californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

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The Honorable Senator Pan
California State Senate Health Committee
1021 O Street, Room 7320
Sacramento, CA 95814

Re: SB 1014 (Hertzberg) – Oppose Unless Amended

Dear Senator Pan:

I am writing today on behalf of CaliforniaHealth+ Advocates, the advocacy affiliate of the California Primary Care Association (CPCA) that advocates on behalf of California's 1,300 community health centers (CHCs) which provide high-quality, comprehensive care to 7.2 million people in California each year. We appreciate the dialogue spurred by this proposal and, like the author, remain committed to addressing our state's health care workforce challenges but we are respectfully writing today to oppose the bill in its current form, unless it is amended.

The urgent workforce and funding concerns for California's Community Health Centers (CHCs) are real. It is for this very reason that the California Primary Care Association (CPCA) and California Health+ Advocates have, for years, highlighted the health care workforce shortages and are currently requesting over $150 million in new workforce investments and other resources to directly benefit all CHC's. We have also worked tirelessly with the Department of Health Care Services to advance state law authorized by the Legislature to advance an Alternative Payment Methodology (APM) that provides the necessary resources for community health centers to provide timely, high-quality care to its patients and communities.

For the reasons detailed below, we do not believe SB 1014 addresses the workforce and access challenges faced by California's community health centers and respectfully request consideration of alternative approaches to help support California's healthcare workforce.

Operational challenges with SB 1014

SB 1014 seeks to create a supplemental payment pool (SPP) for community health centers referred to by the legislation as the Enhanced Clinically Integrated Program (ECIP).

CPCA has been involved in creating a separate SPP program with DHCS since 2020 which, once approved by CMS, will provide supplemental payments to qualifying non-hospital 340B community clinics to secure, strengthen, and support the community clinic and health center delivery system for Medi-Cal beneficiaries. The supplemental payments will support clinics that apply and certify that they are providing additional levels of engagement to integrate and coordinate health care and manage the array of beneficiary health complexities. Creating this SPP program for non-hospital 340B community clinics was extremely challenging due to the strict rules CMS applies to SPP programs. Supplemental payments must be separate from, and in addition to the payments for services rendered to Medicaid enrollees. Additionally, supplemental payments are for a class of providers in Medi-Cal. **As written, SB 1014 runs**

afoul of both of these conditions, and we believe would not be able to be approved by CMS for matching resources.

While it is not clear how payments would be allocated under the methodology proposed by SB 1014, it appears that the intent is that the resources solely be used for staff salary increases. CMS requires that supplemental payment programs provide for new services for Medicaid beneficiaries that are not already paid for. Furthermore, CMS will not allow predetermined amounts to be allocated to any given provider. The amount of the supplemental payment 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 an FQHC would have to newly provide that the additional SPP would pay for in amounts that would allow for an FQHC to raise all salaries to a minimum wage of $25/hour.

While SB 1014 suggests that the ECIP would be a voluntary program for FQHCs, only FQHCs 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. Accordingly, some health centers 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. Moreover, such an allocation of funding based on whether the FQHC is participating in a joint-labor management committee constitutes an impermissible mandate requirement on a class of providers in violation of federal law. FQHCs 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. Furthermore, the LMCC as specified in the legislation do not account for the unique governance requirements applicable to FQHCs, set forth at 42 U.S.C. § 51c.304, that mandate patient-majority governing bodies with authority for establishing an FQHC's personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices.

CPCA and our member health centers have been committed to building out a value-based Alternative Payment Methodology for over a decade that rewards CHCs for keeping patients well, instead of the current model that supports payment based on the number of visits with a primary care provider. Nationally, the entire health care delivery system is moving towards value-based payment which incentivizes quality care and away from fee-for-service payments that are based on the quantity of encounters. California must be a leader in transforming health care payment and delivery. SB 1014 does not align with value-based payment and transformation efforts long underway in California.

Additionally, SB 1014 in its current form does not appear allowable based on federal Medicaid payment rules. Federally qualified health centers (FQHCs) 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 supplemental payment for training and salaries, but salary costs are already included in the PPS rate. If a health center 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. SB 1014 appears to be duplicative of current payment allowances.

Lastly, 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, as described at 42 C.F.R. § 431.10(e).

At this time, we would 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 community health centers, big and small, rural, and urban, must have equitable access to resources to support their employees and community focused mission
- Not hinder FQHCs current capacity to provide timely access to health care and community services
- Governance structures must comply with the federally mandated governance structures for Federally Qualified Health Centers
- 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

For these reasons, we must respectfully oppose SB 1014 unless it is amended to address the concerns outlined above.

Andie Martinez Patterson
Senior Vice President
CaliforniaHealth+ Advocates

cc: Members, Senate Health Committee
Senator Hertzberg