

Senate Bill No. 131

CHAPTER 548

An act to add Sections 14132.101 and 14132.102 to the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 5, 2005. Filed with
Secretary of State October 5, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 131, Chesbro, Medi-Cal: federally qualified health centers and rural health clinics: reimbursement rates.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and under which health care services are provided to qualified low-income persons. Federally qualified health center (FQHC) services and rural health clinic (RHC) services described under federal law are covered Medi-Cal benefits. Existing law requires that FQHCs and RHCs be reimbursed on a per-visit basis and defines "visit" for this purpose as a face-to-face encounter between the FQHC or RHC patient and designated health care providers under prescribed conditions.

Existing law authorizes an FQHC to elect to be reimbursed on a fee-for-service basis for pharmacy and dental services.

Existing law establishes procedures for a federally qualified health center or rural health clinic to submit scope-of-service rate change requests to qualify for an adjustment to its per-visit rate.

This bill, notwithstanding existing law, would deem a scope-of-service change request to be timely when filed within 150 days following the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred.

Existing law provides for the establishment of a commission to operate a local initiative that provides or arranges for the delivery of health care services in all or part of the geographic area of Los Angeles County. Existing law authorizes the department to obtain approval for a demonstration or pilot project under applicable federal laws in connection with the local initiative in Los Angeles County.

This bill, with certain exceptions, would require FQHCs that are receiving cost-based reimbursement under the terms of the Los Angeles County Section 1115 Waiver Demonstration Project on June 30, 2005, referred to as "Los Angeles cost-based FQHCs," to transition to a prospective payment system rate upon expiration of that waiver.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.101 is added to the Welfare and Institutions Code, to read:

14132.101. (a) Notwithstanding paragraphs (4) and (5) of subdivision (e) of Section 14132.100, a scope-of-service change request, whether mandatory or permissive, shall be timely when filed within 150 days following the beginning of the federally qualified health center's or rural health clinic's fiscal year following the year in which the change occurred.

(b) Notwithstanding subdivision (a), and notwithstanding subdivision (e) of Section 14132.100, a federally qualified health center described in Section 14132.102 shall be deemed to have filed a scope-of-service change in a timely manner upon compliance with the requirements set forth in subdivision (c) of Section 14132.102.

SEC. 2. Section 14132.102 is added to the Welfare and Institutions Code, to read:

14132.102. (a) With the exception of clinics and hospital outpatient departments that are subject to Section 14105.24, federally qualified health centers (FQHCs) that are receiving cost-based reimbursement under the terms of the Los Angeles County 1115 Waiver Demonstration Project on June 30, 2005, shall be required to transition to a prospective payment system (PPS) rate upon expiration of that waiver. These FQHCs shall be referred to in this section as "Los Angeles cost-based FQHCs."

(b) For visits occurring on or after July 1, 2005, Los Angeles cost-based FQHCs shall receive a PPS rate equivalent to the following:

(1) FQHC sites that were in existence during the FQHC's 2000 fiscal year shall be permitted to elect their 2000 per-visit rates or the average of the 1999 and 2000 per-visit rates as reported on the cost reports submitted for those fiscal years adjusted as described in subdivision (c).

(2) FQHC sites that were first qualified as an FQHC after the site's 2000 fiscal year shall receive a base rate equivalent to the first full fiscal year rate, as audited on the cost report submitted for that fiscal year and adjusted as described in subdivision (c).

(3) Sites that were first qualified as an FQHC after the site's 2000 fiscal year, and that have not yet filed a cost report for their first full fiscal year shall have a rate set in accordance with subdivision (i) of Section 14132.100 and adjusted as described in subdivision (c).

(c) The base rates described in this section shall be adjusted in the manner described in subdivision (d), paragraphs (1), (2), (3), and (7) of subdivision (e), and subdivision (f) of Section 14132.100.

(d) For Los Angeles cost-based FQHCs, as defined in subdivision (a), no new cost reports shall be required in order to claim scope-of-service changes occurring in fiscal years prior to July 1, 2005. Only the following information shall be required by the department:

(1) A description of the events triggering any applicable rate changes in the form of Worksheet 1 of the Change in Scope-of-Service Request form

developed for fiscal years 2004 and thereafter, modified to identify the applicable fiscal year in which the scope change occurred.

(2) The two worksheets to the Change in Scope-of-Service Request form summarizing the health center's health care practitioners and services for the applicable fiscal year or years.

(e) Change in Scope-of-Service Request forms for changes occurring prior to July 1, 2005, shall be filed with the department no later than July 1, 2006, and shall be deemed to have been filed only when both the Medi-Cal cost report for the applicable period and the referenced Change in Scope-of-Service Request form worksheets have been filed with the department. The date of filing shall be the date on which either the Medi-Cal cost report or the referenced Change in Scope-of-Service Request forms are received by the department, whichever is later.

(f) Notwithstanding Section 14132.107, the department shall calculate a tentative scope-of-service rate adjustment based on 80 percent of the difference in the "as reported" scope-of-service per visit cost. This adjustment shall occur no later than 150 days after receipt of the Medi-Cal cost report and the referenced Change in Scope-of-Service Request forms. Within 12 months after receipt of request forms, the department shall complete its FQHC fiscal year audit of the Medi-Cal cost report and associated Change in Scope-of-Service Request and final rate adjustment pursuant to that audit. The final rate adjustment will be retroactive to July 1, 2005. Nothing in this subdivision shall be construed to extend the time period for review and finalization of cost reports as set forth in Section 14170.

(g) The department shall, by no later than March 30, 2006, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and only to the extent that all necessary federal approvals are obtained and there is an appropriation for the purposes of implementing this section, the department may implement this section without taking any regulatory action and by means of a provider bulletin or similar instructions.