April 29, 2025

Lindy Harrington
Assistant State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Submitted electronically via: dhcspahca@dhcs.ca.gov

RE: Protect Access to Health Care Act Stakeholder Advisory Cmte. (PAHCA-SAC) - Considerations for CY 2025 and CY 2026 Funding Allocations

Dear Ms. Harrington:

On behalf of our 750,000 members and their families, **Service Employees International Union (SEIU) California** would like to commend the Department of Health Care Services (DHCS) for officially launching the Protect Access to Health Care Act (PAHCA) Stakeholder Advisory Committee (PACHCA-SAC) with its first meeting on Monday April 14, 2025. SEIU California is proud to represent workers across the continuum of care—from those providing care in long-term care facilities, acute care hospitals, and community clinics. As the DHCS and the PAHCA-SAC committee begin their deliberations, we write today to offer initial considerations.

At a time when federal actions threaten California's Medi-Cal funding, it is 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. **At every opportunity, we ask DHCS and PAHCA-SAC to seek opportunities to prioritize patient care and improve working conditions.**

In particular, we appreciate the initial, focused attention of the DHCS and PAHCA-SAC on the 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.

With this in mind, while we recognize the deep pressure some industry representatives are placing on DHCS to move quickly, we encourage thoughtful decision making. Please find below specific considerations relating to the Services and Supports for Primary Care; Graduate Medical Education; and Medi-Cal Workforce domains for the CY 2025 and CY 2026 allocations.

SERVICES AND SUPPORTS FOR PRIMARY CARE ($50M)

Compared to other CY 2025 and CY 2026 domains, the Proposition 35 Services and Support for Primary Care domain language offers DHCS flexibility on who these funds can be allocated to. For this reason, we were disappointed to hear DHCS align themselves with the nonprofit clinic industry association, California Primary Care Association, in their remarks indicating that these funds are to be used exclusively to nonprofit FQHCs or FQHC look-Alikes, commonly referred to as community clinics or health centers, at the inaugural April 14, 2025 PAHCA-SAC meeting. Based on our analysis of the Proposition language, there is no legal basis to do so.

At a time when DHCS should be taking every opportunity to consider how Proposition 35 allocations can best be utilized in these unprecedented times, we think this $100 million ($50 million annually) bucket is one that warrants deeper discussion. While we appreciate that for this, and other domains, DHCS has yet to formally propose to the PAHCA-SAC a payment methodology for this bucket, we were disheartened to see DHCS highlight in the meeting and in meeting materials a past MCO Tax Spending Plan to support community clinics via an expanded Community Clinic Directed Payment Program for nonhospital 340B community clinics.

SEIU CA is opposed to utilizing proposition funding to expand the Community Clinic Directed Payment program for nonhospital 340B community clinics. Early in the Newsom administration, when the establishment of CalRx[1] threatened 340B savings, DHCS stood up the non-hospital 340B supplemental payment program for community clinics with the intention that dollars would be reinvested in care coordination, and other needs.[2]

[1] Medi-Cal Rx https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
[2] SPA 21-0015 Public Notice https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0015-Public-Notice.pdf

At that time, SEIU CA expressed understanding but also the need for clear accountability to guarantee these dollars were appropriately reinvested in patient care. Years in, SEIU CA has concerns with the current methodology, and there is no public transparency on how these dollars have been spent. Currently, 90% of the funding is targeted to the clinics with the highest utilizations, as opposed to the clinics with better quality outcomes, and only 10% of the directed payment funding is tied to one quality measure of patients seeing their assigned primary care provider in the prior 12 months. In fact, there is no robust link to quality improvement, workforce stability, or patient access—priority areas for SEIU CA. *If the non-hospital 340B supplemental payment program is to be continued, let alone expanded, how will things be different? For this, and other buckets, is DHCS prepared to create clear transparency and accountability?* For these reasons, and given the greater federal scrutiny on Medi-Cal spending today, we cannot endorse this as a solution today.

SEIU CA not only called for transparency upon the creation of this supplemental payment program, but has continued to call for greater transparency for non-profit, community clinics in other ways too. SB 779 (2023, Chaptered), an SEIU CA-sponsored effort, will require increased disclosure of patient demographic, workforce, and workforce development data at the clinic site level in the annual HCAI Primary Care Clinic Annual Utilization Report in order to better assess health care equity, quality, and access.[3] This effort will not be fully implemented until 2028.

Since SB 779's passage, SEIU CA continues to see an urgent need to uplift the importance of fiscal transparency. Even as Congress threatens cuts to Medicaid funding,[4] certain clinic CEOs and executives are irresponsibly spending precious clinic resources on unrelated expenditures.[5] Several community clinics have been mired in

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

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

[5] 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

scandals over allegations of false reporting and fraudulent claims,[6][7][8][9] and across the state, many clinic workers report chronic understaffing, high workloads, staffing turnover, and long wait times for patients.[10] Clinic workers also have sounded the alarm on increasing pressure to rush patients in appointments,[11] without sufficient time to answer patients' questions. Meanwhile, 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.[12][13][14] As a result, SEIU CA has taken the additional step this legislative cycle of introducing AB 1113 (M. Gonzalez) to provide clear guardrails on how revenue is being spent at California's nonprofit community clinics.

As PAHCA-SAC and DHCS deliberate on this bucket, it is critical that we ensure investments are placing patients and the frontline workforce that care for them above excessive administrative and management expenses and profits. At a minimum, we must guarantee that the methodology ensures that funds do not go to clinics that mistreat healthcare workers and fail to put patients first.

Rather than distributing funds through a utilization-based formula to clinics, such as under the directed payment program for non-hospital 340B clinics, PAHCA-SAC should make good use of the wide potential of this funding bucket to prioritize improving patient care and working conditions. Additionally, as we consider the deep cuts threatening Medicaid, as well as other cuts that are undermining local government, California's fragile public health infrastructure, and under attack providers (like those

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[6] 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"

[7] 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

[8] 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

[9] 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

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

[11] SEIU CCWU interviews with workers.

[12] 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 https://docs.google.com/document/d/10O2_SAXlr4coj3p50Gjwbg3UpHJR_pDh/edit

[13] 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

[14] 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

providing trans care and/or abortion access), one must consider how those changes influence our approach today.

Graduate Medical Education ($75M)

SEIU CA continues to support investments in graduate medical education training in California. SEIU CA has a long and on-going track record of supporting similar Song-Brown and Proposition 56 investments. As DHCS knows well, we can not fulfill the promise of coverage without a strong pipeline to grow and retain California's physician workforce. Countless reports have highlighted this persistent problem[15] and the need to continue to invest. [16] Due to the strength of our existing programs, California boasts the best retention rate of Graduate Medical Education residents staying in the state where they do their residency training, at more than 70%.[17] 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 this training. For these reasons, SEIU encourages continued investment in, and the stabilization and expansion of, current programs over investments in new 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.**

WORKFORCE ($75M)

SEIU CA is deeply supportive of the $75 million annual investments to Medi-Cal Workforce in CY 2025 and CY 2026. Given the tremendous leadership the Department of Health Care Access and Information (HCAI) is increasingly playing in workforce development as well as its warehousing of the most significant statewide data on health care utilization and workforce, it is uniquely positioned to invest these funds through a newly established Medi-Cal Workforce Pool. 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.

[15] UCSF_PCP_Workforce_Study_Rpt_2_-_Final_081517.pdf
[16] Understanding Graduate Medical Education in California - California Health Care Foundation
[17] 2023 Report on Residents Executive Summary | AAMC

As California continues to face persistent healthcare workforce challenges,[18] we believe investments in healthcare Labor Management Cooperation Committees (LMCCs) are a critical tool to bring healthcare employers and workers together to meet the dynamic workforce needs. Local, regional, and statewide multiemployer LMCCs create meaningful partnerships to support and advance their workforce and patient care. LMCCs—as they bring together employers and labor—are an investment in partnering with workers to lift the quality of care and identify shared strategies to address immediate workforce needs. Ultimately, increasing worker retention, increasing staffing, reducing turnover, and reducing patient wait times will lead to improved quality of care and health outcomes. The Department of Health Care Access and Information is well equipped to administer this program and encourage the DHCS to provide the necessary resources so that the funding can support training programs for those delivering care to Californians.

In conclusion, we share 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,

Original Signed by

Beth Malinowski
Government Relations Advocate
SEIU California

CC: Lindy Harrington, Assistant State Medicaid Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS
Alek Klimek, Assistant Deputy Director, Health Care Financing Department, DHCS

[18] How California Is Strengthening Its Health Workforce: An Explainer - California Health Care Foundation

April 25, 2025

Lindy Harrington, Assistant Medicaid Director
Rafael Davtian, Deputy Director, Health Care Financing
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Re: LHPC Written Input on April 14, 2025, PAHCA-SAC Meeting Materials

Dear Directors Harrington and Davtian,

On behalf of the 17 local health plans that collectively serve over 70% of Medi-Cal managed care enrollees across the state, the Local Health Plans of California (LHPC) thanks the Department of Health Care Services (DHCS) for the opportunity to provide input on Proposition 35 (Prop 35) stemming from conversation and meeting materials that were presented at the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC) meeting held on April 14, 2025. This letter provides Prop 35 implementation input and recommendations that we believe are crucial to engage in meaningful and productive conversations for decision making that will be needed to meet the intent and requirements of Prop 35. **Overall, we urge DHCS to move forward with Prop 35 implementation thoughtfully but expeditiously, consistent with the will of the California voters who passed the proposition by an overwhelming majority.**

PAHCA-SAC Meeting Process Recommendations

As chairperson of the PAHCA-SAC, I respectfully request that the DHCS consider establishing a process for collaborative planning between the Department and myself in advance of future PAHCA-SAC meetings. The goal of this process would be to align on the meeting agenda and materials prior to public posting, ensuring that they are developed and shared in a timely manner that allows all participants to prepare effectively. This collaboration will contribute to more productive and transparent meetings and will support the committee's purpose of providing feedback for consideration by the Department regarding the implementation of Prop 35. I am happy to make myself available as soon as possible to begin planning for a productive meeting in May.

LHPC recommends that DHCS develop a workplan and timeline for developing, finalizing, and submitting all Prop 35 funding mechanisms necessary for federal approval to the Centers for Medicare and Medicaid Services (CMS). These will be needed to ensure there are key milestones or deadlines DHCS is working toward in order to submit the required documentation to CMS, a precursor to implementation of all the Prop 35 funding allotments that are eligible for federal matching funds.

Request for Specific DHCS Proposals to Effectuate Prop 35 Provider Rate Increases

LHPC strongly recommends DHCS propose specific funding mechanisms for each category of providers or services outlined in Prop 35 and present these proposals to the PAHCA-SAC for discussion and feedback. While LHPC appreciates DHCS' open-ended request for feedback and recommendations from the committee, we are concerned that it will generate many disparate ideas for how to implement Prop 35 thus delaying progress toward implementation. Based on the information that was presented and included in the PAHCA-SAC meeting materials, it appears that DHCS is strongly considering implementing some form of directed payments through the managed care delivery system to effectuate the Prop 35 increases. We request DHCS share more specific thinking about how directed payments may be leveraged to implement the different provider rate increases within Prop 35.

Therefore, during the next PAHCA-SAC meeting, LHPC recommends that in addition to discussing overall feedback from committee members, **DHCS should provide proposed methodologies for each of the CY 2025 and 2026 Prop 35 domains that DHCS believes would receive CMS approval, are feasible to implement without significant administrative complexities, and would allow for the full expenditure of CY 2025 and 2026 Prop 35 allocations, including federal matching funds for all relevant categories.** Specific proposals by DHCS that meet these criteria will ensure that the PAHCA-SAC is focusing on funding mechanisms that are feasible to implement. It will also support the Department in finalizing the overarching funding structure and move forward with defining the important details that will underly each of the financing mechanisms.

LHPC Prop 35 Implementation Recommendations

In addition to the recommendations outlined above, LHPC offers high-level implementation recommendations in the short-term (approach for CY 2025 and 2026) that are consistent with LHPC Prop 35 implementation principles of simplicity, access, and quality. Given that Prop 35 outlines specific dollar allocations for CYs 2025 and 2026, and percentage allocations thereafter, we believe DHCS should plan for a short-term approach that would be reevaluated for CY 2027.

For the short-term approach in CYs 2025 and 2026, LHPC is generally supportive of DHCS pursuing a directed payment approach through the managed care delivery system, however, **we strongly recommend DHCS work closely with local plans and committee members on the important details and parameters of what the directed payment methodology should look like for each Prop 35 domain**. **There must be a balance between developing an approach that minimizes complexity, while also considering ways to address provider payment inequities and disparities that lead to access challenges.** For example, this may mean that directed payment methodologies consider existing provider payment rates or other benchmarks.

DHCS must also ensure that directed payments support beneficiary access to care through robust provider networks. As such, DHCS should continue its current directed payment policy which requires that providers be contracted with the plan in order to receive enhanced funding via directed payments. The only exception should be for services mandated by federal or state law to be reimbursed regardless of network provider status.

In addition, DHCS must ensure that all Prop 35 payment mechanisms or payment methodologies supplement any existing funding, ultimately resulting in net new dollars for all providers that are eligible for the provider rates increases with the goal of further increasing access to care.

Funding Allocations that Do Not Necessitate Federal Approval

Lastly, LHPC strongly urges DHCS to proceed with implementing the funding allocations and payment increases for Graduate Medical Education (GME) and abortion services, as these changes do not require federal approval. Due to the nature of the GME program cycle, if the 2025 funds are not expended immediately, critical workforce funding will be delayed thus exacerbating California's current healthcare workforce shortage. With respect to abortion services, the general parameters for enhanced funding were outlined in DHCS' policy proposal from January 2024, and we recommend DHCS move forward with implementation after consultation with plans and providers to confirm the parameters proposed last year are still achievable.

Thank you for the consideration of LHPC's recommendations outlined in this letter. LHPC and local plans are committed to partnering with DHCS and the members of the PAHCA-SAC on timely and thoughtful implementation of Prop 35 to support improved access and outcomes for the 1 in 3 Californians that rely on the Medi-Cal program.

Sincerely,

Original Signed by

Linnea Koopmans
Chief Executive Officer
Local Health Plans of California

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

UNIVERSITY OF CALIFORNIA HEALTH

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April 25, 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) and as a member of the Protect Access to Health Care Act Stakeholder Advisory Committee, I am writing to provide input concerning the allocation of Proposition 35 funds to hospital providers.

UC Health's six academic health centers are an essential part of California's health care safety net system. As designated public hospitals, 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.

This letter provides input for the allocation of Proposition 35 funds for hospital outpatient services, emergency department facility services, designated public hospitals (DPHs), and behavioral health facility throughput. The intent of the voters in enacting Proposition 35 was to guarantee that health care taxes be used to improve Medi-Cal members' access to care. In recognition of the strong positive correlation between provider rates and access, the measure furthers this goal by dedicating funds raised by the managed care organization tax for provider rate enhancements and certain workforce initiatives, including graduate medical education

investments overseen by the UC. In order to implement the measure in furtherance of these goals, the Department of Health Care Services (DHCS) should fully expend Proposition 35 funds on hospital providers in a way that is timely, easy to implement, allows for ongoing flexibility, and can be targeted.

Hospital Outpatient Services and Emergency Department Facility Services

Concerning funding for hospital outpatient services and emergency department facility services, given the limited time in which to develop payment approaches for 2025 and 2026, DHCS should employ the approach suggested below for the 2025 and 2026 calendar year funding, which would allow time to adequately vet proposals and plan for the shifting landscape of federal rules for funding provided in 2027 and beyond.

- For calendar year 2025 funding, the state should pursue a state-only grant program, which would initiate payments to hospitals in a timely manner and not require additional federal approval. Grant amounts could be based on a hospital's respective inpatient and outpatient Medi-Cal utilization, with a minimum grant amount for the smallest hospitals.

- For calendar year 2026 funding, DHCS should reserve a portion of the total amounts for targeted increases to fee-for-service (FFS) rates for select outpatient and emergency department codes and use remaining funds for directed payment programs. This approach would allow DHCS to fully fund hospitals, maximize federal financial participation, and would allow for ongoing flexibility to achieve various policy goals. DHCS can work with the hospital field in the coming few months to develop the details of this proposal.

Designated Public Hospitals (DPHs)

For funding allocated to DPHs beginning in 2025, DHCS should use a similar grant approach as that suggested above for hospital outpatient services and emergency department facility services. Specifically, funding for DPHs should be used toward inpatient services provided for and paid for by the Medi-Cal FFS program. Given that DPHs do not receive state General Fund support for supplemental payments, a grant approach would help to reduce the non-federal share burden that has historically been placed on DPHs.

Behavioral Health Facility Throughput

Regarding the behavioral health facility throughput funding for calendar years 2025 and 2026, DHCS should provide a combination of across-the-board per diem rate increases for inpatient psychiatric services and either payments or grants to help emergency departments provide care to individuals with behavioral health needs, including care that is currently unreimbursed.

I understand that organizations representing hospitals will be submitting similar input concerning the allocation of these funds, and I urge DHCS to expend Proposition 35 funds in alignment with our collective suggested approach. Thank you for considering our input and request.

Sincerely,

Original Signed by

Tam 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

April 23, 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 a member of the Protect Access to Health Care Act Stakeholder Advisory Committee, I am writing to urge the Department of Health Care Services to expedite the release of $75 million for graduate medical education (GME) for calendar year 2025 to UC, to ensure an effective and timely rollout of Proposition 35 GME funds to medical residency and fellowship programs across the state. In order to provide funding to these training programs by the start of the academic year, UC must receive funds as soon as possible, and by no later than July 1, 2025.

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. Proposition 35 GME funding builds upon the CalMedForce grant program, funded by Proposition 56, which UC oversees, by expanding the specialties eligible for funding, further supporting expansion of existing GME programs, and supporting the accreditation process of new programs. Although Proposition 56 allows funding to be awarded to accredited residency programs outside of Family Medicine, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Emergency Medicine, UC has not been able to do so because demand for funding has far superseded the amount of funding available. In the last award cycle, over $139 million in funding was requested but only $25 million was available for grant awards.

As with Proposition 56, UC will oversee the programs and activities supported by Proposition 35 GME funds, with priority for accredited residency and fellowship programs that serve Medi-Cal patients and are located in physician shortage areas, with the goal of increasing the number of GME positions in California. Through seven award cycles, CalMedForce has provided over 780 awards totaling more than $255 million to residency programs across 32 counties (https://calmedforce.shinyapps.io/CMF_dashboard/). To continue this progress, the process and timeline for issuing awards in 2025 must align with the 2025-2026 academic year, which begins July 1, 2025.

The timing sensitivities associated with recruiting GME trainees and administering funds should also be considered. Accredited GME programs must follow strict requirements in the recruitment of new and incoming residents, including a timeline for the national "Match" process. The Accreditation Council of Graduate Medical Education (ACGME) oversees the accreditation of residency and fellowship programs in the U.S and determines the number of accredited positions a GME training program can have, whether it be a new or expanding program. This designation is required for eligibility of both Proposition 35 and 56 GME grant funding. Lastly, a call for applications with time for submission, to review and score of applications, and make funding announcements so GME programs can make the proper planning decisions, at minimum take four months to complete. Thus, to ensure a successful rollout of Proposition 35 GME funds and to maximize participation in the program for FY 2025-26, funding must be allocated to UC as soon as possible, and by no later than July 1, 2025.

Unlike other allocations of Proposition 35 funds, for which Protect Access to Health Care Act Stakeholder Advisory Committee input is necessary to develop payment methodologies, Proposition 35 GME funding can be administered based on the longstanding approaches that have been used to administer Proposition 56 GME funding. Priority will be placed on GME positions in programs which deliver care to populations which are under-resourced and/or in shortage areas to address the physician shortage, the maldistribution of physicians, and health care disparities in California. Moreover, the administration of GME funding is not predicated on federal approval.

The UC is eager to continue this important work to increase the size of the physician workforce in California. Thank you for considering our request.

Sincerely,

Original Signed by

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

April 25, 2025

Department of Health Care Services
1501 Capitol Ave,
Sacramento, CA 95814

Re: PAHCA-SAC Input

Dear Lindy Harrington:

Thank you very much for the opportunity to provide recommendations in my role as a member of the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC). On behalf of dental providers, I would like to thank DHCS for its commitment to improving the Medi-Cal Dental program. Proposition 35 is a significant opportunity to build on the previous successes in strengthening the dental program and increasing oral health access among Medi-Cal beneficiaries. Understanding that the Improved Dental Services dollars focused on specialist and restorative dental care will not kick in until 2027, this letter highlights other avenues where Prop. 35 funding has the potential to improve access to dental care by increasing the ability of hospitals to see dental patients in their operating rooms and expand specialist care through dental residencies.

In my role as a private practice dentist as well as my position as Chief Dental Officer at La Clínica, I see a wide range of patients, including those with disabilities and special health care needs that require special dental equipment or anesthesia for basic dental services. In both settings, we work on providing as many of the dental services we can in-office. However, there are many children with special health care needs or medically complex individuals that must be seen in a hospital setting. Unfortunately for these patients and their families, this often means they will face a significant wait before they can receive necessary care in an appropriate setting. In talking with other dental providers, I find that long wait times, often over a year, is a typical wait time for hospital dentistry.

We have continued to hear for over a decade that facilities, especially hospitals, struggle to maintain operating room access to dental services because the facility rates are so low and in some instances are significantly lower than the facility fees for similar medical services. This has been such a consistent national problem that starting in 2023, the Center for Medicare and Medicaid Services (CMS) made two different code level changes to address this issue. CMS reassigned the code used for dental anesthesia, CPT 41899, to APC 5871 (with a geometric mean of $1,973.71) instead of the previous code, APC 5161 (geometric mean of $212.05). CMS found that APC 5871 was the most appropriate, clinically related APC group for this code. In that same rule, CMS also created a new code, HCPCS code

G0330, that describes facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia (e.g. general, intravenous sedation (monitored anesthesia care)) and use of an operating room." CMS applied APC 5871 to this new code as well.

The CMS final rule noted extensive comments from families of patients with disabilities explaining the long waiting lists, the need to travel long distances and the limited number of providers available. I can attest that at our Children's Hospital Dental clinic we have patients coming from as far as the Oregon border for care at our site. During these delays in care, patients' dental health often further deteriorates, which can result in greater pain for patients, infection, a need for more complicated procedures, or avoidable tooth loss. Commentors also noted that hospitals have reduced their operating room availability for dental procedures, which has led to significant backlogs in patients, mostly Medicaid beneficiaries, being unable to receive timely dental treatment in hospital operating rooms. These are the exact issues that my California dental colleagues and I see every day across our state.

In the three years since this rule, 24 states have adopted or upgraded the fees for CPT 41899 or G0330 to help address this nearly universal challenge. California is not unique regarding this long-standing issue as the dental community has tried to address this for many years.

To address this longstanding concern, I encourage the Department to explore whether a portion of the Prop. 35 funds assigned to community and outpatient procedures or hospitals could be used to increase facility fee rates for dental treatment provided in hospital operating rooms.

Additionally, in the materials presented on April 14 at the PAHCA-SAC meeting it was noted that Prop 35. allocates $75 million annually to Graduate Medical Education (GME) in 2025 and 2026. I urge the Department to consider allowing a portion of the GME funding to support the expansion of dental residency GME programs in the state. While not every dentist will go through a residency program, dental residencies train dentists in specialties such as oral maxillofacial surgery, endodontics(root canals), prostodontics(dentures etc), and periodontics(most critical for our pregnant and diabetic patients), providing them with refined and additional skills that allow them to treat the most complex cases. There are also three types of dental residency programs: General Practice Residency, Advanced Education in General Dentistry and Pediatric Dentistry that focus on additional training for residents caring for children and those with special health care needs. California's network of community health centers play a pivotal role in the training of diverse dentists and physicians through the Teaching Health Center (THC) GME program. THC programs are accredited community-based training programs dedicated to training dentists in community-based settings with a focus on rural and underserved communities. Prop. 35

provides a crucial opportunity to support and expand training in the dental workforce to care for the underserved Medi-Cal population.

It would be a significant benefit to Medi-Cal members if Prop. 35 could be used to increase hospital access for necessary dental care while also growing the specialist dental workforce.

I look forward to working with the Department and Advisory Committee to see Prop. 35 funds allocated that will lead to increased access to care and overall improved health outcomes for patients. Thank you for your consideration of these comments. If you have any questions about this letter, please reach out to me at aterlet@aol.com or (510) 207-1471.

Sincerely,

Original Signed by

Dr. Ariane Terlet, DDS

Cc:

Richard Figueroa, Deputy Cabinet Secratary, Office of Governor Gavin Newsom
Michelle Baass, California Department of Health Care Services
Dana Durham, California Department of Health Care Services
Rosielyn Pulmano, Health Policy Consultant, Office of Assembly Speaker
Brianna Pittman-Spencer, California Dental Association
Monica Montano, California Dental Association
Kathyrn Scott, California Hospital Association
Francisco Silva, Esq., California Primary Care Association

April 24, 2025

VIA ELECTRONIC TRANSMISSION TO DHSCPAHCA@dhcs.ca.gov

Lindy Harrington, Assistant State Medicaid Director

California Department of Health Care Services

RE: Implementation of Proposition 35 Investments to Expand Access to Abortion and Family Planning, and Strengthen our Community Clinics and Health Centers Statewide

Dear Ms. Harrington:

As Co-CEO of Essential Access Health (Essential Access) and proud appointed member of the Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC), I am writing to submit the following comments and recommendations regarding the implementation of the Protect Access to Health Care Act ("Proposition 35") 2025 investments focused on expanding abortion and family planning services and strengthening access to essential health care at community clinics and health centers statewide.

Essential Access advances reproductive equity and champions high quality sexual and reproductive health care for all. We have served as the Title X federal family planning grantee for California since the program was established in 1970. Last year, the Title X provider network served more than 500,000 patients at more than 350 health centers collectively operated by federally qualified health centers, City and County Health Departments, universities, hospitals, Urban Indian health centers, stand-alone family planning clinics, and Planned Parenthood affiliates. As the administrator of three state-funded abortion access grant programs established post-Roe, Essential Access has supported the delivery of abortion and contraceptive services for more than 130,000 patients to date at a wide range of health settings that care for Medi-Cal and Medi-Cal eligible patients.

In November 2024, California voters overwhelmingly voted to support the investments in Medi-Cal outlined in Proposition 35. I strongly urge the Department of Health Care Services (Department) to consider and adopt the following comments and recommendations, and I am looking forward to continuing to partner with the Department to support effective and timely imlementation of Proposition 35 as a PAHCA-SAC member.

Increase Reimbursement for Abortion Services

I recognize the extensive time, energy, resources, and engagement that went into the development of the Department's 2024 proposals for implementing the $90 million investment from the Medi-Cal Provider Payment Reserve Fund (MPPRF) to support family planning and abortion access as part of the 2024-25 Governor's Proposed Budget. The Department's original proposals to implement uniform base rate increases for both surgical and medication abortion, as reflected in the September 2024 Medi-Cal Provider Payment Increases 2025 Reproductive Health Stakeholder Policy Brief, is an important first step toward strengthening California's network of abortion providers and in turn, access to abortion care statewide.

Considering the urgency for action, I recommend that the Department move forward with implementing the proposed base rate increases for both surgical and medication abortion services to at least $1,150, inclusive of Proposition 56 supplemental payments and effective retro-actively to January 1, 2025, without further delay.

Based on information included in the Department's September 2024 Stakeholder Brief, the cost of these increases is estimated to be $70 million.

I recommend that the Department leverage the remaining $20 million to further increase access to abortion and family planning, including through additional base rate increases and/or the use of targeted supplemental payments to improve reimbursement for higher complexity abortion services.

High complexity procedures are costly to provide. If California is truly to protect access for Californians and individuals forced to travel from their home state for abortion care, reimbursement rates for more complex visits must be increased beyond the uniform base rate.

Other states have recognized the importance of reimbursement rates being consistent with the actual cost of delivering care. Specific examples can be found in this report on Medicaid reimbursement including information about NY, IL, CT, NM, MD and NJ having more than doubled their payment rates since 2017. Illinois now reimburses $1920 for a D&E.

In addition, all provider types should receive the same reimbursement for the same service delivery. Doing so will help reduce stigma and support the expansion of access points for abortion care statewide.

I encourage the Department to engage a wide range of stakeholders in dialogue as soon as possible to develop a methodology, process, and timeline for leveraging the $20 million that might remain after the base rate increase is implemented to provide highber base rate and/or supplemental rate increases for more complex visits, and exploring other possible Proposition 35 domains that might support the delivery of complex procedures including those provided in hospitals. I would be happy to participate in and Chair if needed, a separate Working Group of content experts to support the development of a short-term solution for 2025 and lay the groundwork for a longer-term solution that could take effect starting in 2027.

Strengthen Our Community Health Centers + Access to Primary Care

Community Health Centers (CHC) in our provider network and that operate statewide are a critical part of the Medi-Cal system and key access points for care for Medi-Cal patients. CHCs continue to provide a higher portion of Medi-Cal primary care visits each year.

To strengthen access to essential and comprehensive primary care services at CHCs, including I support and urge the Department to seriously consider recommendations from the California Primary Care Association (CPCA) and implement the following:

- Allow CHCs the option to carve out services and devices like expensive long-acting reversible contraception from the PPS rate with the intent to reimburse CHCs for these services and devices outside of the PPS rate and work with CHC representatives on appropriate supplemental payment structures;

- Seek federal authority for an APM that augments the yearly inflationary factor to keep pace with rising costs in California;

- Work with CPCA to establish a comprehensive payment program that supports the ability of CHCs to provide high quality care to Medi-Cal patients in alignment with other statewide efforts to advance health equity; and

- Bolster the primary care workforce by investing in the training of diverse primary care providers through the Teaching Health Center (THC) Graduate Medical Education (GME) program that reflect and represent the communities they serve.

Accelerate Implementation of Proposals that Do Not Require Federal Action

While the Department and PAHCA-SAC must consider how to operationalize investments for a wide range of domains and the Department must seek federal approval to support implementation in a number of areas, I strongly urge the Department to move forward immediately with recommendations and proposals that do not require federal action.

1. The increase in base rates for both surgical and medication abortion to at least $1,150 retroactive to January 1, 2025, which does not require federal approval, should be implemented and adopted without delay. This proposal has been in development for over a year and has the support of key Medi-Cal abortion and family planning providers. In addition, I strongly urge the Department to move forward as soon as possible with forming an ad hoc Working Group of content experts - or developing a proposal for input from key stakeholders - to develop short- and long-term solutions for increasing reimbursement rates for more complex abortion services. This is critical considering the high cost of providing this care, and the access barriers that exist because of the untenably low rates currently available.

2. There is a need for additional investments in primary care residencies to address current primary care shortages that are expected to be exacerbated and worsen in the future without further action. Sexual and reproductive health are key components of primary care. CHCs play a pivotal role in the training of diverse primary care providers through the THC GME program. Proposition 35's investments in the Medi-Cal workforce should be prioritized to include community-based primary care residencies, like THCs, to meet the current and future demand for primary care, while also ensuring the primary care workforce reflects California's diverse populations. It is my understanding that advancing investments in THCs does not require federal approval. With the state having sole discretion related to implementation with stakeholder input, I urge the Department to quickly move forward with operationalizing these new investments.

As a member of the PACHA-SAC, I appreciate the opportunity to provide the comments and recommendations above. I am looking forward to working with you and the Department to support effective and timely implementation of Proposition 35 to expand access to sexual and reproductive health and other essential health care, and get much needed investments out to the field to support Medi-Cal patients and providers as soon as possible. If you have any questions, you can reach me by phone at 415.518.4465 or email at amoy@essentialaccess.org.

In partnership,

Amy Moy, Co-CEO

Essential Access Health

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

April 25, 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 to recommend that DHCS urgently submit a State Plan Amendment ("SPA") to CMS to increase the payments to private ground emergency medical transportation ("GEMT") providers using the funds described in Welfare and Institutions Code section 14188.108.3. I request that DHCS submit this SPA before June 30, 2025.

I request that the SPA include an add-on increase to fee-for-service rates for GEMTs consistent with the rates described in DHCS' Medi-Cal Provider Payment Increases 2025 Private Ground Emergency Medical Transportation: Stakeholder Policy Brief from September 17, 2024. Consistent with that Policy Brief, I propose: (1) an elimination of the AB 97 rate reduction for private GEMT providers, and (2) the creation of an add-on that will increase the Medi-Cal fee schedule commensurate with approximately 75% the Medicare rates. I believe that this will help DHCS transition to a methodology that more closely approximates Medicare reimbursement, while at the same time providing a structure that will support rural transportation providers.

I propose that this SPA be submitted by June 30, 2025, for dates of service April 1, 2025, through December 31, 2025, at which point a new SPA will be submitted for the calendar year 2026 rates for ground emergency medical transportation services to implement Welfare and Institutions Code section 14199.115. It is my hope and the sincere expectation of California's unionized private EMS workforce, that given the lack of complexity this methodology presents, and the fact that the methodology is based on DHCS's own recommendation and calculations, that, if timing necessitates, DHCS submit an individual SPA seeking CMS approval exclusively for private ground emergency ambulance transport reimbursement. I am concerned that continued delays in this funding will begin to impact our state's EMS recruitment and retention of first responders and will further disrupt the marketplace as California's drastic disparity in reimbursement continues to favor higher cost public GEMT operators over private emergency ambulance providers.

The rates I describe above would be dollar increases to current Medi-Cal fee schedule rates, not a percentage of Medicare methodology for ease of implementation. In other

words, an increased fee schedule would not impact current Medi-Cal rules for coverage, billing, etc. The resulting fee schedule would be as follows:

Procedure Code	Procedure Code Description	Current Medi-Cal FFS Aggregate Reimbursement (inclusive of QAF Add-on)	Proposed Prop 35 Dollar Increase Add-On	Medi-Cal FFS Aggregate Reimbursement (inclusive of QAF Add-on and Prop 35 Add-on)
A0429	Basic Life Support-Emergency	$339.00	$41.78	$380.78
A0427	Advanced Life Support Level 1-Emergency	$339.00	$111.47	$450.47
A0433	Advanced Life Support, Level 2	$339.00	$323.92	$662.92
A0434	Specialty Care Transport	$339.00	$431.54	$770.54
A0225	Neonatal Emergency Transport	$400.72	$598.02	$998.74
A0425	Ground Mileage	$3.55	$3.39	$6.94

I note that while HCPCS codes A0434 and A0425 are billable for emergency and non-emergency transports, only private emergency transports will be eligible for these increased rates. Likewise, dry runs that are currently eligible for payment will continue to be eligible for payment at the base rate but will be ineligible for this proposed Prop 35 add-on.

I request that DHCS include the following language in the SPA: “The resulting total payment amount in the table above is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.”

I thank you for your quick response to implement this recommendation.

Sincerely,

Original Signed by

Jason Sorrick

Cc: Alek Klimek (via e-mail to alex.klimek@dhcs.ca.gov)
Hatzune Aguilar (via e-mail to hatzune.aguilar@dhcs.ca.gov)

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April 25, 2025

Lindy Harrington, Assistant State Medicaid Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS
Department of Health Care Services (DHCS) PAHCA-SAC Team
1501 Capitol Ave. Sacramento, CA 95814

Re: Written input following April 14, 2025, Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC)

Dear Lindy, Rafael, and Department of Health Care Services (DHCS) PAHCA-SAC Team,

Thank you for the opportunity to provide feedback on the information and materials presented at the April 14, 2025 PAHCA-SAC meeting. During our meeting DHCS presented materials explaining the governance for the PAHCA-SAC Committee, the framework of Proposition 35, the existing payment methodologies each category of allocation, and some of the methodologies that could be applicable to the distribution of Proposition 35 funds in both the Fee-For-Service (FFS) and managed care environments.

DHCS requested that committee members and the public provide comments on the information and materials as presented, as well as any suggestions regarding methodologies that the Department may utilize for distribution of the funds. For the purpose of this comment letter, the comments on methodology are only applicable to the managed care environment.

Comments regarding form and structure of the meeting:

1. The Department should consider providing the Advisory Committee with additional information to support the work of the Advisory Committee as follows:
   - A list of which categories require federal approval and which do not, in the opinion of the Department
   - A comprehensive list of all methodologies that can be employed to operationalize the MCO tax
   - A clear list of the steps that must be taken in order for the MCO tax funds to be considered encumbered
   - A meeting schedule for the rest of the calendar year 2025 (meetings can always be canceled if not needed)
   - A legend of acronyms for Advisory Committee members who are new to this environment
2. The Department should consider working with the Advisory Committee to develop a detailed workplan that clearly states:
   - Deadlines for submission of state plan amendment (SPA) or other materials required to effectuate the methodology and distribution of funds

- A target date by which the Department wishes to have the 2025 funds designated as encumbered
- Date(s) by which the Department intends to share its methodology proposal with the Advisory Committee for development and implementation of Proposition 35 requirements, including distribution of the MCO tax.

3. The hybrid meeting optionality is greatly appreciated. Many thanks to the Department for its flexibility.

Comments related to payment methodologies and processes:

1. I encourage the Department to consider how this funding can be aligned to other funding mechanisms already in flight to optimize impact and results (e.g., targeted rate increase, behavioral health transformation/ children and behavioral health initiative, etc.).
2. I encourage the Department to consider how these funds can support critical work in flight to achieve the Department's bold goals, including health equity and improving access to care.
3. I respectfully request that the Department eliminate Uniform Dollar Increase as a potential methodology given the extreme difficulty in implementing this methodology for the targeted rate increase (TRI) in specific markets. For the following reasons:
    - managed care plans (MCPs) were required to ensure downstream, delegated and capitated providers are adhering to TRI despite MCPs not having line of sight into IPA payments and IPAs rightful resistance to sharing that information
    - in order to comply, MCPs are required to attest that all capitated contracts are updated to reflect TRI rates. MCPs cannot unilaterally force a provider to sign a contract

For these reasons, I respectfully request that the Department consider a pass-through methodology similar to Prop56 or a minimum fee schedule methodology.

Thank you for the opportunity to submit these comments.

Respectfully,

Original Signed by

Kristen Cerf
President and Chief Executive Officer
Blue Shield of California Promise Health Plan

Clinica Sierra Vista

April 24, 2025
California Department of Health Care Services
Re: Protect Access to Health Care -Stakeholder Advisory Committee. Written comments

Dear DCHS staff,

I would like to extend my sincere appreciation to the staff for hosting the inaugural committee meeting on April 14th. Please find below my written comments regarding the materials presented during the meeting.

The Role of Community Health Centers in California

Community Health Centers (CHCs) is a broad term that refers to community-based health care organizations that deliver comprehensive and culturally competent care to medically underserved populations regardless of a patient's ability to pay. CHCs include FQHCs, FQHC Look-Alikes, rural health centers and other health centers that serve special patient populations.

Approximately 15 million Californians are enrolled in Medi-Cal, and among them, 7.7 million—over half—receive their care through community health centers.

Expanding Beyond Primary Care

Given their substantial presence in the primary care landscape, CHCs have expanded their services to foster continuity of care that addresses the complex health needs of Californians. In addition to primary care, CHCs serve as key stakeholders in domains such as reproductive health, specialty care, hospital-based services, graduate medical education, among others. Their contributions across these areas underscore the necessity of including CHCs in all phases of funding discussions and initiatives across the healthcare delivery system. Failing to ensure the financial stability of CHCs would jeopardize access to care for nearly half of all Medi-Cal beneficiaries.

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Challenges in the Current Payment Model

Reliance on the PPS Methodology

CHCs primarily receive reimbursement through a federal payment methodology called Prospective Payment System (PPS), a cost-based compensation model. While PPS rates are adjusted annually by an inflationary factor, the adjustments have not kept pace with actual cost increases. For example, in 2025, the Medicare Economic Index (MEI) was only 3.5%, despite salaries and supply costs rising at significantly higher rates.

Primary Care and Behavioral Health/Optometry/Specialty Integration

CHCs are expected to address not only medical needs but also behavioral health and social determinants of health. However, current PPS rules prevent CHCs from billing for multiple medical services on the same day. For instance, if a patient is seen by a primary care provider and then referred to a different provider during the same day of service, only one PPS payment is permitted.

For a CHC to receive the PPS rate when providing care by different medical services, the patient must return on a different day resulting in delays in access to care and possible consequences on the patient's health. In addition, given the transportation and access challenges faced by many Health Center patients, this limitation hinders integrated, patient-centered care.

A more flexible Alternative Payment Methodology (APM) could resolve this issue. Under this model, the initial visit would continue to be reimbursed under PPS, while same-day visits with other providers (e.g., behavioral health, optometry, specialty care) could be reimbursed separately under the APM without being subject to reconciliation.

Extended Care Team Members

The current PPS framework also excludes many vital care team members from reimbursement eligibility. Providers such as clinical pharmacists and community health workers (CHW)—who play essential roles in chronic disease management and preventive care—are not currently recognized for direct compensation under PPS. This omission restricts the ability of CHCs to deliver fully integrated, team-based care.

An Alternative Payment Model that compensates for services not covered under the PPS model could address this issue to maintain high quality coordination of care and appropriate utilization. If clinical pharmacists or CHW can see patients for chronic disease management and bill an APM for those services, primary care providers will have more access to care to attend other healthcare needs.

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Reproductive Health and Specialty Care

The cost of clinical devices, including Long-Acting Reversible Contraceptives (LARCs), has risen at rates well above the annual inflationary adjustments. Yet, CHCs are only reimbursed for a single PPS rate per visit, even if multiple complex services are provided. For example, if a provider offers family planning counseling and inserts a contraceptive device during the same visit, only one PPS payment is received, with any additional reimbursement subject to reconciliation. This makes the delivery of comprehensive reproductive health services financially unsustainable.

Supplementing the procedure compensation for separated procedure expenses, such as LARCS via APM could promote better access to reproductive health in community health centers.

As an example, the state of Georgina followed a similar approach in 2015 which the costs of the LARCS were carved out of the PPS rate and payment was provided for the devices. Securing funding for LARCSs subsequently resulted in decreasing the rate of unintended pregnancies from 60% in 2010 to 43% in 2017.

Hospital Services and Specialty Domains

Community Health Centers often provide critical inpatient support, including obstetrical and newborn care, especially in communities where they serve as trusted primary care providers. However, CHC-affiliated physicians delivering care in hospital settings are reimbursed through standard fee-for-service models, which do not adequately compensate for the cost of services or align with PPS rates.

To ensure sustainability, CHCs providing hospital services should receive either targeted rate increases, or supplemental payments equivalent to PPS professional service rates via APMs or through Targeted Rate Increases payments. These payments must not be subject to any form of reconciliation to maintain financial viability.

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Transportation

CHC are mandated to provide transportation assistance to patients. In the current state, CHCs pay directly for transportation costs for patients under a sliding fee scale and health plans pay for transportation expenses as long as the transportation is requested during a specific time frame. However, Health plans typically ask for a 48h notice of transportation in order to pay for the expenses. This excludes patients with last minute changes and patients seeking same day visits. In those cases, CHCs have to absorb the transportation costs.

Supplemental funding via an Alternative payment model should be able to reimburse for transportation expenses to support access to care.

Graduate Medical Education (GME)

CHCs are uniquely positioned to support the training of the next generation of healthcare providers. Research has shown that residents trained in Medically Underserved Areas are more likely to stay in those areas after completing training.
CHCs can be involved in graduate medical education by serving as continuity sites for residency programs or becoming sponsoring institutions themselves. However, graduate medical education funding opportunities are generally restricted to the sponsoring institution, leaving CHCs responsible for the preceptor compensation and other training-related costs when collaborating with other organizations. Even though “resident physician” outpatient visits are still reimbursable under the PPS rates, the number of patients seen per day by trainees is lower to support training and safe patient care.
Dedicated funding should be made available to support CHCs that contribute to GME but are not the primary recipients of federal training funds.

This is particularly urgent considering projections from the California Department of Health Care Access and Information (January 2024), which indicate that nearly 40% of the state's physicians plan to retire within the next decade.
Assembly Bill 2357, which proposes establishing a new medical school in Kern County, represents another forward-thinking response. Full funding of this initiative is essential to developing a future physician workforce while experienced clinicians are still available to serve as mentors.

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Recommendations to DHCS

1. **Structure the PACH funding as an MCP directed payment and obtain Federal Approval for an APM Methodology:**
   The APM methodology would allow FQHCs and RHCs to retain the differential between the APM rates and the PPS rates.
2. **Supplement PPS Inflationary Adjustments:**
   Seek federal approval for the APM to supplement the annual inflationary factor to better reflect California's real-world costs in regard to staffing, supplies, and overall operational costs.
3. **Carve out the costs of specific services from PPS rates**.
   Work with CHCs or CHC representatives to allow the option to carve out the cost of specific services from PPS rates. These services should be reimbursed outside of the PPS rate and not subject to reconciliation.
4. **Funding for transportation**
   Provide supplemental payments to FQHC when providing transportation services.
5. **Exclude Supplemental APM Payments from Reconciliation:**
   Any payments made under the new APM model should not be subjected to reconciliation processes, thus allowing CHCs to confidently invest in expanded services and infrastructure.
6. **Ensure Protection of Existing Funds:**
   Supplemental payments must be treated as distinct funding streams and should not replace existing funding or grants.
7. **GME supplemental funding for CHCs**
   Provide supplemental funding to CHCs to support graduate medical education when collaborating with other organizations.
8. **Funding for new UC medical school in Kern County**
   Provide funding for the creation of the new UC Medical School in Kern County

Conclusion

Community Health Centers are indispensable to California's healthcare system, particularly for underserved and vulnerable populations. Ensuring their financial sustainability and expanding their capacity to deliver comprehensive care requires structural reforms in how they are reimbursed. Implementing an equitable, flexible, and forward-looking payment model is critical to advancing access, quality, and innovation in community-based care.

Electronically signed:

Irving Ayala-Rodriguez, M.D.

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References:

1.- Chapman, A., & Pellón, S. (2022, May). *Medi-Cal explained: How health centers are paid*. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/05/MediCalExplainedHealthCentersPaid.pdf

2.-Waxman Strategies. (2021, October 22). *Medicaid reimbursement policy options for expanding access to long-acting reversible contraception at federally qualified health centers*. https://waxmanstrategies.com/wp-content/uploads/2021/10/Waxman-LARC-10.22.21.pdf

3.- California Department of Health Care Services. (2023, August 23). *Frequently asked questions for Medi-Cal transportation services*. https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_General_FAQ.aspx

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February 7, 2025

Rafael Davtian, Deputy Director, Health Care Financing
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Sent via email to: Rafael.Davtian@dhcs.ca.gov

Re: Proposition 35 Primary Care Spending Plan Proposal for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

Dear Deputy Director Davtian,

On behalf of over 1,300 community health centers (CHCs) that provide high-quality, comprehensive care to more than 7.7 million Californians annually, the California Primary Care Association (CPCA) appreciate you considering proposals to ensure investments in primary care reach the full breadth of Medi-Cal providers, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in order to meaningfully impact access, equity, and quality of care for Medi-Cal patients.

Introduction

Prop 35 provides that the increased reimbursement rates and other payments stemming from the primary care and specialty care accounts will be "considered separate and apart from any other reimbursement and shall not be considered during, or factored into, any annual reconciliation." (Welf. & Inst. Code § 14199.108.5(b).) Moreover, Prop 35 specifies that the funding from the MCO Tax "shall not be used to replace or supplant state revenue sources already in existence" before the time Prop 35 is effective. "Moneys [derived from the MCO Tax] shall only be used 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." (Welf. & Inst. Code § 14199.107(a)(1).)) Together, these provisions are to be read as requiring that FQHCs/RHCs receive increased payments from MCO Tax sources and that these funds cannot be considered or recouped in the context of any annual reconciliation processes beginning in January 1, 2025. Welfare and Institutions Code section 14199.108.5 specifically applies the non-reconciliation and non-supplantation language to expenditures during calendar

years 2025 and 2026 (Welf. & Inst. Code § 14199.108.3) in addition to allocations for 2027 and beyond.

As mandated by Prop 35, the State, in consultation with the Stakeholder Advisory Committee (Welf. & Inst. Code § 14199.121(a) and 14199.129.), must carefully construct the mechanism for distributing the primary care and specialty care funding to FQHCs/RHCs, in addition to non-clinic practitioners, to ensure that such funding is not recouped by the State through reconciliation. CPCA has conducted extensive research on viable options for the State and developed mutually inclusive proposals, outlined below, for how the State can implement this mandate.

Recommendation 1: Increased Rates through an APM paid as State Directed Payments

Federal law allows states to provide payment to an FQHC or RHC under an alternative payment methodology that (1) is agreed to by the State and the center or clinic; and (2) results in payment to the center or clinic of an amount which is *at least* equal to the amount otherwise required to be paid to the center or clinic under PPS. (42 U.S.C. § 1396a(bb)(6).) APMs offer states flexibility in designating payment models that enable FQHCs and RHCs to retain additional reimbursement beyond their PPS rates in order to increase access to quality care for Medi-Cal patients. Historically, states and the Centers for Medicare & Medicaid Services (CMS) view any add-on to the PPS rate as an APM. For example, Illinois made a $50 million investment in its CHCs in 2021 and another $50 million in 2023 which was used to increase PPS rates by approximately 11.5% in each of those years. These increases to PPS rates took place via an APM reflected in State Plan Amendment (SPA) # 23-0034.

In 2024, revenues from an MCO tax were used to fund Targeted Rate Increases (TRIs) for primary care, obstetric care, and non-specialty outpatient mental health services provided by eligible Medi-Cal providers. The State implemented the TRI payments through a state directed payment authorized pursuant to 42 C.F.R. § 438.6(c). Directed payment arrangements may be effectuated by imposing a minimum or maximum fee schedule, providing for a uniform rate increase (a type of directed payment that requires MCOs to pay a uniform dollar or percentage increase in payment above negotiated base payment rates), or developing a value-based payment methodology (such as pay-for-performance incentives and shared savings arrangements). Hence, the State can once again utilize a directed payment to implement increased payments rates under Prop 35.

Because managed care plans (MCPs) are required to reimburse contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that the MCP would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC, FQHCs and RHCs were paid the TRIs when applicable (Welfare & Institutions Code § 14087.325(d), 42 U.S.C. 1396b(m)(2)(A)(ix).) In 2024, however, these TRIs were subject to reconciliation, as such MCPs and FQHCs and RHCs needed to track the amounts of the TRIs to determine amounts that would be subject to reconciliation. Because these systems were put in place for the 2024 TRIs, a similar methodology could be utilized to track and identify increased rates paid under Prop 35 that would not be subject to reconciliation.

CPCA recommends DHCS structure the Prop 35 primary care account spending plan as a MCP directed payment arrangement and seek federal authority for an alternative payment methodology (APM) that allows FQHCs and RHCs to retain the differential between the APM and the PPS rates.

Recommendation 2: Supplemental Reimbursement through an APM for Inadequately Reimbursed Costs

FQHCs are paid using a prospective payment system (PPS) methodology, which is a per visit rate calculated on a cost-related basis. This rate is increased by the percentage increase in the MEI for that fiscal year and can be adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year. (42 U.S.C. § 1396a(bb).) There are some costs, however, that can fluctuate at any given time making it difficult to accurately capture these in costs in the rates. An example of these are certain pharmaceutical costs such as vaccines, laboratory services, and long-acting reversible contraceptives (LARCs). Accordingly, these costs should be based on actual acquisition cost and not included in the PPS rates. This provides a mechanism for the FQHC to be adequately compensated and gives the FQHC the ability to maintain an adequate stock, thus increasing access to important preventive care and family planning services for Medi-Cal recipients. Delaware has taken this approach which is reflected in State Plan Amendment # 17-003.

Another cost that may not be adequately captured is the cost for Community Health Workers (CHWs). Pursuant to Welfare & Institutions Code § 14132.100(g) and Attachment 4.19-B of the California State Plan, only FQHC visits with specified physicians and other non-physician health professionals are eligible for PPS or an All-Inclusive Rate (AIR) reimbursement. A CHW visit does not constitute a PPS-eligible visit under current law and the State Plan. The same issue is true

for Certified Wellness Coach (CWC) services hence the Department will submit SPA 25-0014 to (CMS) to seek federal approval to adopt CWC as a new state plan benefit. The proposed SPA is proposing to reimburse FQHCs, RHCs, and Tribal FQHC providers a supplemental reimbursement amount through an APM for services provided by CWCs. A similar approach could be taken for CHWs.

Another area where FQHCs' current reimbursement through Medi-Cal fails to adequately cover the costs of services patients need access to is transportation. FQHCs are currently absorbing the costs of required and necessary patient transportation, a service they are mandated by the Health Services and Resources Administration (HRSA) to provide as FQHCs but are costs that are not currently being reimbursed by DHCS. While there is an existing transportation benefit through Medi-Cal administered by MCPs, that benefit doesn't allow for flexibility to address urgent and immediate patient transportation needs, and administrative barriers make it infeasible for patients to get timely transportation services, which results in FQHCs subsidizing the costs instead. A supplemental payment to FQHCs who provide transportation services needed by their Medi-Cal patients could be established to ensure that these services remain available and sustainable.

CPCA recommends 1) DHCS work with CPCA to allow FQHCs the option to carve out the cost of specific services from PPS rates with the intent to reimburse these carved out services outside of PPS; 2) DHCS work with CPCA to establish supplemental payments outside of PPS for necessary Medi-Cal services that are not included in the PPS rate or otherwise reimbursed within PPS.

Recommendation 3: Increasing the Annual Inflationary Factor

The Medicare Economic Index (MEI) is used to adjust FQHC Prospective Payment System (PPS) rates annually. Historically, however, the MEI has lagged behind other inflationary factors, such as the Consumer Price Index (CPI) and Market Basket. Accordingly, FQHC rates have also lagged behind and have not caught up with the actual cost of care. As such, other states, including Texas and Washington, have implemented APMs that apply higher than MEI adjustments to PPS rates. For example, Texas adds 0.5% to the MEI and Washington employs a state-specific healthcare index if it exceeds MEI.

CPCA recommends DHCS seek federal authority for an alternative payment methodology that augments the yearly inflationary factor to keep pace with rising costs in California.

California Primary Care Association

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Thank you for considering proposals to ensure the additional investments in Medi-Cal primary and specialty care services provided for in Prop 35 include FQHCs/RHCs so that the investments have a consequential impact on the capacity and outcomes of the Medi-Cal system given that CHCs provide a plurality of primary care and specialty medical care to Medi-Cal enrollees. We look forward to working with the Department, the Legislature, and other stakeholders to ensure we achieve our collective goal of advancing access, quality, and equity for Medi-Cal patients. For clarification or additional information regarding CPCA's comments, please contact CPCA's Deputy General Counsel, Catrina Reyes, at creyes@cpca.org or CPCA Director of Health Center Optimization, Emily Shipman, at eshipman@cpca.org.

Respectfully,

Original Signed by

Allie Budenz
Vice President of Health Center Optimization
California Primary Care Association

cc: Alek Klimek, Assistant Deputy Director, Health Care Financing
Lindy Harrington, Assistant State Medicaid Director

January 10, 2025

Michelle Baass, Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

RE: Proposition 35 Primary Care Spending Plan Proposal for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

Sent via email to Michelle.Baass@dhcs.ca.gov

Dear Director Baass,

On behalf of over 1,300 community health centers (CHCs) that provide high-quality, comprehensive care to more than 7.7 million Californians annually, the California Primary Care Association (CPCA) appreciate you considering efforts to ensure investments in primary care reach the full breadth of Medi-Cal providers, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in order to meaningfully impact access, equity, and quality of care for Medi-Cal patients.

Need for Greater Investments in Primary Care

California spends from 6.1 percent to 10.8 percent on primary care, while the average among OECD countries is 14 percent.[1] A Commonwealth Fund analysis identified this underinvestment in primary care as one of four fundamental reasons the U.S. health system ranks last among high-income countries.[2] Accordingly, in order for us to achieve better health outcomes, investments in primary care are critical, and must reach ***all*** Medi-Cal providers, including CHCs.

Investing in primary care drives improvement in health outcomes and access by providing healthcare providers with the supports and resources to expand their care teams to include services of staff who are appropriately trained and credentialed to provide critical care coordination and other support services, such as Community Health Workers, who are not currently billable provider types for FQHCs/RHCs. This type of care team funding and expansion ultimately frees up primary care providers to work at the top of their scope, creating greater access to primary care providers across the Medi-Cal network. In addition to expanding care teams, investing in primary care can increase the supply of primary care providers which would further increase access. For example, Rhode Island experienced an increased supply of primary care providers per capita during the time period in which the state increased primary care investments.[3]

[1] Investing in Primary Care: A State-Level Analysis, Patient-Centered Primary Care Collaborative and Robert Graham Center (July 2019), available at https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.
[2] Eric C. Schneider and David Squires, From Last to First – Could the U.S. Health Care System Become the Best in the World?, THE COMMONWEALTH FUND (July 17, 2017), available at https://www.commonwealthfund.org/publications/journal-article/2017/ jul/last-first-could-us-health-care-system-become-best-world.
[3] *Supra* at 1.

As a whole, investments in primary care such as those included in Proposition 35 would promote access to care and health equity, improve patient outcomes and experience, increase the supply of primary care providers, and reduce health care spending.

Intent of Proposition 35

Proposition 35, the "Protect Access to Health Care Act," passed the 2024 general election with significant support, receiving approximately 67% of the vote. Success at the ballot box reflects strong endorsement from California voters for sustained investments in the State's Medicaid program. The intent behind Prop 35, among other things, is to increase access to quality healthcare by establishing a dedicated funding stream to be used for increasing reimbursement rates and other supports to healthcare providers that treat Medi-Cal patients and investments in building an adequate healthcare workforce, bed capacity, and treatment options. (Welf. & Inst. Code § 14199.102(a).)

CHCs are a critical piece of California's Medi-Cal healthcare delivery system. FQHCs alone provided care to 5.3 million California patients in 2022, an increase of 31% from 4.1 million in 2015. Of these 5.3 FQHC patients, two-thirds were Medi-Cal enrollees.[4] Another CHCF report found that FQHCs, FQHC Look-Alikes, and RHCs delivered 43.7% of all Medi-Cal primary care visits in 2019, and that year after year, clinics continue to provide a higher proportion of all Medi-Cal primary care visits.[5] We further understand from our membership that CHCs likewise provide an increasing volume of Medi-Cal specialty medical care services. CHCs play a crucial role in ensuring access to specialist services for Medi-Cal enrollees by employing strategies such as contracting with or employing specialists to provide access (in person or through telehealth) for their patients to see a specialist.[6]

Given the pivotal role of FQHCs/RHCs in rendering primary and specialty care to Medi-Cal enrollees, any additional investments in Medi-Cal primary and specialty care services, including those in Prop 35, must include FQHCs/RHCs, particularly as FQHCs/RHCs provide a plurality of primary care and specialty medical care to Medi-Cal enrollees. Otherwise, those investments will not have a consequential impact on the capacity and outcomes of the Medi-Cal system. Moreover, while clinics have existed since 1965, both clinics and the health care environment in which they operate have evolved significantly over the past 60 years. The scope of services has expanded as health care delivery reform has moved towards comprehensive, whole-person care that includes addressing social drivers of health. Current payment methodologies, however, have not kept up with these changes in health care delivery and therefore, many of the services FQHCs/RHCs provide to fill the unmet needs of their local communities remain unfunded.

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[4] California Health Care Foundation, California Health Care Almanac: California's Health Care Safety Net (July 2024), available at https://www.chcf.org/wp-content/uploads/2024/07/HealthCareSafetyNetAlmanac2024.pdf (as of January 9, 2025).https://www.chcf.org/wp-content/uploads/2024/07/HealthCareSafetyNetAlmanac2024.pdf.

[5] H. DuPlessis and M. Goddeeris, 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.

[6] California Health Care Foundation, The Changing Landscape of California's Federally Qualified Health Centers (June 2021) https://www.chcf.org/wp-content/uploads/2021/06/RegionalMarketAlmanac2020CrossSiteAnalysisFQHC.pdf.

The intent that the increased investments in primary and specialty care provided for in Prop 35 are to include FQHCs/RHCs is reinforced by the explicit language in Prop 35 that provides that the increased reimbursement rates and other payments stemming from the primary care and specialty care accounts will be "considered separate and apart from any other reimbursement and shall not be considered during, or factored into, any annual reconciliation." (Welf. & Inst. Code § 14199.108.5(b).) Moreover, Prop 35 specifies that the funding from the MCO Tax "shall not be used to replace or supplant state revenue sources already in existence" before the time Prop 35 is effective. "Moneys [derived from the MCO Tax] shall only be used 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." (Welf. & Inst. Code § 14199.107(a)(1).)) **Together, these provisions are to be read as requiring that FQHCs/RHCs receive increased payments from MCO Tax sources and that these funds cannot be considered or recouped in the context of any annual reconciliation processes beginning in January 1, 2025.** Welfare and Institutions Code section 14199.108.5 specifically applies the non-reconciliation and non-supplantation language to expenditures during calendar years 2025 and 2026 (Welf. & Inst. Code § 14199.108.3) in addition to allocations for 2027 and beyond.

As mandated by Prop 35, the State, in consultation with the Stakeholder Advisory Committee (Welf. & Inst. Code § 14199.121(a) and 14199.129.), must carefully construct the mechanism for distributing the additional primary care and specialty care funding to FQHCs/RHCs, in addition to non-clinic practitioners, to ensure that such funding is not recouped by the State through reconciliation. CPCA has conducted extensive research on viable options for the State and developed proposals for how the State can implement this mandate, including through mechanisms already utilized by the State, such as directed payments and alternative payment methodologies, as well as those with federal approval and precedence in other states. We look forward to discussing these proposals with you.

Thank you for considering efforts to ensure the additional investments in Medi-Cal primary and specialty care services provided for in Prop 35 include FQHCs/RHCs so that the investments have a consequential impact on the capacity and outcomes of the Medi-Cal system given that CHCs provide a plurality of primary care and specialty medical care to Medi-Cal enrollees. We look forward to working with the Department, the Legislature, and other stakeholders to ensure we achieve our collective goal of advancing access, quality, and equity for Medi-Cal patients. For clarification or additional information regarding CPCA's comments, please contact CPCA's Deputy General Counsel, Catrina Reyes, at creyes@cpca.org or CPCA Director of Health Center Optimization, Emily Shipman, at eshipman@cpca.org.

Respectfully submitted,
Original Signed by

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