HEALTH CENTER PARTNERS of Southern California

Member Talking Points
2022 Day at the Capitol

Telehealth

We thank the administration and legislature for the current Trailer Bill Language, which includes continuation of pay parity for audio-only and telehealth visits, past the PHE.

Health Care Workforce

We respectfully ask the administration and legislature to commit $51M in NEW funding for educational debt relief, advanced practice clinician training program, and residency programs, that are most essential to CHCs recruiting and training their future workforce while maintaining the workforce of today. We also ask that the current investment of $150M be maintained.

- We thank the Governor's intent to bolster California's health professional workforce with $1.7B in investments across Labor and HHS, especially in Community Health Workers (specifically as it relates to BH).
- $51m in NEW CHC Workforce Funding:
    - $29.3 million for Loan Repayment & Scholarships Programs
        - $10.6M for the California State Loan Repayment Program to increase the number of awards granted to primary care and behavioral health providers.
        - $17M for the Allied Health Loan Repayment Program to enhance private investment and provide 1,060 new awards across all underserved areas in the state.
        - $1.7M for the Allied Health Scholarship Program to build on private investment and double program awards through an additional 125 scholarships.
    - $16 million for Advanced Practice Clinicians Training Programs
        - $15 million to support 150 Nurse Practitioner postgraduate fellowship slots in primary care within underserved communities and through the Song-Brown Healthcare Workforce Training Program.
        - $1 million to support 10 or more Physician Assistant postgraduate fellowship slots in primary care within underserved communities and through the Song-Brown Training Program.
    - $5.7M for Graduate Medical Education
        - $5.7M for Teaching Health Centers through the Song-Brown Primary Care Residency Program to support significant expansion via an additional 33 program awards.
- Severe workforce shortages and growing salary gaps make it difficult for health centers to recruit and retain an integrated, multi-disciplinary workforce to provide high-quality care.
- The COVID-19 pandemic has only exacerbated this, increasing health center provider shortages due to burn-out, early retirement, sickness, and marketplace competition.
- The state Workforce Development Programs provide education, professional development, and financial aid to health profession students.
    - These programs train the next generation of health professionals – ensuring the future workforce reflects the diversity, skills, and needs of the communities it serves.
    - These prepare students for careers in primary care, dentistry, community-based medicine, public health, informatics, nursing, and geriatrics.

Discussion Prompts

- Salary comps (Kaiser)
- CHC reimbursement costs are set (inflation)
- Equity issues of taking on large student loans
- Data on your staff vacancy rates.
- Any successful recruitment/retainment programs?

SB 1014 (Hertzberg) Enhanced Clinically Integrated Program for FQHCs

Both HCP and CPCA have taken an OPPOSE UNLESS AMENDED position.

- **SB 1014 runs afoul of both conditions, and we believe would not be able to be approved by CMS for matching resources.**
    - SB 1014 seeks to create a supplemental payment pool (SPP) for community health centers (CHCs) referred to by the legislation as the Enhanced Clinically Integrated Program (ECIP).
    - CMS requires SPP provide for new services for Medicaid beneficiaries that are not already paid for.
    - SPP must be separate from, and in addition to the payments for services rendered to Medicaid enrollees.
    - CMS will not allow predetermined amounts to be allocated to any given provider.
    - SPP are for a class of providers in Medi-Cal.
    - The amount of the SPP must be tied directly to delivering a service and at a flat amount per class of provider.
    - It is hard to imagine what type of service a CHC would have to newly provide that the additional SPP would pay for in amounts that would allow for an CHC to raise all salaries to a minimum wage of $25/hour.
- **While SB 1014 suggests that the ECIP would be a voluntary program for CHCs, only CHCs who participate and fund a "Bona fide labor-management cooperation committee [LMCC]" that includes representatives of organized labor unions will be eligible to participate in ECIP and access the workforce funds.**
    - Some CHCs would have access to the funds while the vast majority would not regardless of the patient or community need or impact on access to health care.
    - Such an allocation of funding based on whether the CHC is participating in a joint-labor management committee constitutes an impermissible mandate requirement on a class of providers in violation of federal law.
    - CHCs are a Medicaid provider class defined in federal statute.
    - CMS does not allow arbitrary preconditions on a class of providers who are delivering the same services to Medicaid beneficiaries as those with the LMCCs.
    - The LMCC as specified in the legislation do not account for the unique governance requirements applicable to CHCs, that mandate patient-majority governing bodies with authority for establishing an CHCS's personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.

- **Appears to be duplicative of current payment allowances.**
    - CHCs can only receive payments in addition to their PPS rates that are for services or costs not already included in the PPS rate.
    - SB 1014 intends to provide a SPP for training and salaries, but salary costs are already included in the PPS rate.
    - If a CHC receives a payment twice for the same service, the state will "reconcile" those dollars back and force the CHC to give money back to the state.
- **The governance structures outlined in SB 1014 are problematic.**
    - The bill would require DHCS to establish a board of individuals that would be responsible for determining the eligibility criteria and creating a process for applying for and distributing funds.
    - However, delegation of DHCS' policymaking functions to a statewide board is impermissible under federal law.
- **CHCs propose exploring alternative approaches that achieve the following guiding principles:**
    - Leverage existing mechanisms to invest in workforce development, like state level programs and regional programs through workforce investment boards.
    - Solutions must be allowable and approvable by both DHCS and CMS.
    - All CHCs, big and small, rural, and urban, must have equitable access to resources to support their employees and community focused mission.
    - Not hinder CHCs current capacity to provide timely access to health care and community services.
    - Governance structures must comply with the federally mandated governance structures for CHCs.
    - Solutions must support and strengthen value-based payment that incentivizes patients to be healthy.
    - Solutions should aim to leverage existing payment structures or funding programs to minimize complexity and administrative burden.

Discussion Prompts

- CHCs are appreciative of the proposed additional funding, however, CHCs should have control over the workforce funding for their staff.
- How have you used the Federal ARP funding to retain and recruit additional workforce.

SB 966 (Limon): ASW/AMFT Flexibilities and MFT Change in Scope

Both HCP and CPCA SUPPORT this Bill.

- Would permanently extend flexibilities allowed during the declared public health emergency (PHE) to hire and bill for ASWs and AMFTs, therefore sustaining continuity of care for patients and increasing access to a diverse behavioral health workforce.
- Would remove the current administrative barrier to utilizing LMFTs by aligning FQHC/RHC Medi-Cal Change in Scope-Of-Service Request (CSOSR) requirements for both medical and behavioral health services, ensuring health centers are not disadvantaged when trying to bring in critical behavioral health workforce.

Discussion Prompts

- If made permanent how would your CHC use these staff?
- How many additional BH patients would you be able to see?
- How many LMFTs would you hire if the Scope Change was removed?

340B / SPP Fund

It is critically important the state commit an additional $50M general fund commitment, which would draw down an additional $50M federal match, to strengthen the non-hospital clinic supplemental payment pool to a larger pool of funds that better represents the true cost of this transition.

- Governor Newsom continues to remain committed to providing a non-Hospital 340B Clinics Supplemental Payment Pool (SPP) Fund of $105M annually.
- While we are pleased to see the administration's ongoing commitment to the SPP, this proposal ignores CHCs ongoing request to recognize the full financial burden of the Medi-Cal Rx transition.
- Since 2019, the California Primary Care Association (CPCA) conducted two member surveys to understand the financial impact that the pharmacy transition (Medi-Cal Rx) would have on CHCs 340B savings.
    - After reviewing this data, CPCA believes CHCs will experience losses that are greater than $200M.

Member Prompts

- What PROGRAMS or SERVICES CHCs will or have you been forced to eliminate?
- What percentage of your budget relies on 340B Savings?

SB 939 (Pan): Prescription Drug Pricing–"Pick Pocketing Bill"

Both HCP and CPCA SUPPORT this Bill.

- In recent years, CHCs have grown increasingly concerned about actions by pharmacy benefit managers (PBMs), manufacturers and others who are taking 340B savings from CEs while also threatening patient access to critical medicines available through the federal 340B Program.
- Would prohibit the type of discriminatory actions by PBMs and drug manufacturers as described above when providing 340B drugs to CEs and their patients.
- How the Bill Directly Affects CHCs:
    - Rebates-A new proposed platform allows manufacturers the ability to remove up-front 340B discounts and instead provide a rebate on the back end.
    - Contract Pharmacies -HRSA put out a guidance requiring manufacturers to send 340B drugs to contract pharmacies, but that is now under litigation. As a result, State action to protect this program will ensure that patients most in need get access to these drugs.
    - Mail In Pharmacy -Some manufacturers, have discussed plans to only allow their drugs to be provided to patients via mail in orders. This concerns CHCs since it would remove the ability for patients to choose how they acquire drugs (LGBTQ and BH patients).

Member Prompts

- How will this directly affect your patients?
- How will this directly affect your Workflow and Funding Reimbursements (Budget)?

MCM Procurement - San Diego County New Model

We ask that HCP is involved the in the Procurement selection process.

- HCP agrees that a reduction is warranted as the complexity of seven administrative payer processes creates challenges by increasing the administrative burden and cost, while lacking a return on quality outcomes.
- This planned reduction should be thoroughly analyzed to identify the appropriate number of health plans for the San Diego market to ensure that a competitive market will drive quality outcomes, meet patient expectations, and ensure access standards are met.
- A radical reduction to two managed care plans will have unintended consequences for our community including:
    - Reduction of patient choice of health plan;
    - Reduction in patient satisfaction;
    - Reduction of health plan focus on quality due to limited plan choice;
    - Limitation of competitive negotiations among providers and payers;
    - Reduction of provider panels due to lack of negotiation ability;
    - Reduction of patient access due to provider panel loss; and,
    - Impact upon payer and provider innovation that would advance value-based care/payment due to lack of ability to negotiate.
- In making such changes, we recommend that criteria be established to guide health plan expectations within the San Diego Geographic Managed Care model to include:
    - Measurable and sustainable improvements in patient care and health quality outcomes;

- Improvements to network adequacy standards including transparency and accountability in network operations and oversight, and sufficiency of primary care providers, specialists and hospital facilities within and across provider networks;
- Increased and sufficient geographic coverage across the diverse county with access to primary care, specialty care, and hospital facilities, and regarding sufficient access, acceptable travel times, and wait times;
- Limited network disruptions;
- Patient choice;
- Continuity of care; and,
- Increased innovation in value-based care and payment design.

Member Prompts

- How will this directly affect your patients?
- What additional work will this cause your CHC staff (i.e. patient outreach) – how do you plan to fund this?
- Discuss how this will affect the ASM/SEN constituents – (i.e. phone calls, confusion)?

Kaiser DHCS Contract

The HCP Board Position is to Oppose Unless Amended

HCP Proposes the Following Amendments:

- At least maintain if not increase community benefit support for FQs, FQ networks, and RACs in CA to offset the imbalance in patient population acuity, given that KP will take the walking well, leaving high acuity patients to the FQs, who will have increased population health management and care costs associated with this population.
- Given the imbalance in acuity in these populations, the FQs, FQ networks, and RACs should receive not only increases in community benefit but FQs should receive a higher reimbursement rate structure.
- Given the imbalance in acuity in these populations, care quality score baselines for KP and for FQ patient populations need to be readjusted**,** as rate structures, PMPMs, and P4Ps will be affected by the differences between the patient populations. Reimbursement methodologies need to be changed accordingly so that FQs are not penalized for their higher acuity population in currently existing reimbursement schemes.
- Given the requirement to reach 50% or 90% increases in care quality quickly, after assuming a higher acuity patient population, these deadlines should be pushed back to allow FQs time to adjust to these changes while working to improve population health delivery to these patients and to improve their care quality and health outcomes.
- Given the unique complexity of GMC County San Diego, HCP/IHP should be included in the KP design team's discussions for increased visibility and transparency to ensure realistic goals are set and can be accomplished.