

ASSEMBLY BILL

No. 690

Introduced by Assembly Member Wood

February 25, 2015

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 690, as introduced, Wood. Medi-Cal: federally qualified health centers: rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals.

This bill would include a marriage and family therapist within those health care professionals covered under that definition.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

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

1 SECTION 1. Section 14132.100 of the Welfare and Institutions
 2 Code is amended to read:
 3 14132.100. (a) The federally qualified health center services
 4 described in Section 1396d(a)(2)(C) of Title 42 of the United States
 5 Code are covered benefits.
 6 (b) The rural health clinic services described in Section
 7 1396d(a)(2)(B) of Title 42 of the United States Code are covered
 8 benefits.
 9 (c) Federally qualified health center services and rural health
 10 clinic services shall be reimbursed on a per-visit basis in
 11 accordance with the definition of “visit” set forth in subdivision
 12 (g).
 13 (d) Effective October 1, 2004, and on each October 1, thereafter,
 14 until no longer required by federal law, federally qualified health
 15 center (FQHC) and rural health clinic (RHC) per-visit rates shall
 16 be increased by the Medicare Economic Index applicable to
 17 primary care services in the manner provided for in Section
 18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
 19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
 20 by the Medicare Economic Index in accordance with the
 21 methodology set forth in the state plan in effect on October 1,
 22 2001.
 23 (e) (1) An FQHC or RHC may apply for an adjustment to its
 24 per-visit rate based on a change in the scope of services provided
 25 by the FQHC or RHC. Rate changes based on a change in the
 26 scope of services provided by an FQHC or RHC shall be evaluated
 27 in accordance with Medicare reasonable cost principles, as set
 28 forth in Part 413 (commencing with Section 413.1) of Title 42 of
 29 the Code of Federal Regulations, or its successor.
 30 (2) Subject to the conditions set forth in subparagraphs (A) to
 31 (D), inclusive, of paragraph (3), a change in scope of service means
 32 any of the following:
 33 (A) The addition of a new FQHC or RHC service that is not
 34 incorporated in the baseline prospective payment system (PPS)
 35 rate, or a deletion of an FQHC or RHC service that is incorporated
 36 in the baseline PPS rate.
 37 (B) A change in service due to amended regulatory requirements
 38 or rules.

- 1 (C) A change in service resulting from relocating or remodeling
2 an FQHC or RHC.
- 3 (D) A change in types of services due to a change in applicable
4 technology and medical practice utilized by the center or clinic.
- 5 (E) An increase in service intensity attributable to changes in
6 the types of patients served, including, but not limited to,
7 populations with HIV or AIDS, or other chronic diseases, or
8 homeless, elderly, migrant, or other special populations.
- 9 (F) Any changes in any of the services described in subdivision
10 (a) or (b), or in the provider mix of an FQHC or RHC or one of
11 its sites.
- 12 (G) Changes in operating costs attributable to capital
13 expenditures associated with a modification of the scope of any
14 of the services described in subdivision (a) or (b), including new
15 or expanded service facilities, regulatory compliance, or changes
16 in technology or medical practices at the center or clinic.
- 17 (H) Indirect medical education adjustments and a direct graduate
18 medical education payment that reflects the costs of providing
19 teaching services to interns and residents.
- 20 (I) Any changes in the scope of a project approved by the federal
21 Health Resources and ~~Service~~ *Services* Administration (HRSA).
- 22 (3) No change in costs shall, in and of itself, be considered a
23 scope-of-service change unless all of the following apply:
- 24 (A) The increase or decrease in cost is attributable to an increase
25 or decrease in the scope of services defined in subdivisions (a) and
26 (b), as applicable.
- 27 (B) The cost is allowable under Medicare reasonable cost
28 principles set forth in Part 413 (commencing with Section 413) of
29 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
30 Regulations, or its successor.
- 31 (C) The change in the scope of services is a change in the type,
32 intensity, duration, or amount of services, or any combination
33 thereof.
- 34 (D) The net change in the FQHC's or RHC's rate equals or
35 exceeds 1.75 percent for the affected FQHC or RHC site. For
36 FQHCs and RHCs that filed consolidated cost reports for multiple
37 sites to establish the initial prospective payment reimbursement
38 rate, the 1.75-percent threshold shall be applied to the average
39 per-visit rate of all sites for the purposes of calculating the cost
40 associated with a scope-of-service change. "Net change" means

1 the per-visit rate change attributable to the cumulative effect of all
2 increases and decreases for a particular fiscal year.

3 (4) An FQHC or RHC may submit requests for scope-of-service
4 changes once per fiscal year, only within 90 days following the
5 beginning of the FQHC's or RHC's fiscal year. Any approved
6 increase or decrease in the provider's rate shall be retroactive to
7 the beginning of the FQHC's or RHC's fiscal year in which the
8 request is submitted.

9 (5) An FQHC or RHC shall submit a scope-of-service rate
10 change request within 90 days of the beginning of any FQHC or
11 RHC fiscal year occurring after the effective date of this section,
12 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
13 RHC experienced a decrease in the scope of services provided that
14 the FQHC or RHC either knew or should have known would have
15 resulted in a significantly lower per-visit rate. If an FQHC or RHC
16 discontinues providing onsite pharmacy or dental services, it shall
17 submit a scope-of-service rate change request within 90 days of
18 the beginning of the following fiscal year. The rate change shall
19 be effective as provided for in paragraph (4). As used in this
20 paragraph, "significantly lower" means an average per-visit rate
21 decrease in excess of 2.5 percent.

22 (6) Notwithstanding paragraph (4), if the approved
23 scope-of-service change or changes were initially implemented
24 on or after the first day of an FQHC's or RHC's fiscal year ending
25 in calendar year 2001, but before the adoption and issuance of
26 written instructions for applying for a scope-of-service change,
27 the adjusted reimbursement rate for that scope-of-service change
28 shall be made retroactive to the date the scope-of-service change
29 was initially implemented. Scope-of-service changes under this
30 paragraph shall be required to be submitted within the later of 150
31 days after the adoption and issuance of the written instructions by
32 the department, or 150 days after the end of the FQHC's or RHC's
33 fiscal year ending in 2003.

34 (7) All references in this subdivision to "fiscal year" shall be
35 construed to be references to the fiscal year of the individual FQHC
36 or RHC, as the case may be.

37 (f) (1) An FQHC or RHC may request a supplemental payment
38 if extraordinary circumstances beyond the control of the FQHC
39 or RHC occur after December 31, 2001, and PPS payments are
40 insufficient due to these extraordinary circumstances. Supplemental

1 payments arising from extraordinary circumstances under this
2 subdivision shall be solely and exclusively within the discretion
3 of the department and shall not be subject to subdivision (l). These
4 supplemental payments shall be determined separately from the
5 scope-of-service adjustments described in subdivision (e).
6 Extraordinary circumstances include, but are not limited to, acts
7 of nature, changes in applicable requirements in the Health and
8 Safety Code, changes in applicable licensure requirements, and
9 changes in applicable rules or regulations. Mere inflation of costs
10 alone, absent extraordinary circumstances, shall not be grounds
11 for supplemental payment. If an FQHC's or RHC's PPS rate is
12 sufficient to cover its overall costs, including those associated with
13 the extraordinary circumstances, then a supplemental payment is
14 not warranted.

15 (2) The department shall accept requests for supplemental
16 payment at any time throughout the prospective payment rate year.

17 (3) Requests for supplemental payments shall be submitted in
18 writing to the department and shall set forth the reasons for the
19 request. Each request shall be accompanied by sufficient
20 documentation to enable the department to act upon the request.
21 Documentation shall include the data necessary to demonstrate
22 that the circumstances for which supplemental payment is requested
23 meet the requirements set forth in this section. Documentation
24 shall include all of the following:

25 (A) A presentation of data to demonstrate reasons for the
26 FQHC's or RHC's request for a supplemental payment.

27 (B) Documentation showing the cost implications. The cost
28 impact shall be material and significant, two hundred thousand
29 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
30 is less.

31 (4) A request shall be submitted for each affected year.

32 (5) Amounts granted for supplemental payment requests shall
33 be paid as lump-sum amounts for those years and not as revised
34 PPS rates, and shall be repaid by the FQHC or RHC to the extent
35 that it is not expended for the specified purposes.

36 (6) The department shall notify the provider of the department's
37 discretionary decision in writing.

38 (g) (1) An FQHC or RHC "visit" means a face-to-face
39 encounter between an FQHC or RHC patient and a physician,
40 physician assistant, nurse practitioner, certified nurse-midwife,

1 clinical psychologist, licensed clinical social worker, *marriage*
2 *and family therapist*, or a visiting nurse. For purposes of this
3 section, “physician” shall be interpreted in a manner consistent
4 with the Centers for Medicare and Medicaid Services’ Medicare
5 Rural Health Clinic and Federally Qualified Health Center Manual
6 (Publication 27), or its successor, only to the extent that it defines
7 the professionals whose services are reimbursable on a per-visit
8 basis and not as to the types of services that these professionals
9 may render during these visits and shall include a physician and
10 surgeon, podiatrist, dentist, optometrist, and chiropractor. A visit
11 shall also include a face-to-face encounter between an FQHC or
12 RHC patient and a comprehensive perinatal services practitioner,
13 as defined in Section 51179.1 of Title 22 of the California Code
14 of Regulations, providing comprehensive perinatal services, a
15 four-hour day of attendance at an adult day health care center, and
16 any other provider identified in the state plan’s definition of an
17 FQHC or RHC visit.

18 (2) (A) A visit shall also include a face-to-face encounter
19 between an FQHC or RHC patient and a dental hygienist or a
20 dental hygienist in alternative practice.

21 (B) Notwithstanding subdivision (e), an FQHC or RHC that
22 currently includes the cost of the services of a dental hygienist in
23 alternative practice for the purposes of establishing its FQHC or
24 RHC rate shall apply for an adjustment to its per-visit rate, and,
25 after the rate adjustment has been approved by the department,
26 shall bill these services as a separate visit. However, multiple
27 encounters with dental professionals that take place on the same
28 day shall constitute a single visit. The department shall develop
29 the appropriate forms to determine which FQHC’s or RHC rates
30 shall be adjusted and to facilitate the calculation of the adjusted
31 rates. An FQHC’s or RHC’s application for, or the department’s
32 approval of, a rate adjustment pursuant to this subparagraph shall
33 not constitute a change in scope of service within the meaning of
34 subdivision (e). An FQHC or RHC that applies for an adjustment
35 to its rate pursuant to this subparagraph may continue to bill for
36 all other FQHC or RHC visits at its existing per-visit rate, subject
37 to reconciliation, until the rate adjustment for visits between an
38 FQHC or RHC patient and a dental hygienist or a dental hygienist
39 in alternative practice has been approved. Any approved increase
40 or decrease in the provider’s rate shall be made within six months

1 after the date of receipt of the department's rate adjustment forms
2 pursuant to this subparagraph and shall be retroactive to the
3 beginning of the fiscal year in which the FQHC or RHC submits
4 the request, but in no case shall the effective date be earlier than
5 January 1, 2008.

6 (C) An FQHC or RHC that does not provide dental hygienist
7 or dental hygienist in alternative practice services, and later elects
8 to add these services, shall process the addition of these services
9 as a change in scope of service pursuant to subdivision (e).

10 (h) If FQHC or RHC services are partially reimbursed by a
11 third-party payer, such as a managed care entity (as defined in
12 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),
13 the Medicare Program, or the Child Health and Disability
14 Prevention (CHDP) program, the department shall reimburse an
15 FQHC or RHC for the difference between its per-visit PPS rate
16 and receipts from other plans or programs on a contract-by-contract
17 basis and not in the aggregate, and may not include managed care
18 financial incentive payments that are required by federal law to
19 be excluded from the calculation.

20 (i) (1) An entity that first qualifies as an FQHC or RHC in the
21 year 2001 or later, a newly licensed facility at a new location added
22 to an existing FQHC or RHC, and any entity that is an existing
23 FQHC or RHC that is relocated to a new site shall each have its
24 reimbursement rate established in accordance with one of the
25 following methods, as selected by the FQHC or RHC:

26 (A) The rate may be calculated on a per-visit basis in an amount
27 that is equal to the average of the per-visit rates of three comparable
28 FQHCs or RHCs located in the same or adjacent area with a similar
29 caseload.

30 (B) In the absence of three comparable FQHCs or RHCs with
31 a similar caseload, the rate may be calculated on a per-visit basis
32 in an amount that is equal to the average of the per-visit rates of
33 three comparable FQHCs or RHCs located in the same or an
34 adjacent service area, or in a reasonably similar geographic area
35 with respect to relevant social, health care, and economic
36 characteristics.

37 (C) At a new entity's one-time election, the department shall
38 establish a reimbursement rate, calculated on a per-visit basis, that
39 is equal to 100 percent of the projected allowable costs to the
40 FQHC or RHC of furnishing FQHC or RHC services during the

1 first 12 months of operation as an FQHC or RHC. After the first
2 12-month period, the projected per-visit rate shall be increased by
3 the Medicare Economic Index then in effect. The projected
4 allowable costs for the first 12 months shall be cost settled and the
5 prospective payment reimbursement rate shall be adjusted based
6 on actual and allowable cost per visit.

7 (D) The department may adopt any further and additional
8 methods of setting reimbursement rates for newly qualified FQHCs
9 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42
10 of the United States Code.

11 (2) In order for an FQHC or RHC to establish the comparability
12 of its caseload for purposes of subparagraph (A) or (B) of paragraph
13 (1), the department shall require that the FQHC or RHC submit
14 its most recent annual utilization report as submitted to the Office
15 of Statewide Health Planning and Development, unless the FQHC
16 or RHC was not required to file an annual utilization report. FQHCs
17 or RHCs that have experienced changes in their services or
18 caseload subsequent to the filing of the annual utilization report
19 may submit to the department a completed report in the format
20 applicable to the prior calendar year. FQHCs or RHCs that have
21 not previously submitted an annual utilization report shall submit
22 to the department a completed report in the format applicable to
23 the prior calendar year. The FQHC or RHC shall not be required
24 to submit the annual utilization report for the comparable FQHCs
25 or RHCs to the department, but shall be required to identify the
26 comparable FQHCs or RHCs.

27 (3) The rate for any newly qualified entity set forth under this
28 subdivision shall be effective retroactively to the later of the date
29 that the entity was first qualified by the applicable federal agency
30 as an FQHC or RHC, the date a new facility at a new location was
31 added to an existing FQHC or RHC, or the date on which an
32 existing FQHC or RHC was relocated to a new site. The FQHC
33 or RHC shall be permitted to continue billing for Medi-Cal covered
34 benefits on a fee-for-service basis until it is informed of its
35 enrollment as an FQHC or RHC, and the department shall reconcile
36 the difference between the fee-for-service payments and the
37 FQHC's or RHC's prospective payment rate at that time.

38 (j) Visits occurring at an intermittent clinic site, as defined in
39 subdivision (h) of Section 1206 of the Health and Safety Code, of
40 an existing FQHC or RHC, or in a mobile unit as defined by

1 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
2 and Safety Code, shall be billed by and reimbursed at the same
3 rate as the FQHC or RHC establishing the intermittent clinic site
4 or the mobile unit, subject to the right of the FQHC or RHC to
5 request a scope-of-service adjustment to the rate.

6 (k) An FQHC or RHC may elect to have pharmacy or dental
7 services reimbursed on a fee-for-service basis, utilizing the current
8 fee schedules established for those services. These costs shall be
9 adjusted out of the FQHC's or RHC's clinic base rate as
10 scope-of-service changes. An FQHC or RHC that reverses its
11 election under this subdivision shall revert to its prior rate, subject
12 to an increase to account for all MEI increases occurring during
13 the intervening time period, and subject to any increase or decrease
14 associated with applicable scope-of-services adjustments as
15 provided in subdivision (e).

16 (l) FQHCs and RHCs may appeal a grievance or complaint
17 concerning ratesetting, scope-of-service changes, and settlement
18 of cost report audits, in the manner prescribed by Section 14171.
19 The rights and remedies provided under this subdivision are
20 cumulative to the rights and remedies available under all other
21 provisions of law of this state.

22 (m) The department shall, by no later than March 30, 2008,
23 promptly seek all necessary federal approvals in order to implement
24 this section, including any amendments to the state plan. To the
25 extent that any element or requirement of this section is not
26 approved, the department shall submit a request to the federal
27 Centers for Medicare and Medicaid Services for any waivers that
28 would be necessary to implement this section.

29 (n) The department shall implement this section only to the
30 extent that federal financial participation is obtained.

O