DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MEETING MINUTES

PROTECT ACCESS TO HEALTH CARE ACT STAKEHOLDER ADVISORY COMMITTEE (PAHCA-SAC)

Date:	Monday, April 14, 2025
Time:	11:30 a.m. – 3 p.m.
Type of meeting:	Hybrid
Members Present:	9
Public Attendees Present:	349
DHCS Staff Presenters:	Lindy Harrington, Assistant State Medicaid Director; Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing; Aditya Voleti, Chief, Fee-for-Service Rates Development
Additional Information:	Here is the PowerPoint presentation used during the meeting. Please refer to it for additional context and details.

PAHCA-SAC Membership Roll Call

- Linnea Koopmans; Present; In-Person
- Ariane Terlet, DDS; Present; Virtual
- Jason Sorrick; Present; In-Person
- Beth Malinowski; Present; In-Person
- Sergio Aguilar-Gaxiola, MD, PhD; Present; In-Person
- Tam Ma; Present; In-Person
- Amy Moy; Present; In-Person
- Kristen Cerf; Present; In-Person
- Irving Ayala-Rodriguez; Present; In-Person

PAHCA-SAC Agenda

11:30 – 11:40	Welcome, Opening Comments, Roll Call, and Agenda
11:40 – 11:55	Committee Governance and Election of Chairperson
11:55 – 12:25	Managed Care Organization Tax and Proposition 35
12:25 – 1:05	Medi-Cal Financing Background
1:05 – 1:30	Committee Member Questions and Discussion
1:30 – 1:40	Break
1:40 – 2:35	Considerations for Calendar Year (CY) 2025 and CY 2026 Domains
2:35 – 3:05	Committee Member Questions and Discussion
3:05 – 3:25	Public Comment
3:25 – 3:30	Final Comment and Adjourn

Election of 2025 Chairperson

Type of Action: Action

Recommendation: Nominate and elect the 2025 Chairperson

Presenter: Lindy Harrington, Assistant State Medicaid Director, opened the floor for nominations for the 2025 Chairperson

Materials/Attachments: Statement of Interest – Linnea Koopmans

Action: The motion to elect Linnea Koopmans as Chairperson was made by Tam Ma and seconded by Jason Sorrick.

- Aye: 9 (Koopmans, Terlet, Sorrick, Malinowski, Aguilar-Gaxiola, Ma, Moy, Cerf, Ayala-Rodriguez)
- Didn't Vote: 0
- Members Absent: 0
- Abstentions: 0

Welcome, Opening Remarks, and Committee Governance

Type of Action: Information

Presenter: Lindy Harrington, Assistant State Medicaid Director

Discussion Topics:

- This was the first meeting of the Proposition 35 Stakeholder Advisory Committee, marking the official start of the required consultation process. Per statutory requirements, the Department of Health Care Services (DHCS) may not advance any proposal without first consulting stakeholders through this forum.
- DHCS emphasized that the meeting's purpose was to initiate dialogue with stakeholders on the development and implementation of funding strategies and methodologies under Proposition 35.
- In response to circulating misinformation, DHCS provided clarifications:
    - No federal deadlines have been missed related to Proposition 35.
    - No federal funding has been lost.
    - The first tax collection under Proposition 35 is scheduled for April 30, 2025, indicating that the timeframe for spending and fund distribution is just beginning.
- DHCS explained that funds generated under Proposition 35 are protected and can only be used for the purposes outlined in the PAHCA.
- DHCS introduced the governance structure of the PAHCA-SAC:
    - The PAHCA-SAC is consultative, not decision-making.
    - Final authority remains with DHCS.
    - The PAHCA-SAC must adhere to Bagley-Keene requirements:
        - Meetings are open to the public.
        - Agendas must be posted at least 10 days in advance.
- No formal action can occur on items not listed on the agenda, barring emergencies or a need to take immediate action that came to PAHCA-SAC's attention after the agenda was posted.
    - PAHCA-SAC administration:
        - Chairperson election conducted during session: Linnea Koopmans
        - Chairperson serves two-year terms and is eligible for reelection.

Managed Care Organization (MCO) Tax and Proposition 35

Type of Action: Information

Presenter: Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing

Discussion Topics:

- This presentation provided an overview of the MCO Tax and Proposition 35, establishing foundational context for how DHCS plans to structure and implement funding strategies under this voter-approved measure. Proposition 35, passed by California voters in November 2024, provides permanent statutory authority for a Managed Care Organization (MCO) Tax beginning in January 2027. For calendar years 2025 and 2026, it establishes fixed spending allocations totaling approximately $8.5 billion across 12 defined categories. From 2027 onward, the allocation model shifts to a percentage-based structure spanning about 20 accounts.
- The current MCO Tax structure was authorized through AB 119 and later expanded via SB 136 and AB 160. The MCO Tax is tiered based on enrollment size and member type (Medi-Cal vs. commercial) and has been federally approved through December 31, 2026. Revenues are deposited into two main funds: the Health Care Oversight and Accountability Fund (covering administrative costs and certain provider payments) and the Improving Access to Health Care Fund (supporting broader investments). Although Proposition 35 authorizes the tax structure beyond 2026, federal approval will still be required, and potential federal rule changes could significantly impact the state's ability to maintain current revenue levels or tax design flexibility.
- Proposition 35 does not prescribe specific payment methodologies. Instead, DHCS is authorized to establish them—subject to federal approval and consultation with the PAHCA-SAC. The first MCO Tax collection under Proposition 35 will occur on April 30, 2025, followed by quarterly collections. Funds are continuously appropriated and can be spent beyond the designated calendar year, provided they are encumbered, that is, committed to a specific purpose, by the end of each applicable year.

Medi-Cal Financing Background

Type of Action: Information

Presenter: Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing; Aditya Voleti, Chief, Fee-for-Service Rates Development

Discussion Topics:

- The Medi-Cal financing presentation provided context for how California funds and operates its Medi-Cal program, which serves more than 14 million Californians. Medi-Cal is funded jointly by the state and federal government, with federal financial participation (FFP) based on the Federal Medical Assistance Percentage (FMAP). FMAP rates vary by population and service type, ranging from the base 50% to higher rates for programs like the Children's Health Insurance Program (CHIP) and Affordable Care Act (ACA) Medicaid expansion. The current total Medi-Cal program budget is estimated at $174 billion, with $107 billion in federal funds, $37 billion in General Funds, and $30 billion from other state sources, including continuously appropriated special funds, such as those under Proposition 35.
- The Medi-Cal program operates under two main delivery systems: fee-for-service (FFS) and managed care. Under FFS, providers are paid directly by the state using rates established in the Medi-Cal fee schedule. Changes to these payment methodologies require a State Plan Amendment (SPA), which must be publicly noticed 30 days in advance and submitted by the end of the quarter to allow retroactive federal approval. It typically takes 6 to 18 months to implement.
- In the managed care delivery system, DHCS contracts with health plans and pays capitation rates on a per-member, per-month basis. These rates are actuarially certified annually and must be approved by the federal Centers for Medicare & Medicaid Services (CMS). When DHCS directs how managed care plans reimburse providers, it must use State-Directed Payments (SDP), which are subject to strict federal conditions: they must align with actuarial principles, be tied to service delivery or utilization, apply uniformly across provider classes, advance quality strategy goals, and include a robust evaluation plan. Starting in 2027, all SDP submissions and amendments must be prospective, eliminating the current flexibility for retroactive changes. These tools—SPAs and SDPs—are critical to operationalizing Proposition 35 and other Medi-Cal investments.

Committee Member Questions and Discussion

Type of Action: Information

Presenter: Lindy Harrington, Assistant State Medicaid Director; Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing; Aditya Voleti, Chief, Fee-for-Service Rates Development

Discussion Topics:

- **Member asked** if DHCS could clarify their statement on slide 23 about not missing any deadlines and confirm whether the full amount of funds allocated for Calendar Year (CY) 2025 remains eligible for federal financial participation (FFP). The member noted that it appeared to be more a matter of how the payment mechanisms are designed. **DHCS responded** that for a SPA to take effect on January 1, 2025, public notice would have been required by December 31, 2024, which was not feasible because the committee had not yet been appointed. However, the funds remain segregated and are still available for their intended purposes. DHCS is designing methodologies to ensure the funds are used appropriately and to draw down federal matching funds. SPAs are only one type of federal authority being considered. **Member followed up** and noted that the minimum fee schedule used for the 2024 MCO targeted rate increase (TRI) for primary care and behavioral health was operationally challenging to implement, especially in a highly capitated system like California's, which should be taken into account when considering methodologies to be employed under Prop 35.
- **Member asked** where federally qualified health centers (FQHC) fall within the Medi-Cal delivery system framework shown on slide 32. **DHCS responded** that FQHCs participate in both FFS and managed care. They receive partial payments from managed care plans and supplemental "wraparound" payments from DHCS to bring them to their Prospective Payment System (PPS) rate. At the end of the fiscal year, a reconciliation ensures that providers receive the full PPS rate across both revenue streams.
- **Member commented** that community health centers account for approximately 44–45% of all primary care visits among Medi-Cal members. The PPS system is complex and should be better understood by the committee. The member requested a dedicated presentation on PPS compensation. The member also noted that Article 8, Section F of Proposition 35 requires two full-time staff to support the PAHCA-SAC committee and asked for clarification on who those individuals are. Additionally, the member shared that the timely receipt of materials and agendas is important for the committee to make informed

recommendations, and the member suggested that the Medi-Cal 101 presentation could have been included as a standalone agenda item.

- **Member asked** whether slide 45 represented a comprehensive list of SDP options for managed care. **DHCS responded** that the slide was meant to be informational and not limiting. It outlines available SDP mechanisms, but other options are under consideration. Further discussions around each domain will follow. **Member followed up** by asking whether the committee would have an opportunity to see the full range of options DHCS is considering. **DHCS responded** that each domain will be discussed in greater depth, and committee feedback will help shape the development of proposals.
- **Member asked** for clarification on the requirement to encumber funds by the end of CYs 2025 and 2026, as referenced on slide 26. **DHCS responded that** Proposition 35 defines encumbered funds as those associated with payments to Medi-Cal providers under federally approved or pending methodologies. Unlike the typical state fiscal year, Proposition 35 uses a CY basis and has its own definition of encumbrance.
- **Member asked** whether any draft payment methodologies had been developed for CY 2025 and whether the committee would have the opportunity to review them. **DHCS responded** that no proposals have been finalized. DHCS is required to consult with the committee before proposing anything and must seek input before moving forward.
- **Member asked** whether DHCS had engaged with the new federal administration regarding preferred approaches or expedited pathways for approval. **DHCS responded** that while the new CMS administrator has begun sharing a vision, detailed guidance is still forthcoming. DHCS noted that it is operating under current regulations and has not received indications that any particular approach would be expedited.
- **Member asked** about the status of the federal Medicaid budget, citing concerns over potential impacts on covered populations. **DHCS responded** that they are monitoring the situation and relying on the most recent estimates. The current funding levels reflect what is needed to operate the program under existing rules. If federal changes occur, DHCS will revisit and adjust accordingly. **Member** followed up to note that the role of the committee is to ask challenging questions on behalf of the populations served, especially in light of such uncertainty.

Considerations for CY 2025 and CY 2026 Domains

Type of Action: Information

Presenter: Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing; Aditya Voleti, Chief, Fee-for-Service Rates Development

Discussion Topics:

- The presentation reviewed implementation considerations for Proposition 35 allocations in CYs 2025 and 2026. DHCS outlined operational pathways for distributing funds, including FFS, managed care, SPAs, and SDPs. Payment changes may be implemented in either delivery system depending on feasibility, and most methodologies are utilization-based—making it difficult to cap spending to the dollar amounts allocated in Proposition 35. DHCS must instead design payment methodologies that are actuarially sound, federally approvable, and fiscally sustainable, while consulting the PAHCA-SAC throughout the process.
- Key funding domains include $691 million annually for primary care, $575 million for specialty care, and $355 million for emergency department (ED) services. These categories build on the 2024 TRI, which set baseline payments at 87.5% of the lowest Medicare rate for primary care, maternity, and non-specialty mental health services. The TRIs was implemented across both FFS and managed care and will remain in place through 2029 under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration waiver, contingent upon federal approval of an MCO Tax at or above AB 119 levels. DHCS noted that many procedure codes are shared across provider types, making it difficult to track primary, specialty, and ED physician payments separately, as required under Proposition 35's accounting structure.
- Other Proposition 35 domains include $245 million annually for outpatient and community procedures, $90 million for family planning and abortion services, $50 million for services and supports to primary care, $15 million for ground emergency medical transportation (GEMT), $75 million for graduate medical education (GME), $75 million for workforce expansion, and $300 million for behavioral health facility throughput. Family planning services are eligible for a 90% federal match, but abortion services are funded entirely with state dollars and do not require federal approval. DHCS emphasized that payment rates

under Proposition 56 for family planning already exceed Medicare levels, potentially limiting further increases.

- For hospital-based domains, DHCS highlighted the complexity of existing supplemental payment programs across designated public hospitals (DPH), district/municipal public hospitals, and private hospitals. These programs vary by delivery system and service type and are largely self-financed through intergovernmental transfers (IGT) for public hospitals and quality assurance fees (QAF) for private hospitals. Directed payments in managed care, which include value-based incentive structures, are expected to increase by $9.5 billion between 2024 and 2025. While total payments are tracked by CMS, hospitals typically consider only the net federal share as a program benefit. DHCS will need to integrate Proposition 35 investments with these existing financing structures.

Committee Member Questions and Discussion

Type of Action: Information

Presenter: Lindy Harrington, Assistant State Medicaid Director; Rafael Davtian, Deputy Director, Health Care Financing; Alek Klimek, Assistant Deputy Director, Health Care Financing; Aditya Voleti, Chief, Fee-for-Service Rates Development

Discussion Topics:

- **Member asked** whether DHCS is considering moving forward with payment increases for abortion care, given that such services are ineligible for federal matching funds and, therefore, do not require SPA approval. **DHCS responded** that there is more flexibility for abortion care funding since federal approval is not required. DHCS will look to the committee for input on potential methodologies or payment structures to implement.
- **Member asked** whether adopting a Medicare-based structure for GEMT rates, such as using ZIP codes, would also apply to the base rate and QAF, or only to funding from Proposition 35. **DHCS responded** that a robust methodology had been developed under prior legislation (SB 159), which included geographic rate variations. While the SPA base rate remains static, rate add-ons would be tailored to meet geographic distribution targets. **Member followed up** to recommend factoring in local labor and fuel costs, which significantly affect provider operations in high-cost regions like San Francisco and Los Angeles. The member emphasized that any methodology should support workforce stability

and may need to diverge from the Medicare model. **DHCS responded** that they appreciated the input and would consider it when developing proposals. DHCS also invited the member to share any specific ideas or modeling approaches. **Member followed up** to suggest modeling a portion of payment against current patient populations to better understand the impact. The member stressed that long-term contracts, union agreements, and local operating costs must be considered to avoid financially straining providers.

- **Member commented** on the complexity of PPS reimbursement for FQHCs and the limitations it poses for community health centers. The member asked whether DHCS is exploring supplemental payment models to augment PPS, such as alternative payment model (APM), that could offer more timely support. The member noted that community health centers operate across multiple care settings—urgent care, hospitals, etc.—and often do not receive PPS rates for services provided outside clinic walls.
- **Member asked** whether dental is included under the GME allocation, noting the existence of advanced education programs in general dentistry that serve vulnerable populations. **DHCS responded** that Proposition 35 does not further define or subcategorize the GME funding. If members have input regarding the inclusion of dental programs, DHCS is open to considering that feedback.
- **Member followed up** by asking when dental will be discussed and how subcommittees will be formed. **DHCS responded** that dental becomes a separate category in Proposition 35 beginning on January 1, 2027. Discussions will likely begin in 2026. Proposition 35 allows the committee to form subcommittees, and DHCS is available to support that process.
- **Member asked** whether DHCS could provide a forecast of which domains for which they expect to receive federal approval and which might face challenges. The member also asked for clarification on which types of providers could be included under the "services and supports for primary care" domain, beyond FQHCs and rural health centers (RHC). **DHCS responded** that Proposition 35 does not narrowly define "services and supports for primary care," and it could be interpreted broadly. More specific categories will be established in 2027, including a dedicated account for clinics.
- **Member asked** whether DHCS plans to share a work plan and timeline for proposal development and CMS submissions, given the number of domains to address in a limited timeframe. The member also asked if DHCS would be

presenting specific proposals for member response. **DHCS responded** that they are currently seeking feedback from the committee by April 25. While specific proposal timelines have not been finalized, feedback will help determine the next agenda. Members are encouraged to share both general and specific input on how methodologies should be prioritized.

- **Member recommended** that DHCS set a regular cadence of meetings and share draft proposals, noting that the content presented so far has been largely educational. **DHCS responded** that members are welcome to submit input even if not fully developed, including ideas on timing, distribution, or geographic factors. This feedback will help inform proposals.
- **Member commented** that DHCS should consider using the 2023 budget agreement as a foundation when developing methodologies for 2025 and 2026. Much stakeholder input already went into that process, and it would be beneficial to build from there. The member also encouraged DHCS to take early action in domains that do not require federal approval, such as reproductive health and GME, and noted that timelines for GME are tied to the national residency match cycle.
- **Member echoed** the prior comment about urgency and added that the committee should consider cross-cutting principles like equity in designing payment methodologies. The member recommended that equity and workforce considerations be core to eligibility criteria and program design.
- **Member asked** for clarification on how to submit feedback, who to send it to, and whether member proposals could be shared publicly so the group could see each other's ideas. **DHCS responded** that feedback should be submitted to DHCS by April 25. Due to open meeting laws, committee members cannot deliberate outside public meetings. However, DHCS will make feedback publicly available for review.
- **Member asked** how DHCS plans to process committee feedback and move forward in a timely way to avoid delays in CMS submissions or risk losing access to funds. **DHCS responded** that the next meeting is planned for May. While some methodologies have been previously developed, they must be reassessed due to changes in how funds are categorized in 2025 versus 2027. DHCS is seeking committee input before finalizing proposals.
- **Member commented** that a second meeting should be scheduled soon, ideally before September. **DHCS responded** that they anticipate more than two

meetings this year due to the volume of work and the transition from 2025–2026 to 2027 planning. A follow-up meeting will occur before September. **Member followed up** to suggest that domain-specific subcommittees may allow for more consensus-based recommendations across shared stakeholder areas, such as primary care or hospital care. This could be more productive than independent proposals from individual members.

- **DHCS commented** that subcommittees will consist of one or more committee members and should be structured to remain manageable. DHCS is currently recruiting for two full-time staff positions to support the committee and will share interim contact information with members until those roles are filled.

Public Comment

Type of Action: Public Comment

Discussion Topics:

- Erin Kelly, on behalf of the Children's Specialty Care Coalition, which represents more than 3,000 pediatric subspecialty physicians statewide, expressed appreciation for the convening of the PAHCA-SAC and emphasized that this is a critical step in implementing Proposition 35. Kelly noted that chronic underfunding of the Medi-Cal provider network and the disproportionately high volume of Medi-Cal patients have created an acute workforce crisis in the pediatric specialty care network, resulting in serious access challenges for children and youth with complex and chronic needs. More than one-third of appointment wait times exceed three months, and fellowship fill rates for half of pediatric subspecialties are at or below 50% nationwide. National reports and organizations, such as the American Academy of Pediatrics and the Children's Hospital Association, have called for states to raise pediatric rates to at least Medicare parity. Kelly emphasized that rate stabilization through Proposition 35 is essential, especially since specialty care is included in the 2025 implementation, and urged DHCS and the committee to consider broader inclusion of pediatric codes, including inpatient codes. A letter was submitted on this issue.
- Janice Rocco, representing the California Medical Association and its more than 50,000 members, shared enthusiasm for participating in Proposition 35 implementation after three years of work. Rocco noted that specific dollar amounts for CY 2025 were negotiated with the Governor and Legislature in 2023. She emphasized that the priority now should be to move forward quickly to

deploy the 2025 funding. Based on the payment methodologies discussed, Rocco recommended that a federal notice be issued by the end of the quarter to allow for directed payments in the following quarter. She stressed that most methodologies would require federal approval, so early engagement with CMS, the committee, and stakeholders is critical.

- Monica Montana of the California Dental Association (CDA) expressed appreciation for the opportunity to discuss Proposition 35 and acknowledged DHCS' commitment to improving the Medi-Cal dental program. Montana stated that Proposition 35 builds on past efforts to strengthen dental services, and that funding will support improvements in restorative and specialty care, increase provider participation, and help expand the dental workforce. CDA looks forward to working with DHCS and the committee on this long-term and permanent funding solution to improve access to dental care.
- Stacey Wittorff, on behalf of Planned Parenthood Affiliates of California, representing seven affiliates operating 115 health centers statewide, noted that approximately 85% of patients served by these health centers receive care through Medi-Cal or Family PACT (Planning, Access, Care, and Treatment). Wittorff expressed support for DHCS' previous proposal to use the majority of the $90 million in Proposition 35 funding for abortion and family planning to improve rates for abortion care. Providers are facing unprecedented demands and federal threats. While recognizing the need to invest across multiple domains, Wittorff urged the committee to move forward immediately in areas that do not require federal approval, such as abortion care. Planned Parenthood looks forward to partnering with DHCS and committee.
- Kristine Shultz, representing the California Optometric Association, emphasized that optometrists provide more than eye exams and glasses; they deliver primary eye care, diagnose systemic and eye conditions, and coordinate care with other providers. Shultz stated that optometrists should be treated and reimbursed as primary care providers and thanked the committee for its time.
- Dennis Cuevas-Romero, Vice President of Government Affairs for the California Primary Care Association, representing nearly 2,300 FQHCs and community health centers statewide, echoed members' sense of urgency about moving funding quickly to support primary care. Cuevas-Romero emphasized that this is a unique opportunity to invest in primary care, and that additional funding for community health centers should not be subject to reconciliation, as clearly written in the initiative. He also highlighted that the "services and supports for

primary care" domain is intended for clinics and health centers, and thanked the committee and DHCS for recognizing that.

- Adam Dorsey of the California Hospital Association thanked DHCS for the significant work involved in launching a new program. Dorsey recommended that discussions begin to focus on long-term implementation starting in 2027 while also moving quickly to implement a uniform dollar increase for 2025 and 2026. This approach would allow a timely submission to CMS for the initial implementation period.
- Tim Madden, representing the California Chapter of the American College of Emergency Physicians, thanked DHCS and participants for meeting. Madden shared that emergency physicians were included in the Governor's 2024–25 budget with an allocation of $100 million and have already worked with DHCS on rate methodology. He noted that Proposition 35 aligns with that funding level and represents an opportunity to proceed with implementation. Madden explained that many EDs have already increased staffing in anticipation of the funds, which benefits all patients, not just those covered by Medi-Cal. He encouraged the committee to recognize the urgency and move forward with this domain.
- Dr. Ali, O.D., an optometrist in rural California, shared that their clinic saw more than 4,000 Medi-Cal patients last year and is one of the few Medi-Cal providers in the area. Private equity has acquired many practices in the region, reducing access for Medi-Cal patients. Ali emphasized that optometry is a primary care service; patients are seen without referral, and urgent or complex conditions are managed and coordinated with specialists. One case involved a patient with severe vision loss who was diagnosed and referred the same day to an ophthalmologist after extensive staff coordination. The visit was reimbursed at $26.40. Ali described providing critical services, such as glaucoma treatment, diabetes screenings, and emergency eye care while operating seven days a week. Ali urged DHCS to include optometry in Proposition 35 rate increases to ensure continued access for underserved populations.
- Allie D'Accurzio, Director of Reimbursement at NeuroPace, described the company's implantable RNS system used for treating drug-resistant epilepsy. D'Accurzio explained that the Current Procedural Terminology (CPT) codes for electrode implantation (61863, 61864, 61850, 61860) are currently excluded from the Medi-Cal fee schedule, even though related codes, such as those for the neural stimulator itself, are included. The omission limits access to this therapy,

and D'Accurzio requested that DHCS add the missing codes to ensure full coverage of the procedure.

- Amanda Berry, on behalf of Health Center Partners of Southern California and Integrated Health Partners, emphasized the central role of community health centers in Medi-Cal and stated that Proposition 35 presents a once-in-a-generation opportunity to strengthen that system. Berry supported tying reimbursement increases to quality and ensuring full inclusion of FQHCs. Berry also encouraged support for risk-bearing networks that improve outcomes and offered to collaborate through subcommittees.
- Bryce Docherty, representing the California Orthotic and Prosthetic Association, requested Proposition 35 funding and TRI for orthotic and prosthetic services under the outpatient and community procedures domain. Docherty shared data on the prevalence of limb loss and limb difference and the cost-effectiveness of orthotic and prosthetic care. He emphasized the importance of including these services in rate increases to improve access for Medi-Cal patients.
- Dr. Benjamin Pezeshki, a primary care physician in downtown Los Angeles and medical director of an independent physician association, reported seeing more than 12,000 Medi-Cal patients annually. Pezeshki stated that more representation from managed care stakeholders is needed on the committee and that many providers are unclear about the future of TRI and Proposition 56. Pezeshki requested clearer communication from DHCS moving forward.
- Joanne Preece, with the Community Clinic Association of Los Angeles County, representing 66 health center organizations that serve more than 2 million people, expressed support for Proposition 35 and appreciation for the committee's work. Preece emphasized the importance of preserving FQHC funding outside the reconciliation process and aligned with the comments from CPCA and other clinic leaders. Preece also acknowledged the urgency of implementation.
- Dr. Marcia Raggio, on behalf of the California Academy of Audiology, described the access challenges facing California's deaf and hard-of-hearing population. Raggio explained that audiologists serve all age groups, from newborns to seniors, and provide essential diagnostic and treatment services. With fewer than 2,400 audiologists statewide, limited reimbursement has further reduced access. Raggio requested TRIs to support audiologists and improve care for this population.

- Ryan Witz from the District Hospital Leadership Forum stated support for the comments made by the California Hospital Association and expressed interest in reconvening the committee next month.
- Erin Brennan-Burke, on behalf of Family Health Centers of San Diego, highlighted the importance of upholding the non-reconciliation provision in Proposition 35. Brennan-Burke also noted the value of investing in graduate medical education through Teaching Health Centers, which train primary care physicians in underserved communities and are more likely to serve rural and Medi-Cal populations.
- William Barcellona, with America's Physician Groups, representing more than 70 delegated medical groups serving more than 5 million Medi-Cal members, thanked the committee and noted that written comments would be submitted. Barcellona raised concerns about the underfunding of the 2024 TRI and the lack of actuarial soundness in many MCO capitation rates.
- Yamilet Valladolid from Valley Health Center discussed the challenges FQHCs face in accessing specialty care and the need to hire in-house specialists, which significantly increases costs. Valladolid proposed structuring specialty care payments under Proposition 35 as managed care-directed payments and recommended creating an APM that allows FQHCs to retain funds above the PPS rate. Valladolid also suggested grant or incentive programs for hiring specialists, reimbursements for e-consults and remote patient monitoring, and compensation for care coordination services.
- Dr. Seciah Aquino, Executive Director of the Latino Coalition for a Healthy California, emphasized that Latinos make up more than half of Medi-Cal members and more than 40% of California's population. Aquino urged the committee to create an equity subcommittee that includes community-based organizations, grassroots leaders, and promotores to ensure equitable implementation of Proposition 35 and a representative health workforce.
- Lizette Escobedo, Vice President of Government Relations at AltaMed Health Services, noted that AltaMed is the largest FQHC in California and serves one in five Medi-Cal patients in Los Angeles and Orange counties. Escobedo aligned with earlier comments from CPCA and other clinics and urged the committee to reconvene quickly to begin implementation planning. Escobedo also emphasized the importance of maintaining Proposition 35's non-reconciliation provision to ensure funding is additive and not used to supplant existing resources.

Upcoming PAHCA-SAC Meeting and Next Steps

Type of Action: Information

Presenter: Lindy Harrington, Assistant State Medicaid Director

Discussion Topics

- The next meeting is scheduled for May 19, and meetings will continue to be held in a hybrid format.

Adjournment of Meeting

Name of person who adjourned the meeting: Lindy Harrington, Assistant State Medicaid Director

Time Adjourned: 2:38 p.m.