptly changed the minimum wage for health care workers in California. With the implementation of AB 525, minimum wage abruptly changed from 16 dollars per hour in early 2024 to 21 dollars in late 2024, representing a 24% wage increase. Health care workers deserve fair compensation and CHCs support them. However, CHCs are still in the process of recovering recent changes in operational costs and are not ready for incoming mandated changes. There is already another scheduled incoming increase in minimum wage from 22 dollars per hour in 2027 to 25 dollars in 2028 representing a 10% increase, for which I advise to consider including FHQCs/RHCs in Uniform Dollar Increase payments in a methodology that is not subject reconciliation.

Thank you for your consideration,

Electronically signed:

Irving Ayala-Rodriguez, MD, FAAFP, AAHIVS.
Chief Medical Officer
Clinica Sierra Vista

Clinica Sierra Vista

References:

What Portion of Medi-Cal Primary Care Visits Are Provided by Health Centers? (May 17, 2022) California Health Care Foundation, available at https://www.chcf.org/publication/portion-medi-cal-primary-care-visits-provided-health-centers/#related-links-and-downloads

Impact of Community Health Center Losses on County-Level Mortality: A Natural Experiment in the United States, 2011–2019, available at https://doi.org/10.1111/1475-6773.14648

Historical minimum wages in California, available at https://www.dir.ca.gov/dlse/faq_minimumwage.htm

Health Care Worker Minimum Wage changes in California, available at

https://www.dir.ca.gov/dlse/Health-Care-Worker-Minimum-Wage-FAQ.htm

PPS yearly adjustments, available at https://www.cms.gov/files/document/r12951cp.pdf

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