Legislation

AB 2303 (J. Carrillo) PPS Increase (CPCA Sponsored)

- AB 2303 will:
  - Ensure CHCs have a mechanism to address SB 525 by requiring DHCS, on or before April 1, 2025, to submit a request for approval to CMS to authorize a waiver for specified health care facilities to augment its rate to sustainably implement wage increases.
  - Support CHCs with the funding needed to pay for the costs associated with the minimum wage increase.
  - Require DHCS to seek the necessary federal approvals or waivers to develop and apply a minimum wage add-on as an alternative payment method (APM) to increase payment rates to account for the requirements of SB 525.
  - Require DHCS to consult with CHCs in the development and implementation of a minimum wage add-on. *The added payments would not be subject to the annual reconciliation process.*
  - Require DHCS to make any state plan amendments (SPA) necessary to implement these provisions.
- There is precedent - AB 2303 is modeled after a waiver submitted by New York state and approved by CMS to create an APM add-on to support implementation of a similar state-mandated wage increase.
- FQHCs are paid a predetermined rate Prospective Payment System (PPS), which is intended to reimburse all services provided during a single visit.
  - PPS is restrictive and encounter-based, and a FQHC will only receive its PPS rate if (1) the service is defined as an allowable encounter or set of services as defined under PPS, (2) only one billable service is provided to a patient per day (exception is a medical and dental visit can be provided on the same day), and (3) a defined "billable provider" provides the service.
  - For an FQHC to change its PPS reimbursement rate, it must submit a Change in Scope of Service Request (CSOSR). Current law only allows a CHC to submit a CSOSR under nine strict circumstances, called qualifying events.
  - A state-mandated wage increase is not included in the allowable qualifying events. CMS strictly prohibits a CSOSR due to wage increases alone.
- Although the waiver program is well-intentioned, an implementation delay without permanent fixes to PPS will further disadvantage CHCs in an increasingly competitive market.

SB 1382 (Glazer) OSHPD 3/State Building Standards (CPCA Co-Sponsor)

- This is a re-introduction of AB 1612. Thank you for voting for this bill last session.
- Unfortunately, the Governor vetoed it: *This bill would authorize a licensed primary care clinic to construct or acquire certain primary care clinic facilities and deem those new facilities to be in compliance with the minimum construction standards of adequacy and safety. I support the author's goal to encourage expansion of primary care clinics to increase their capacity to provide care. However, this bill removes important health and safety protections for patients, clinic staff, and the public. Every primary care clinic, regardless of location, should meet the applicable state licensing standards and building codes. This bill exempts certain facilities from those safety measures.*
- This bill would reform current California law by updating the construction and building standards for outpatient clinics by requiring them to comply with county or city building standards.
- This bill would provide that Primary Care Clinic (PCC) in good standing would be able to acquire and operate an existing outpatient setting or build a new outpatient clinic provided they meet their county or city construction standards.
- This bill will decrease barriers for PCC expansion by updating construction and building requirements for outpatient clinics.
- The building standards required by OSHPD 3 are the same for PCCs (including CHCs) and hospital clinics with inpatient facilities.
    - This is a problem because PCCs only provide outpatient services, while hospital clinics can provide up to 25% of their care as inpatient services where patients are admitted to a hospital to stay overnight. In contrast, outpatient services refer to any service or treatment that doesn't require hospitalization.
- Currently, HCAI is restricted from updating PCC standards to the suitable acuity level for a primary care outpatient clinic setting.
    - To fulfill the current construction standards, PCCs are financially burdened, restricting their ability to expand crucial healthcare services to those who need it most.
    - Private physician offices and county clinics are not required to comply with OSHPD 3 standards and display no increased risk to the health and safety of the public.

AB 2703 (Aguiar-Curry) Associate Psychologists (CPCA Co-Sponsor)

- This legislation seeks to replicate the success of SB 966 (Limon, 2022) which allows AMFTs and ASWs to reimburse for services provided under a supervising licensed behavioral health practitioner.
- AB 2703 expands access to BH in FQHCs and RHCs by allowing Associate Psychologists (APs) to work in these settings, and for FQHCs to be reimbursed for the services they provide.
- Despite a shortage of BH professionals, current law does not specifically allow FQHCs or RHCs to be reimbursed for services provided by APs.
    - APs are individuals registered with the Board of Psychology and who have completed their doctoral degree but must still complete 3,000 supervised clinical hours for their licensure.
- To ensure quality of care, associates are registered with the Board of Psychology and supervised by a licensed psychologist.
- APs need to be registered with the Board of Psychology and supervised by a licensed psychologist to bill under their supervisor.

Budget

MCO Tax

- We were pleased to see increased funding for the non-hospital 340B fund included in the Governor's budget from the MCO tax.
    - This investment will result in adding $100M-125M to the CHC 340B funding pool, bringing it closer to the actual total losses in 340B saving when California moved to Medi-Cal Rx.
- These funds have been provided as a supplemental payment through a CMS-approved state plan amendment.
    - However, CHCs have experienced significant delays & payment issues from the SPP.
- CHCs have worked with DHCS to transition the SPP into a directed payment program on January 1, 2025.
    - The directed payment includes an incentive payment component in addition to a reimbursement component tied directly to PPS-reimbursed visits for Medi-Cal managed care members.
    - We are hopeful that moving into a directed payment will allow for real-time payments to be processed for most of the funding and avoid reconciliation issues that we have seen in the SPP.
- We ask for your support in retaining the Governor's proposed $50M increasing CHC 340B funds annually to approximately $205-225M using MCO tax revenues in the FY 2024/25 Budget.

Additional Info

Targeted Rate Increases (TRI)

- CHCs must be able to meaningfully access the investments in primary care, maternal care, and mental health care through the Targeted Rate Increases (TRI) for those investments to have a consequential impact on the capacity of the Medi-Cal system.
- CHC payment increases in 2024 (under the TRI) will have to be reconciled back to the Medi-Cal program.
- The 2025 TRI funding must take the FQHC/RHC PPS payment model into account and ensure these crucial Medi-Cal providers can access these investments in primary care.
    - DHCs should not only focus on TRI that raise the overall primary care payment rates but also supplement it with payments to providers through Medi-Cal Managed Care Plans for population health management (PHM) and quality incentives.
    - Investing in primary care along with PHM and providing incentives to continue driving quality metrics would support providers in expanding 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 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.
    - TRI should flow through a structure that allows the payments to build on existing primary care expenditures rather than supplant existing funding, and that can be utilized by FQHCs/RHCs to increase primary care capacity rather than flowing back out during PPS reconciliation.
        - Funds must be exempt from the reconciliation process to ensure equitable inclusion of FQHC/RHC providers and increase primary care capacity for the entire Medi-Cal system.

END