SB 1549 - Prospective Payment System (PPS) Reform

HCP and CPCA SUPPORT

- AB 1549 seeks to modernize PPS to align with state-led care transformation initiatives.
- PPS is supposed to be a TRUE COST reimbursement.
- This bill ensures CHCs may successfully meet rising operational costs, support a thriving workforce, and continue providing innovative, quality, patient-centered, equitable care to their 7.2 million Medi-Cal members.
- CHCs have a rich history of providing person-centered care that goes beyond physical health to invest in the social drivers that keep communities healthy by reducing chronic illness.
    - State-led transformation initiatives under CalAIM to promote whole-person care are aligned with CHCs across this region.
    - However, payment mechanisms have not kept pace with the changing health care landscape in the state.
- The majority of CHCs in the state of California are FQHCs and are paid according to a complex structure governed by state and federal law.
    - FQHCs are paid a predetermined rate, their Prospective Payment System (PPS), that encompasses reimbursement for all services provided during a single visit.
- PPS is restrictive and encounter-based, and an FQHC will only receive its PPS rate if:
    - the service is defined as an allowable encounter or set of services as defined under PPS
    - only one billable service is provided to a patient per day (with the exception that a medical and dental visit may be provided on the same day)
    - the service is completed by a billable provider.
- The PPS rate is fixed, according to California statute, WIC 14132.100, unless the CHC receives approval for a change in scope of service request (CSOSR).
    - A CSOSR requires a qualifying event.
    - Those currently do not allow for the expanded care team members needed to successfully implement CalAIM, the transition to whole-person care and population health management, nor the transition to value-based care and an alternate payment methodology.
- Additionally, the bill makes changes to clarify the intent of CSOSR.
    - Current law says that CSOSR requests should capture any changes in the "type, intensity, duration, and amount of services" a CHC provides.
    - However, in practice, DHCS has limited this broad requirement by applying an increasingly narrow interpretation that often leads to disapproval of CSOSR unless the CHC offers a new type of service at a service delivery site.
- The proposed language eliminates DHCS' ability to take a significant cost reduction when a CHC attempts to adjust its PPS rate. **This is known as the "20% haircut."**
    - This cost reduction is substantial and does not allow CHCs to receive a true accounting of their costs for the services they provide.
    - CMS has ruled in other states (Hawaii) that this is not legal.
    - This is not in CA state statute.

SB 525 - $25 Minimum Wage for Health Care Workers

HCP and CPCA Oppose Unless Amended.

- CHCs appreciate the bill's intention to support California's health workforce, but without a sustainable funding source, SB 525 would negatively impact CHCs, which are the state's care delivery system for its most vulnerable communities.
- FQHCs receive a fixed funding amount through a Prospective Payment System (PPS) that can only be changed through a triggering event, and increased costs due to wage increases do not qualify.
    - The PPS rate for each health center site is pre-determined and requires the service to be a singular, billable, allowable encounter, provided by a limited list of providers.
- The current funding model results in slim to no margin for health centers and increased costs due to wages with no avenue to adjust revenue amounts will result in cuts and more limited access to care.
- CHCs propose amending the legislation to delay implementation for CHCs until the state seeks and receives approval from CMS granting CHCs the ability to complete a change in scope of service request (CSOSR) and appropriately adjust the PPS rate based on state-mandated wage increases.
- SB 525 compresses salaries and wages. The legislation, as proposed, creates wage compression which can impact employee retention in an already understaffed market. By requiring the minimum wage of $25 per hour to increase annually by at least 3.5% and all salaried employees to make at least $104,000 all employee wages must be reviewed and adjusted to ensure equity across each organization.
- With stagnant revenue, Health Centers would likely need to reduce staff, employ more hourly versus salaried employees, and potentially reduce patient services.
- **ASKS:**
    - Include language delaying implementation until funding is appropriated by the Legislature or another funding mechanism;
    - Include language delaying implementation for CHCs contingent on CMS providing the necessary regulatory approval;
    - Include language permitting CHCs to make a change in scope of service request to increase its PPS rate to meet the requirements of this legislation;
    - Remove the provision requiring employees earn a monthly salary equivalent to no less than double the minimum wage in order to qualify as exempt from the payment of minimum wage and overtime laws (Section 1182.14(f));
    - Remove the annual increase in the minimum wage a year after implementation (Section 1182.14(d)(1));
    - Remove language capturing independent contractors (Section 1182.14(b)(1)(A)(i)).

SB 779 - Clinic Data Expansion

HCP and CPCA Oppose Unless Amended.

- SB 779 seeks to dramatically expand the amount of data reporting requirements on CHCs focusing on 6 major categories: PPS rate, revenue spent on workforce, mergers and acquisitions, detailed labor report, workforce development, and quality/equity.
- The bill is overly broad, duplicative in many areas, and an unnecessary expansion of data reporting requirements.
- At health centers we focus on improving outcomes for our patients. We support data transparency, but collecting data for the sake of collecting data does nothing to improve outcomes, and instead poses an arbitrary administrative burden on our staff. Administrative burdens, such as this, are a primary reason for why health care staff are burning out.
- Please Vote NO in committee or on the floor unless it's amended to remove all duplicative reporting requirements and lessen administrative burdens.

AB 1612 - Removing Licensing Barriers for Providing Access to Care

HCP and CPCA SUPPORT

- AB 1612 will streamline licensing and building standard requirements for CHCs, while continuing to protect the health and safety of patients.
- This bill will update the construction and building standards for outpatient CHCs.
- However, existing law requires that any new such facilities follow heightened requirements - equivalent to those of hospital clinics – even though any new such facilities would not provide inpatient services.
- AB 1612 would allow PCCs to acquire and operate existing outpatient facilities or build new outpatient clinics without the additional and unnecessary burden of standards typically associated with hospital type facilities.
- Current building standards create an undue financial burden for PCCs and act as a deterrent to expanding vital health care services and establishing new clinic sites in new service areas.
    - Removing such mis-associated licensing and building requirements is critical to increasing patient access - AB 1612 will do this.
- To operate in California, CHCs must be licensed as primary care clinics (PCCs) by the California Department of Public Health.
- As part of the PCC licensing requirements, CHCs must also comply with OSHPD 3 building standards as set by The Department of Health Care Access and Information (HCAI), and the California Building Standards Commission.
- OSHPD 3 building standards apply to PCCs, CHCs, as well as to clinical services at general acute care hospitals.
    - Incorrectly so, the existing statute links the requirements for hospital clinics to the requirements for PCCs including CHCs.
- However, hospital clinics and PCCs provide different services.
    - PCCs only provide outpatient services, whereas hospital clinics are allowed to provide up to 25% of their care as inpatient services.
    - PCCs only provide outpatient care; therefore, their facilities should not be held to hospital clinic construction requirements, which are tailored to address the higher acuity needs of inpatient services allowed for hospital-based clinics.
- Decoupling construction requirements for hospital clinics and PCCs is not a novel concept.
    - Private physician offices and county clinics currently operate outside of the hospital-based construction requirements, without any documented risk to public health and safety or environmental protections.
- Statutory language is the only barrier for HCAI to modify PCC standards to align with other similar outpatient clinic settings and acuity levels.
- AB 1612 ensures CHCs will successfully meet rising operational costs, support a thriving workforce, and continue providing innovative, quality, patient-centered, equitable care to their 7.2 million Medi-Cal members.

SB 282 - Same Day Access to Medical and Behavioral Health Care

HCP and CPCA SUPPORT

- SB 282 (Eggman) would allow FQHCs and RHCs to bill Medi-Cal for two visits if patients were provided mental health services on the same day, they have a medical visit.
- California is one of 15 states that DOES NOT allow CHCs to receive reimbursement for providing medical and behavioral health care on the same day.
- Please urge the Budget Chairperson pass the bill out of suspense.

AB 85 - Social Determinates of Health Screenings (SDOH)

HCP and CPCA SUPPORT

- AB 85 would require health plans and insurers to include coverage for SDOH screenings, referrals, and community navigation services.
- AB 85 seeks to improve health outcomes for vulnerable communities and supports the state's efforts to achieve whole person care.
- Please support the bill.

Budget Ask

$60M - Increase Medi-Cal Health Enrollment Navigators Project with one-time funding request ($30M state/$30M Fed Match)

- Between now and June 2024, 15M current Medi-Cal beneficiaries will undergo program recertification, and 700,000+ individuals will become newly eligible for full-scope Medi-Cal benefits through the Health4All adult expansion.
- Culturally and linguistically appropriate health navigation in a patient's trusted medical home must be funded and prioritized in these efforts.
- CHCs are ideally positioned to do this.
- Please sign on to the budget letter supporting this critical funding request.