# California Health+Advocates' 2023 Legislative Priorities

February 21, 2023

Community Health Centers Background

- Today, more than 1,300 community health centers (CHCs) serve the state of California, and provide comprehensive, high-quality care to 7.2 million people.
- Community health centers provide the full spectrum of care, from primary care to dental to behavioral health care and a variety of enabling and wraparound services.
- In many rural communities throughout California, community health centers serve as the only source of medical and wellness care for middle and working-class families in the region.

Health Center Viability

**AB 1549 (W. Carrillo) - Prospective Payment System (PPS) reform** - This proposal will modernize FQHC reimbursement rules, PPS, to align with state-led care transformation initiatives, and ensure health centers can successfully meet rising operational costs, support a thriving workforce, and continue providing innovative, quality, patient-centered, equitable care to the Medi-Cal members they serve.

**AB 1612 (Pacheco) - Eliminating Barriers to Health Access** - This proposal seeks to increase health access by streamlining licensing and building standard requirements (known as OSHPD 3) while continuing to provide necessary patient protection. These heightened standards result in barriers to access for patient care because CHCs are required to utilize their funds for unnecessary construction costs rather than using the funds for patient care by opening additional sites in underserved areas.

**340B** – Health+Advocates will continue to protect the $105M pool of funding secured to help 340B non-hospital clinics with financial challenges caused by Medi-Cal Rx implementation. We will also support state legislation to prohibit pharmacy benefit managers from imposing any undue and burdensome requirement on 340B providers, like CHCs. Finally, we will support advocacy efforts that push for federal reform within the 340B program including protecting contract pharmacy relationships.

Access to Care

**SB 282 (Eggman) - Same Day Access** – This proposal would allow FQHCs and RHCs to bill Medi-Cal for two visits if a patient is provided mental health services on the same day they receive other medical services; it ensures more early intervention in mental illness and guarantees we are using the integrated health services available to our communities at their full potential. Pursuing a pilot program will evaluate how this change impacts patient outcomes and produces overall cost savings.

**Medi-Cal Redeterminations** – Health+Advocates is seeking $60 million to ensure CHCs have access to adequate funding and resources to facilitate Medi-Cal redeterminations, help patients navigate the health plan changes in counties with new plans due to procurement, and prepare for enrollment of the adult Medi-Cal expansion population.

Empowering Communities

**AB 85 (Weber) - Social Determinants of Health** – This proposal seeks to improve access to social determinants of health (SDOH) screenings, referrals, and community navigation services. Additionally, AB 85 aims to close the gap between community-based organizations (CBOs) and providers to improve follow-ups after screening and collaboration efforts with community organizations to assist patients with their needs.

Strong Workforce

Health+Advocates will focus on protecting previous year investments and ensure workforce funding is properly implemented. We will support efforts to secure funding for health center training, loan repayment, and other innovations to recruit and retain diverse allied, primary care, dental, and behavioral health professionals, as well as non-profit program and administrative staff. We will also identify and pursue strategies to sustainably increase wages and provide fair and competitive compensation to successfully recruit and retain health center staff.

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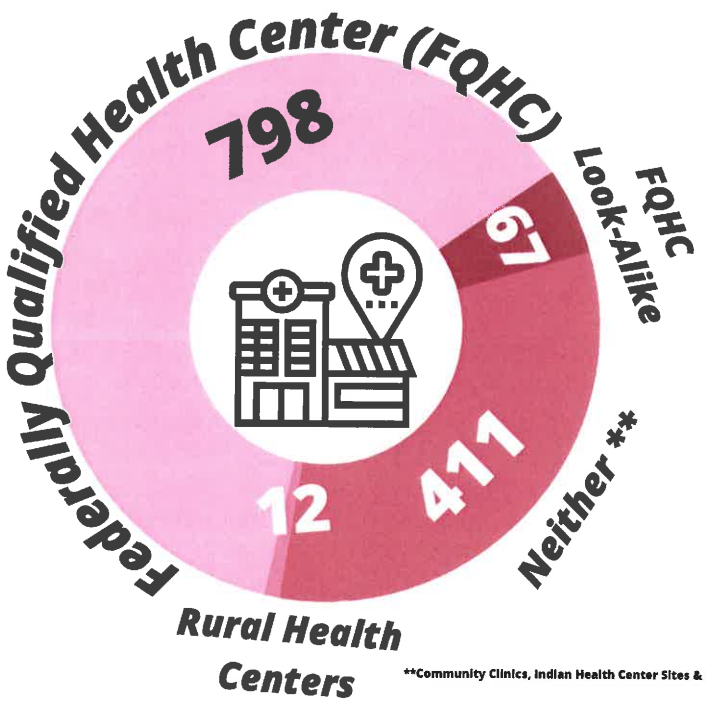
# CALIFORNIA 2022 STATE PROFILE

## OF COMMUNITY CLINICS AND HEALTH CENTERS

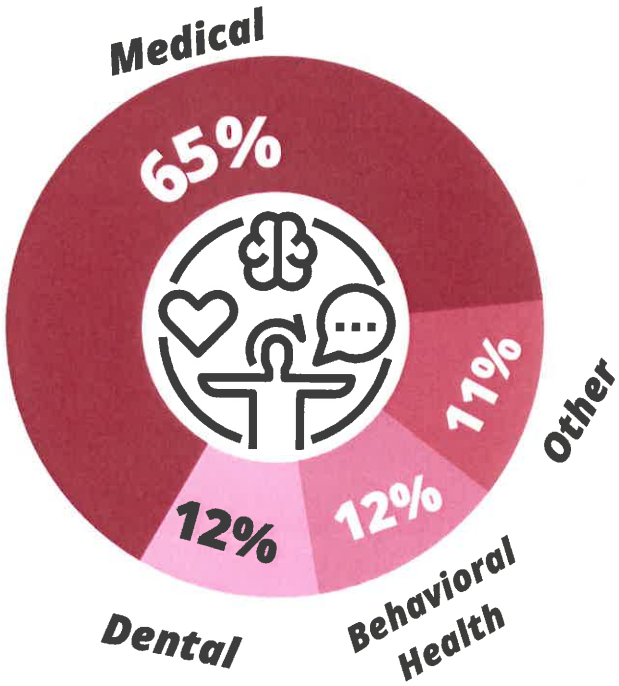
### Community Health Centers (CHCs)

**1276 Total CHCs**



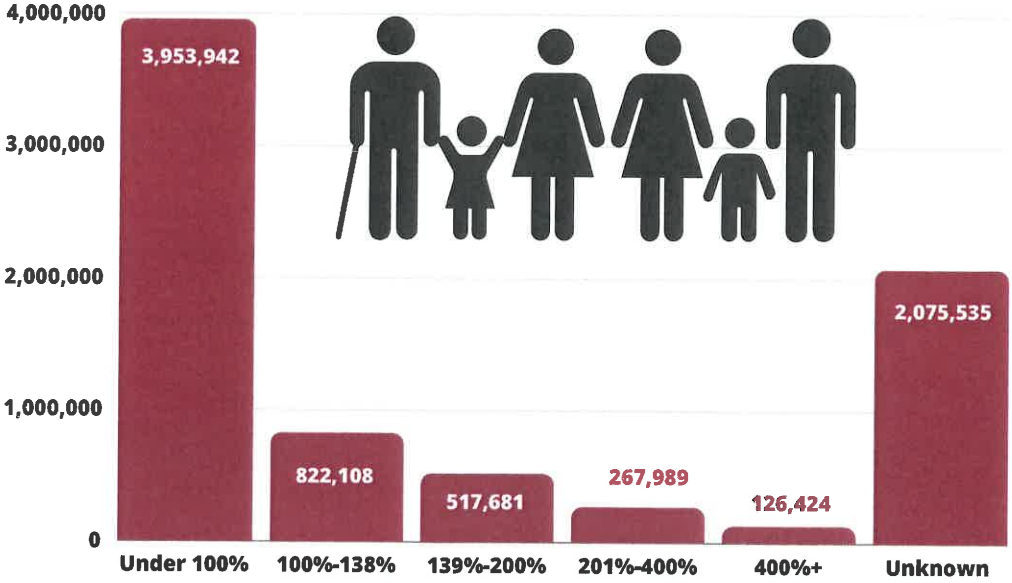

**Community Clinics, Indian Health Center Sites & Free

### Clinical Services




### By Income Levels

**Percent of Federal Poverty Levels**




### TOP COMMUNITY SERVICES

- OUTREACH
- EDUCATION
- NUTRITION
- SOCIAL SERVICES

*Data Source is California Department of Health Care Access and Information (HCAI) 2020 Annual Utilization Report (AUR) & UDS 2021. Report prepared by the CPCA Data Team. 1231 I Street, Suite 400 • Sacramento, CA 95814 • Office: (916) 440-8170 • Fax: (916) 440-8172 • www.cpca.org*

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# CALIFORNIA 2022 STATE PROFILE

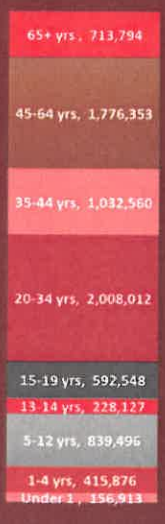
## OF COMMUNITY CLINICS AND HEALTH CENTERS

### Patient Population

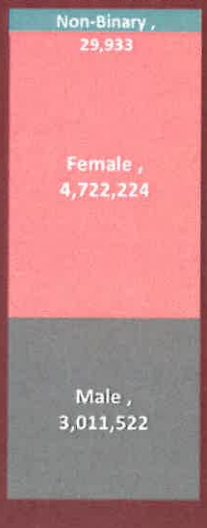
**7.7+ MIL**
**PATIENTS**
1 IN 5 CALIFORNIANS

**24.4+ MIL**
**ENCOUNTERS**

#### BY AGE



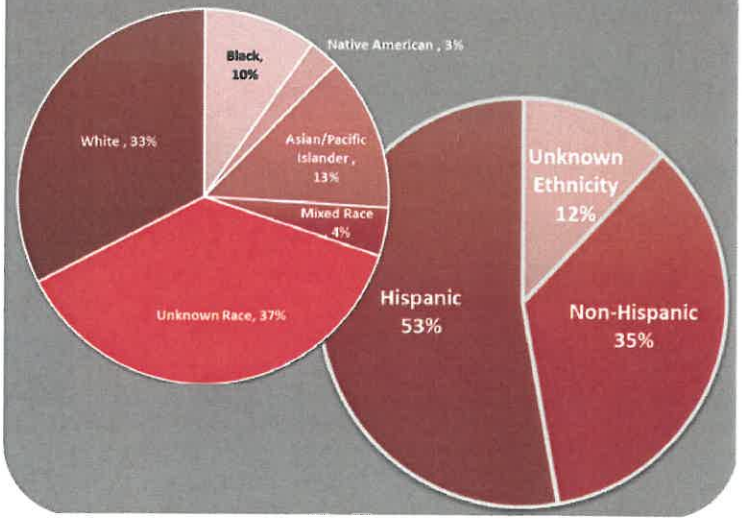

#### BY GENDER




### Special Population

- **336+K** PERSONS EXPERIENCING HOMELESSNESS
- **88+K** SCHOOL BASED CARE PATIENTS
- **33.9K** VETERANS
- **915+K** AGRICULTURAL WORKERS
- **36%** LIMITED ENGLISH PROFICIENCY

#### RACE | ETHNICITY

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# CALIFORNIA 2022 STATE PROFILE

## OF COMMUNITY CLINICS AND HEALTH CENTERS

## Summary Sheet:

### Demographics

| | |
|---|---|
| Total Patients | 7,763,679 |
| Female | 3,011,522 |
| Male | 4,722,224 |
| Non-Binary* | 29,933 |
| Total Encounters | 24,463,230 |

### Poverty Levels

| | |
|---|---|
| Under 100% | 3,953,942 |
| 100-138% | 822,108 |
| 139-200% | 517,681 |
| 201-400% | 267,989 |
| Over 400% | 126,424 |
| Unknown | 2,075,535 |

### Age

| | | | |
|---|---|---|---|
| Under 1 | 156,913 | 20-34 yrs | 2,008,012 |
| 1-4 yrs | 415,876 | 35-44 yrs | 1,032,560 |
| 5-12 yrs | 839,496 | 45-64 yrs | 1,776,353 |
| 13-14 yrs | 228,127 | 65+ yrs | 713,794 |
| 15-19 yrs | 592,548 | 19 > | |

### Ethnicity

| | Patients | % |
|---|---|---|
| Hispanic | 4,104,462 | 53% |
| Non-Hispanic | 2,727,257 | 35% |
| Unknown | 1,191,998 | 15% |

### Special Population

| | Patients |
|---|---|
| Total Homeless | 336,367 |
| Total School-Based | 88,033 |
| Total Veterans | 33,999 |

### AG/Migrant Farmworkers

| | |
|---|---|
| Patients | 915,528 |
| Encounters | 2,633,805 |

### Limited English Proficiency

Patients 36%

### Race

| | | |
|---|---|---|
| Unknown | 1,191,998 | 15% |
| Non-Hispanic | 2,727,257 | 35% |
| Hispanic | 4,104,462 | 53% |
| White (non-hispanic) | 2,999,947 | 39% |
| Black | 387,198 | 5% |
| Native American | 99,626 | 1% |
| Asian/Pacific Islander | 532,944 | 7% |
| Mixed Race | 157,492 | 2% |
| Other Unknown | 1,191,998 | 15% |

### Health Center Services

| | FTE | % | Encounters | % |
|---|---|---|---|---|
| Medical | 6,146.57 | 65% | 18,442,068 | 76% |
| Dental | 1,163.84 | 12% | 2,894,739 | 12% |
| Behavioral Health | 1,139.55 | 12% | 1,433,164 | 6% |
| Other Billable Providers | 1,069.12 | 11% | 1,487,982 | 6% |
| Total | 9,519.08 | | 24,257,953 | |

### Revenue & Utilization by Payer

| | Patients | Encounters |
|---|---|---|
| Medicare | 570,877 | 2,266,110 |
| Medi-Cal | 4,832,844 | 15,353,746 |
| All County*** | 190,666 | 720,742 |
| Private Insurance | 772,535 | 2,238,163 |
| Covered California | 82,554 | 249,523 |
| PACE | 19,730 | |
| Uninsured Services **** | 1,067,191 | 2,001,633 |
| Other Payers | 116,698 | 280,736 |
| BCCCP** | 51,692 | 92,187 |
| CHDP** | 262,691 | 375,372 |
| Family PACT** | 318,747 | 561,257 |

| | |
|---|---|
| Gross Revenue | $8,282,002,361 |
| Write Offs | $2,787,574,534 |
| Net Revenue | $5,494,427,827 |
| Total Operating Expense | $7,372,930,144 |
| Total Operating Revenue | $7,909,123,065 |

### Health Center Types

| | |
|---|---|
| Federally Qualified Health Center Sites (FQHCs) | 798 |
| FQHC Look-Alike Sites | 67 |
| Community Clinics, Indian Health Center Sites & Free | 411 |
| Rural Health Center Sites | 12 |

**Patient counts for Episodic programs (BCCCP, CHDP, Family PACT and Other Episodic Programs) are duplicated. Episodic Programs include Breast Cancer Programs such as the Breast Cancer Early Detection Program (BCCCP) and the Breast and Cervical Cancer Control Program (BCCCP); CHDP = Child Health and Disability Prevention Program; Family PACT = Family Planning Access Care and Treatment Program and other payers covered by a grant. ***All County includes County Indigent/CMSP/MISP, Health Way LA, Alameda Alliance for Health and all encounters in which a county program not listed has reimbursed the clinic. ****Uninsured Services include Self-Pay/Sliding Fee patients who were uninsured and responsible for paying the full amount of charges or a discounted amount.

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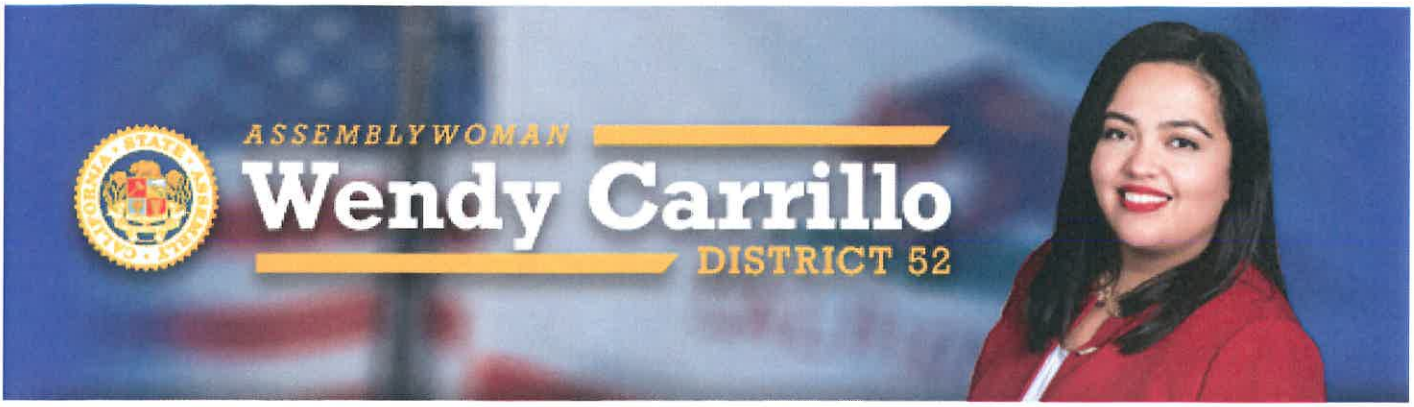


# Assembly Bill (AB) 1549: Prospective Payment Reform

## SUMMARY

AB 1549 would update the Prospective Payment System (PPS) for Community Based Health Centers (CHCs) to reflect their investment in patient outcomes and whole-person care initiatives. Thereby requiring PPS rates to account for expanded services and care coordination costs.

## BACKGROUND AND PROBLEM

California's CHCs provide high quality, comprehensive care to more than 7.8 million Californians annually, regardless of their ability to pay or immigration status. Federally Qualified Health Centers (FQHCs), most licensed CHCs in California, are reimbursed through the Prospective Payment System.

Currently, the PPS rate is based on the range of services the CHC offers. Expanding that range of services triggers a review from the Department of Health Care Services (DHCS) that could allow the CHC to adjust its PPS rate. However, current law only allows a CHC to request that review under specific circumstances. It does not account for other actions CHCs can take to invest in patient outcomes and improve community health. For example, adding expanded care team members and the whole-person care approach of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Transitioning to a value-based care system enables CHCs to focus on delivering high-quality care and prioritizing patients' needs over volume-based care. However, the existing law does not permit CHCs to comprehensively include these care transformation initiatives in their "allowable costs," which results in a lack of reflection in their PPS rate.

## SOLUTION

This bill would, among other things, require the per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific methods and processes used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.

## SUPPORT

California Health+ Advocates (Sponsor)

## BILL STATUS

Amended 03/23/23 – Assembly Health

## STAFF CONTACT

Travis Legault - Legislative Aide
916.319.2052, travis.legault@asm.ca.gov

Version: Amended 03/23/23

# Health Navigation Funding Expansion

*February 27, 2023*

## OVERVIEW

Today, over 1,300 Community Health Centers (CHCs) in California provide high-quality comprehensive care to nearly 7.8 million people – or more than 1 in 5 Californians. CHCs provide the full spectrum of care, from primary care to dental to behavioral health, to everyone who walks through their doors, regardless of their ability to pay, their immigration status, or their individual circumstances.

## THE PROBLEM

Between now and June 2024, 15.2M 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. CHCs serve 4.8M Medi-Cal members and provide a culturally responsive primary care medical home for 1.1M uninsured individuals. For health center patients, Medi-Cal enrollment and renewals are initiated in the clinic setting with trusted enrollment counselors.

In 2022, SB 154 appropriated $59,720,000 over three fiscal years to provide funding to counties and community-based organizations (CBOs) to serve hard-to-reach potentially eligible Medi-Cal populations. However, limited amounts of navigation funding have reached CHCs, and total funding levels are inadequate to meet the upcoming historic need. During the 2022 application period, more than double the amount of navigation funding allocated was requested, and many grantees received only a portion of their funding request requiring a revision of workplans and deliverables to match reduced resources.

Ensuring that local county offices have adequate resources to complete Medi-Cal determinations of eligibility, manage active cases, and renew eligibility is critical. The role of CHCs and CBOs in the *patient navigation* aspect of these efforts, particularly to support communities of color cannot be overlooked as a vital component of this process. CHCs are critical, trusted messengers to support their patients in maintaining coverage through health navigation services. These include supporting patients in completing complex applications, providing in-language services, connecting patients with accurate information regarding immigration-related questions, and acting as an authorized representative in order to interact directly with county staff on behalf of a patient to ensure the application process is completed.

Barriers to successful recertification and coverage continuity will be disproportionately felt by communities of color. A federal Department of Health and Human Services study estimates that during the unwinding period, approximately 17% of white enrollees are predicted to lose coverage nationally, while 64% of Latino enrollees; >50% of Asian/Native Hawaiian/Pacific Islander enrollees; up to 40 percent of Black enrollees, and nearly half of multiracial and other non-white enrollees will lose coverage while still being income eligible.[1] **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.** Thirty-five entities were funded through the navigation project in 2022, including 12 CBOs. Counties have been encouraged to sub-contract with CBOs, but this has been unevenly applied across the state, and community health centers have largely been left un-funded. Statewide, only 33 community health centers received funding to date.

## THE SOLUTION

This proposal seeks to increase Medi-Cal Health Enrollment Navigators Project funding by $60M one-time. CHCs must be prioritized in funding distribution. Augmented funding for local county offices should be directed towards out-stationed workers in CHC settings to expedite Medi-Cal processing in these settings.

## SPONSOR

CaliforniaHealth+ Advocates

## FOR MORE INFORMATION

Dennis Cuevas-Romero, VP of Government Affairs, California Health+Advocates
Meagan Subers, Capitol Connection

[1] *States must act to preserve Medicaid coverage as end of continuous coverage requirement nears.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverage#_ftn7

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[INSERT DATE]

The Honorable Nancy Skinner
Chair, Senate Budget & Fiscal Review Committee
Sacramento, CA 95831

The Honorable Phil Ting
Chair, Assembly Budget Committee
Sacramento, CA 95831

**Re: Budget Request: Health Enrollment Navigators Project Augmentation**

Dear Chair Skinner and Chair Ting:

The California Primary Care Association (CPCA) and the undersigned organizations are writing to urge the legislature to include a one-time budget augmentation of $60 million ($30M general fund; $30M federal match) to enhance the Medi-Cal Health Enrollment Navigators Project to ensure that nearly 16 million Californians maintain access to Medi-Cal coverage on the heels of the COVID-19 pandemic. With this augmentation, the total investment in the Health Enrollment Navigators Project will more accurately reflect the impending need and ensure that essential resources reach the trusted messengers and entities that serve these patient populations.

Between now and May 31, 2024, 15.2M 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, requiring an extraordinary need for health enrollment and navigation services to ensure continuity of coverage, and successful expansion implementation.

In 2022, SB 154 appropriated $59,720,000 for counties and community-based organizations (CBOs) to serve hard-to-reach potentially eligible Medi-Cal populations. During the 2022 application period, more than $140M was requested for navigation funding, and many grantees received only a portion of their funding request. Additionally, limited amounts of navigation funding have reached Community Health Centers (CHCs), where one-third of Medi-Cal patients are served.

Today, over 1,300 CHCs in California provide high-quality comprehensive care to nearly 7.7 million people – or more than 1 in 5 Californians. CHCs serve 4.8M Medi-Cal members and provide a culturally responsive primary care medical home for 1.1M uninsured individuals. For health center patients, Medi-Cal enrollment and renewals are initiated in the clinic setting with trusted enrollment counselors. Ensuring that local county offices have adequate resources to complete Medi-Cal determinations of eligibility, manage active cases, and renew eligibility is essential. However, the role of CHCs and CBOs in the *patient navigation* aspect of these efforts, particularly to support communities of color cannot be overlooked as a vital component of this process.

CHCs and other CBOs are critical, trusted messengers to support their patients in maintaining coverage through health navigation services. These include supporting patients in completing complex applications, providing in-language services, connecting patients with accurate information regarding immigration-related questions, and acting as an authorized representative

in order to interact directly with county staff on behalf of a patient to ensure the application process is completed.

For Medi-Cal redeterminations, barriers to successful recertification and coverage continuity will be disproportionately felt by communities of color. A federal Department of Health and Human Services study estimates that during the unwinding period, approximately 17% of white enrollees are predicted to lose coverage nationally, while 64% of Latino enrollees; >50% of Asian/Native Hawaiian/Pacific Islander enrollees; up to 40 percent of Black enrollees, and nearly half of multiracial and other non-white enrollees will lose coverage while still being income eligible.[1] Culturally and linguistically appropriate health navigation must be funded and prioritized in these efforts.

Increasing the Health Enrollment Navigators Project funding will help close the gap between the true need for navigation services and last year's program budget allocation. **With this in mind, we respectfully request that the budget include an additional $60M dollar appropriation (30M GF; $30 federal match) to expand the Medi-Cal Health Enrollment Navigators Project.**

I look forward to working with you on this important matter.

Sincerely,

[Member] [Member]

[Member] [Member]

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1 *States must act to preserve Medicaid coverage as end of continuous coverage requirement nears.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverage#_ftn7

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March 28, 2023

The Honorable Dave Cortese
Chair, Senate Committee on Labor, Public Employment, and Retirement
1021 O Street, Suite 6740
Sacramento, CA 95414

**Re: SB 525 – OPPOSE UNLESS AMENDED**
**As Amended – March 28, 2023**

Dear Senator Cortese:

CaliforniaHealth+ Advocates, the advocacy affiliate of the California Primary Care Association, representing nearly 1,300 community health centers throughout the state, regretfully opposes, unless amended, Senate Bill 525 (Durazo).

Community health centers (CHCs) provide high-quality, comprehensive care to 7.2 million people in California each year. Our members provide the full spectrum of care, from primary care, dental, and behavioral health services, including a variety of enabling and wraparound services. In many rural communities, CHCs serve as the only source of medical and wellness care for low-to-middle income families in the region. While we appreciate the intent of the bill to support the healthcare workforce in our state, CHCs cannot implement the requirements of the legislation, and fear significant adverse impact to the health care delivery system for our state's most vulnerable communities, in its current form.

The urgent workforce and funding concerns for California's health care providers are real. It is for this very reason California Health+ Advocates have, for years, highlighted the healthcare workforce shortages and requested over $150 million in new workforce investments and other resources last legislative session to directly benefit health care providers, especially at CHCs. SB 525, as currently drafted, would significantly impact CHCs' ability to provide care due to the cascading effect these dramatic wage increases would have without a sustainable funding source. At minimum, CHCs would require a federally approved mechanism for health centers to adjust their Prospective Payment System (PPS) rates and a delayed implementation to ensure sufficient time to operationalize such changes.

<u>PPS Challenges</u>
Because Community Health Centers primarily serve patients enrolled in publicly funded health coverage programs, CHCs are paid for the care they provide through a complex structure governed by state and federal law. Federally Qualified Health Centers (FQHCs) are paid a predetermined rate through PPS that encompasses reimbursement for a set of eligible 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) the service is completed by a billable provider.

Current law only allows a CHC to change their reimbursement rate through a change in scope of service request (CSOSR), under strict circumstances. Those 'triggering events' do not include state-mandated wage increases. The Centers for Medicare and Medicaid Services (CMS) strictly prohibits a CSOSR that is exclusively due to increased costs (including wages). In practice, PPS places CHCs on a 'fixed income' that is not easily modified to meet industry pressures or state-mandated wage increases. Thus, in order for CHCs to implement the provisions of the legislation, the state would need to seek approval from CMS granting the ability to complete a CSOSR due to a state-mandated wage increase. Thereafter, our California State Plan would need to be amended to reflect such an ability to adjust a PPS rate strictly on the basis of a state-mandated wage increase.

Wage and Salary Compression

Notwithstanding the specific challenges faced by our CHCs to implement the provisions of the legislation, there are broader financial challenges not truly considered by SB 525's language. The bill not only proposes a $25 minimum wage, but also requires the minimum to be increased annually by '*the greater of 3.5 percent or the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics nonseasonally adjusted United States Consumer Price Index for Urban Wage Earners and Clerical Workers (U.S. CPI-W).*' This annual increase would create cost pressures not supported by federal or state law and would require CHCs to request a change in scope of services on an annual basis (pending CMS approval for annual adjustments based on mandated wage increases). The Department of Health Care Services (DHCS), which evaluates and assesses the validity of such requests, may not be able to keep up with the workload associated with processing increased CSOSRs.

SB 525 also requires exempt employees at CHCs to 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. This would require any salaried employee to make at least $104,000 per year. Moreover, the minimum wage increase would require CHCs to reevaluate all workers' wages throughout the health center. In order to maintain internal equity for all staff, wage increases would be required throughout the organization. This would have tremendous impact to the finances of our CHCs as many health centers are operating under thin or no margins. These provisions would likely lead to a reduction in overall staff, a shift from salaried employees to hourly employees, and in some circumstances, extreme financial hardship leading to significant reductions of patient services or closure altogether.

Implementation Timeline

Finally, SB 525 requires its provisions to go into effect on January 1, 2024. This timeline is not possible for CHCs. Our members cannot simply increase the cost of its services, like other industries or other health care providers. CHCs would need the support of both the CMS and DHCS to update California law to allow a CSOSR to meet the requirements of the bill. If approval was secured, at the earliest, a January 1, 2026, implementation date would be required.

Summary of Amendments

While CaliforniaHealth+ Advocates understands and appreciates the intent of the legislation, the current language cannot be implemented by CHCs. The bill would need to be amended as follows:

- 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)); and
- Remove language capturing independent contractors (Section 1182.14(b)(1)(A)(i));

For the reasons detailed above, SB 525, as currently drafted, will harm community health centers across the state and reduce patient care for our state's most vulnerable communities. While well intentioned, CaliforniaHealth+ Advocates respectfully requests consideration of alternative approaches to help support California's healthcare workforce. We look forward to working with the author and stakeholders to make sure we find a sustainable solution to support the healthcare workforce in California.

Sincerely,

Dennis Cuevas-Romero
Vice President, Government Affairs
CaliforniaHealth+ Advocates

CC: Senator Maria Elena Durazo
Members of Senate Committee on Labor, Public Employment, and Retirement