CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING MINUTES

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

Date:	Monday, May 19, 2025
Time:	10 a.m. – 3 p.m.
Type of meeting:	Hybrid
Members Present:	9
Public Attendees Present:	174
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; In-Person
- 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; Joined later Virtually
- Kristen Cerf; Present; In-Person
- Irving Ayala-Rodriguez; Present; In-Person

PAHCA-SAC Agenda Summary

The PAHCA-SAC meeting focused on the ongoing implementation of the PAHCA (Proposition 35). DHCS reviewed committee member feedback submitted following the April 14, 2025, meeting and provided updates on the development of PAHCA, including applicable payment methodologies to support access to care.

The meeting concluded with a public comment period, allowing attendees to provide feedback to DHCS and committee members.

Welcome, Opening Comments, Roll Call

Type of Action: Information

Presenter: Lindy Harrington

Discussion Topics: Welcome and roll call

Committee Member Feedback from April 14, 2025, Meeting

Type of Action: Information

Presenter: Alek Klimek

Discussion Topics:

- DHCS presented a summary of written feedback submitted by eight of the nine PAHCA-SAC members following the April 14, 2025, meeting. The feedback focused on payment methodologies, domain-specific proposals, and procedural recommendations. Key themes included the need for Proposition 35 funding to supplement, not supplant, existing funding; alignment with existing payment mechanisms to reduce administrative burden; support for using state directed payments with careful tailoring to each domain; and the potential benefits of using methodologies that do not require federal approval to accelerate fund deployment.
- COMMITTEE MEMBER QUESTION/DISCUSSION
- Committee members emphasized the importance of ensuring all Proposition 35 funds are used for their intended purposes and expressed concern about the potential redirection of significant portions of funding in 2025 and 2026. Members underscored the need for transparency and accountability in how funds are allocated, particularly around clinic funding. They called for funding mechanisms that are not solely based on utilization, but are also tied to quality standards and workforce investment. They emphasized the need to ensure

dollars flow in a way that reflects the values of the Medi-Cal program, especially access to high-quality, equitable care.

- Several members highlighted the structural limitations that community health centers face under current payment systems, particularly the Prospective Payment System (PPS). Concerns were raised that payment methodologies tied to PPS and subject to reconciliation fail to capture the full scope of services provided by community health centers and could limit the impact of new funding. There was advocacy for funding approaches that recognize the unique role and constraints of these providers.
- Additionally, members stressed the critical need to address provider shortages, especially among primary care and specialty providers serving underserved communities, and supported investments in the health care workforce as a foundational strategy to improve access to care.
- Members also emphasized the urgency of timely and advanced access to meeting materials to enable meaningful participation.

PAHCA

Type of Action: Information

Presenter: Lindy Harrington, Alek Klimek, Aditya Voleti, Rafael Davtian

Discussion Topics:

- Decision-making Considerations, Payment Methodology Overview, Targeted Rate Increases (TRI), Managed Care Capitation Rate Increases, Uniform Dollar Increases (UDI), Hospital State Directed Payment (SDP) Programs, Community Clinic Directed Payment (CCDP) Program, and Ground Emergency Medical Transportation (GEMT) Rate Add-on.
- DHCS provided a high-level overview of the Proposition 35 spending plan, emphasizing legal compliance, timely use of funds by the end of 2026, fiscal sustainability post-Managed Care Organization (MCO) Tax expiration, and alignment with Medi-Cal policy goals, like access improvement and workforce investment. The plan allocates $4.656 billion annually across twelve domains for calendar year (CY) 2025 – CY 2026, including Primary Care, Specialty Care, Emergency Departments, Behavioral Health, and Reproductive Health, using a mix of managed care capitation rate increases, TRIs, UDIs, supplemental payments, and workforce initiatives. DHCS proposed $1.1 billion (CY 2025) and

$452 million (CY 2026) to support the non-federal share of managed care capitation base rate increases, reflecting expanded benefits and provider rate adjustments without needing separate federal approvals. DHCS proposed $93 million (CY 2025) and $812 million (CY 2026) to fund UDIs for physician services, stacked on TRIs to meet Behavioral Health Community-Based Organized Networks of Equitable Care (BH-CONNECT) Special Terms and Conditions (STC) demonstration requirements. DHCS proposed $405 million annually (CY 2025 and CY 2026) for hospital SDPs supporting emergency and public hospital services through existing federal mechanisms.

- COMMITTEE MEMBER QUESTION/DISCUSSION
- Committee members voiced significant concerns regarding the equity and inclusivity of the Proposition 35 payment methodologies, particularly emphasizing the exclusion or limited inclusion of Federally Qualified Health Centers (FQHC) and community clinics from key funding streams like TRIs and UDI. Members highlighted the critical role these centers play in access to care and raised alarms about inflationary pressures, workforce shortages, and the disproportionate impact of reconciliation processes on these providers. DHCS acknowledged these concerns, but explained the strategic choices to focus funding where it could have a greater per-unit impact and to avoid diluting resources, while expressing openness to future adjustments and continued stakeholder input.
- The discussion also delved deeply into the GEMT program, where a member representing private emergency medical services (EMS) providers expressed frustration over reimbursement disparities compared to public providers, despite private providers delivering the majority of services. Concerns were raised about how Proposition 35 funds intended for private EMS are partially redirected to support public agencies, creating inequities that threaten the sustainability of private providers. DHCS responded by describing an accelerated six-month add-on payment intended to frontload funding to private EMS providers and noted ongoing work to align payment timing and State Plan Amendment (SPA) structures with fiscal year requirements.
- The discussion also covered CCDP as the primary mechanism to support community clinics, designed to minimize reconciliation risks and enhance funding stability. DHCS emphasized a shift toward incorporating quality metrics alongside utilization-based payments, striving for greater transparency and stakeholder involvement in defining and expanding these measures.

- Members expressed apprehension about the reproductive health funding domain, where a $90 million workforce investment managed by the Department of Health Care Access and Information (HCAI) diverges from stakeholder expectations of universal rate increases for abortion care and related services. Concerns about potential cuts to supplemental payments under Proposition 56 and the vague use of terms like "emergent needs" raised fears about jeopardizing access to critical reproductive health services. DHCS acknowledged these issues and committed to revisiting this topic in more detail, while reaffirming DHCS' efforts to navigate federal regulations and budget uncertainties to support equitable access across all service domains.
- Timely disbursement of Graduate Medical Education (GME) funds was underscored as critical given residency cycles, with offers to coordinate additional stakeholder input to support DHCS planning. In response, DHCS detailed ongoing policy work across multiple domains, targeting federal approval by the end of 2025 and aiming to hold the next PAHCA-SAC meeting by July.
- The discussion also touched on federal Medicaid funding uncertainties and their potential budget impact, with DHCS reaffirming its commitment to implement Proposition 35 within current federal parameters.
- Members raised critical concerns about maintaining funding levels, especially for reproductive and oral health services, and urged protections against cuts and reconciliation mechanisms that could undermine provider participation and patient access.
- Several committee members questioned the timing and implementation details of the new payment methodologies, including the late start date of many UDI investments, which some saw as inconsistent with statutory deadlines. DHCS explained the complexity involved in reviewing thousands of billing codes to ensure a comprehensive and equitable rollout, with some services starting earlier to address urgent needs.
- Committee members sought greater clarity on the post-feedback timeline and overall workplan for finalizing Proposition 35 funding decisions and program development. They emphasized the need for DHCS to pre-schedule future meetings well in advance to facilitate member participation, especially for members traveling long distances.

- DHCS committed to iterative consultation and transparency regarding payment methodologies, eligibility criteria, and program guidance, while clarifying that base rate increases alongside supplemental payments are consistent with Proposition 35's intent for 2025–2026. Concerns about capitation rate allocations potentially diverting funds from targeted services were acknowledged, and DHCS welcomed detailed committee member input on refining eligibility and payment methodologies.

Public Comment

Type of Action: Public Comment

- **Allie Budenz, California Primary Care Association:**
  Representing California's network of more than 2,300 community clinics and health centers, we are the vehicle to deliver on the intent of Proposition 35, especially considering the footprint of health centers within Medi-Cal. Clinics serve one in three patients with Medi-Cal coverage and provide the plurality of primary care services, with more than 43% of primary care services in Medi-Cal offered within health centers. In some areas, health centers are the source of holistic, comprehensive, and high-quality care, and that guarantee is really backed by their recognition as federally-recognized providers through their extensive federal reporting and auditing. Health centers are doing more to meet the needs of the communities they serve. Their scope of services is expansive. It includes behavioral health care, dental care, social services, and other integrated services. However, PPS rates are not keeping pace with the cost of delivering this breadth and depth of services that clinics provide and the costs they incur. The annual inflationary factor that clinics received is applied uniformly across the nation, and California's costs are far exceeding other states. Unlike other providers, when clinics add a service, providers can't just begin billing those claims, like in fee-for-service.
  Now is the time to leverage the community health center network. We commend DHCS' approach to CCDP and leveraging that quality component of the directed payment, which aligns with Proposition 35. We also understand the need for federal evaluation by virtue of it being a directed payment, and we think that's something that DHCS is interested in – that additional transparency. Thank you to DHCS and committee members.
- **Janice Rocco, California Medical Association:**
  We appreciate DHCS' work to plan for 2025 rate increases. However, almost

none of those provider rate increases are reflected in the Governor's budget proposal. The proposal is not aligned with Proposition 35 and instead undercuts the physicians, providers, and facilities necessary to ensure access to care. There are no rate increases for primary or specialty care, family planning, or abortion services in 2025. Instead, there are proposed decreases with the sweeping of Proposition 56 funds. Attempts to divert Proposition 35 funding to fill budget holes gives Congress and CMS arguments for their proposals to eviscerate provider taxes that have existed for decades.

This budget proposal threatens federal funding for all future state budgets that follow this one. You missed the deadline to do January 1, 2025, rate increases for primary and specialty care. You have not missed the deadline to do them for July 1. We would like to work with you to make that happen. We know you've been doing work for 18 months to have proposals ready to submit to CMS by September 30. Thank you.

» **Stacey Whittorf, Planned Parenthood Affiliates of California:**
I represent Planned Parenthood Affiliates of California (PPAC), which includes seven affiliates operating 115 health centers statewide. Our affiliates are a critical piece of the state's Medi-Cal infrastructure, with roughly 85% of patients accessing care through a Medi-Cal program. PPAC is opposed to the Proposition 35 spending plan and the May Revise as currently reflected. We are perplexed by DHCS' decision to ignore SAC input and abandon DHCS' own proposal it twice put forward to use a portion of the $90 million allocated for abortion and family planning services in SB159, which is identical to Proposition 35 in this category to make long needed improvements to reimbursement rates in abortion care.

California's reimbursement rates for procedural abortion are some of the lowest among states that cover them in their Medicaid programs. Providers have long anticipated these rate increases to already be in effect this past January, after DHCS proposed them in 2024. PPAC recognizes the need for a host of investments in the reproductive health care delivery continuum, but at a time when abortion and family planning providers face unprecedented challenges, we urge investments that reflect our values as a reproductive freedom state. PPAC urges DHCS to move forward immediately with this 2024 proposal to increase abortion rates in Medi-Cal, as reflected in the comments we previously submitted to this advisory group. Additionally, PPAC echoes the comments of the California Medical Association and urges DHCS to enact the will of the voters

and ensure that Proposition 35 investments do not simply backfill existing obligations.

- **Yesenia Morales, Northeast Valley Health Corporation / SEIU Local 721, Community Clinic Workers United:**
  Our clinics and employees are chronically understaffed, underpaid, and overworked. Broken payment systems, finicky blood pressure machines, and outdated equipment further hinder our work and jeopardize patient care. This indicates how poorly our funds are being managed at a time when federal actions threaten our Medi-Cal funding. It is more important now than ever that we make sure there is transparency and accountability for every public dollar, including these new funds. We are asking that any money invested in our primary care be used for our patients and improving worker conditions. Thank you for ensuring there is accountability and transparency with how Proposition 35 funds are being utilized and spent throughout clinics.

- **Oscar Mongia, SEIU Community Clinic Workers United:**
  I was a purchasing buyer at Innercare in Central California. I had to do the work of two people, rushing to purchase, approve, and deliver orders because we were short-staffed. Other departments like dental, housekeeping, and optometry were also understaffed. While management spent $600,000 on union-busting to avoid unionizing Innercare, instead of using those funds for staffing or improving working conditions. As federal actions threaten Medi-Cal funding, it is important to ensure transparency and accountability for every public dollar, including this new fund. We ask that all funds invested in primary care prioritize patient care and improved working conditions. Thank you.

- **Tim Madden, California Chapter, American College of Emergency Physicians:**
  We appreciate being included in DHCS' Proposition 35 spending program with a combination of rate increases and supplemental payments. Our request is to have those payments come entirely in the form of rate increases. For our members, we believe this will provide more certainty as they plan their staffing over time and as we look into the out years, which we know we will see an inevitable increase in Medi-Cal members coming into emergency departments as a result of some of the unfortunate cuts in this budget and what seems like the inevitable coming down from the federal level in terms of cuts to the Medicaid program. Thank you.

- **Monica Montano, California Dental Association:**
  Thank you to DHCS for all of your hard work. CDA is very concerned that the May Revise appears to divert all Proposition 35 funds to backfill other Medi-Cal costs, ignoring the initiative's intent and the will of the voters. It sends a clear message to dentists that the state does not intend to increase rates. California's children already have among the worst dental disease rates in the nation. Diverting Proposition 35 increases will significantly impact dental access. With the cost of providing care rising, it is unclear whether dentists will be able to continue serving Medi-Cal members if rates are not increased with Proposition 35.
- **Lechania Davis, BayWell Health Center (West Oakland Health Center):**
  It is important that every public dollar supports patients and frontline workers like me and my coworkers. At my clinic, we are short-staffed due to a lack of medical assistants, and that's a major concern. Our patients deserve quality care. Funding for our clinics should prioritize patient care, which means hiring more medical assistants. Here are some examples of how understaffing is affecting our patients and clinics: one person doing too many jobs, patients waiting months to see a provider, and some leaving without being seen because the wait is too long. We're asking that any money invested go to patients, clinic workers, and clinics. Thank you.
- **Cassandra Hawkins, BayWell Health Center:**
  I work at BayWell Health Clinic in Oakland. At my clinic, we're having real problems, especially in our mental health department. Behavioral health is short-staffed. We have no providers. So when patients come in, there's no one available to see them. We're asking that Proposition 35 funds be used to support clinics, pay staff, and help patients. Thank you.
- **Katrina Cantrell, Women's Health Specialists:**
  I am the Executive Director of Women's Health Specialists, a reproductive, women-controlled 501(c)(3) organization in the far northern part of California. For 50 years, Women's Health Specialists has empowered community members through education, self-help, and clinical services to become informed health care consumers. Governor Newsom's proposed cuts to reproductive health services in the May Revise are simply too hard on supplemental payments to family planning and women's health providers, with potential reductions in funding for independent reproductive health centers. While the proposed action to expand access to medication abortion, the proposed budget cuts are a threat

to reproductive health services in this state and will nullify any possible access. The May Revision proposes eliminating approximately $500 million in supplemental payments for family planning and women's health providers. These supplemental payments do not currently cover the costs of services. Thank you.

- **Kristine Schultz, California Optometric Association:**
  I am the Executive Director of the California Optometric Association. I'm here to urge DHCS to include optometrists as part of the eligible provider list. California has approximately 8,000 optometrists who are ready and willing to expand access to health care, but it is impossible when reimbursement rates are only 25% of what Medicare pays for an eye exam and the rates haven't increased in more than 25 years. Thank you for the opportunity to comment.

- **Adam Dorsey*, California Hospital Association*:**
  Thank you to DHCS. Having said that, I think the voters, when they overwhelmingly passed Proposition 35, really expected increases in provider rates. If your starting place is "Proposition 35 does not pass" versus "Proposition 35 being implemented," then several of the buckets within the initiative are effectively supplanting General Fund resources that would otherwise have been spent. So we've got some real concerns with that. With respect to the emergency department facilities bucket, we hope DHCS will continue working with us and think about how to expeditiously implement those payments in a way that does not interfere with the important proposals already in front of CMS. Thanks very much.

- **Amanda Barry, Health Center Partners of Southern California / Integrated Health Partners:**
  Proposition 35 is a historic opportunity, but only if we implement it with the boldness that it demands. Voters were very clear when they approved this measure: this funding must be protected and invested in care for specific priorities. As a network of FQHCs serving nearly 800,000 patients across San Diego, Riverside, and Imperial counties, we serve Medi-Cal patients every day through integrated, high-performing, and value-based care. Nearly half of all Medi-Cal patients receive care at health centers, but how care is paid for determines what care can be delivered. That's why we support calls for a payment structure that reflects the letter and intent of Proposition 35 to increase reimbursement for Medi-Cal providers, including FQHCs. Now is the time to align payment with outcomes, using the primary care and clinical quality

accounts to fund a SDP methodology that rewards the right care, at the right time, in the right place, by the right provider. FQHCs have delivered value for years, but are often limited by FQHC billable provider types and other rules that restrict their ability to fully integrate and provide care to complex populations. Now is the time to fund them. These accounts should prioritize payment models that support primary care and drive innovation, accountability, and sustainability for health centers. To truly implement Proposition 35 as promised, we urge DHCS to empower managed care plans to partner with FQHCs and risk-bearing FQHC organizations to scale value-based care aligned with CalAIM and Bold Goals 2025, and to tie the clinical quality account dollars to quality measures that ensure investments drive measurable outcomes. Proposition 35 must be transformational. We're happy to partner. Thank you for your time.

- **Eric Loo, College of American Pathologists (CAP):**
  Pathologists are generally ok with going along with the methodology that other physicians will use regarding pathology services covered under the physician fee schedule. However, there's a significant proportion of pathologist work that's not captured by that fee schedule. This is typically referred to as the clinical professional component (CPC) of pathology. It's completely overlooked by the current methodology, yet it routinely accounts for 20% to 25% of gross revenue for hospital-based pathology practices. In smaller, more rural practices, that proportion can easily rise to one-third or even half of a practice's revenue. To maintain timely access to lab services, particularly in underserved areas, we hope the committee will take this factor into account. The reimbursement for CPC isn't easily captured by simply modeling after Medicare, since Medicare pays it through Part A facility payments, which are recouped differently. However, the Medi-Cal program has its own fee schedule for lab services that includes a clear method for professional allocation to pathologists for lab oversight. Therefore, CSP proposes a proportional increase to this allocation to match increases in the anatomic pathology professional component fee schedule. We'll be submitting a letter to clarify these points further.

- **Erin Kelly, Children's Specialty Care Coalition (CSCC):**
  We represent more than 2,500 pediatric subspecialists serving Medi-Cal's most medically vulnerable children. Thank you for the additional details on the Proposition 35 spending plan for the next two years; we appreciate all the work that went into it. That said, it appears that much of the funding is being used to supplant existing Medi-Cal General Fund spending rather than offering greater

support to providers or meaningfully increasing access. We recognize there are challenges in getting these dollars out and ongoing federal risks regarding the ability to draw down MCO-related funds. We hope the advisory committee and DHCS will consider pediatric specialty care when developing the methodology and specified codes for the UDI payments described today. This workforce is facing a crisis in recruitment and retention. We don't have enough providers to meet the rising demand for care. National bodies have called for pediatric codes to be paid at minimum Medicare parity to address this crisis. A significant share of pediatric specialty care still exists in the fee-for-service environment because of the California Children's Services program, so the methodology must account for both managed care and fee-for-service. Thank you for the opportunity to provide comments.

- **James Florey, Children First Medical Group, Alameda County:**
  I am the chief medical officer for Children First, an exclusively Medicaid-managed care providerfor children, accountable and delegated by Alameda Alliance for Health. I also serve on the board of the Children's Specialty Care Coalition. My question is a structural one: would you please comment on what appears to be a structural bias toward fee-for-service in the disposition of Prop 35 TRI funds through the 87.5% Medicare allowable rate? Managed care organizations like ours achieve comparable or better outcomes through infrastructure investment, population health, and utilization management, but we do so at the expense of our own capital structure. We're concerned that we may be systematically excluded from further support because of the structural incentives baked into this methodology, compared to the very different incentives faced by fee-for-service direct contractors or FQHCs. Thank you for your time.

- **Karen Stout, California Nurse-Midwives Association:**
  We support the investments being made in the workforce to expand access to midwifery care. Despite excellent clinical outcomes, midwifery care continues to be underutilized in California. Workforce funding is currently limited and insufficient to meaningfully address critical reproductive health needs in the state. We strongly support investments in midwifery education for licensed midwives and nurse midwives. Loan repayment and scholarships are essential to growing a culturally and linguistically competent midwifery workforce, one capable of addressing racism-based health disparities. However, we remain concerned that some of these workforce supports are supplanting the original

intent for reproductive health allocations under Proposition 35. We look forward to continuing to work with this group and DHCS to identify new, innovative strategies to address these concerns. We'd also like to explore separating workforce investments from the broader reproductive health allocations in Proposition 35. Thank you.

- **Nick Brokaw, California Academy of Audiology:**
  I'm with the California Academy of Audiology, representing the state's licensed audiologists. I really appreciate the work of this committee and urge you all to keep audiologists in mind as you work through the methodologies for TRIs. We will follow up with a letter to expand on those comments.

- **Ryan Spencer, American College of Obstetricians and Gynecologists – District IX:**
  We oppose the diversion of Proposition 35 funds from their original intent as clearly stated in the initiative. We align our comments with those of CMA, Planned Parenthood, and others who expressed similar concerns. We would also like to emphasize and support the comments of Dr. Eric Loo regarding the need for fair payment for professional pathology services.

- **Selene Betancourt, California Pan-Ethnic Health Network (CPEHN):**
  Thank you for the opportunity to comment. We have concerns with the proposal to use MCO Tax revenue to increase base capitation rates for managed care plans, many of which reported growing net income in early 2024, while critical health services are being cut for California's immigrant communities. We're also concerned that uniform dollar add-ons and untargeted investments will not improve access or quality of care for communities of color, which continue to face the greatest health disparities. We encourage DHCS to prioritize more equitable strategies, like the former Equity and Practice Transformation Payments program. Finally, we urge DHCS to consider the long-term sustainability of these investments. With the MCO Tax facing serious federal risk, California must avoid creating a fiscal cliff in 2027 and commit to accountable investments that deliver measurable improvements in care quality. Thank you.

Upcoming PAHCA-SAC Meeting and Next Steps

Type of Action: Information

Presenter: Lindy Harrington, Assistant State Medicaid Director

Discussion Topics

- The next meeting 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: 1:31 p.m.