

AMENDED IN ASSEMBLY MAY 28, 2015

AMENDED IN ASSEMBLY APRIL 21, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 858

Introduced by Assembly Member Wood
(Coauthor: Senator McGuire)

February 26, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

AB 858, as amended, Wood. Medi-Cal: federally qualified health centers and rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) 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 an FQHC or RHC and specified health care professionals. Existing law allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services it provides.

This bill would provide that a maximum of 2 visits, as defined, taking place on the same day at a single location shall be reimbursed when either after the first visit the patient suffers illness or injury requiring

additional diagnosis or treatment or the patient has a medical visit, as defined, and another health visit, as defined, or both. The bill would require an FQHC or RHC that currently includes the cost of encounters with more than one health professional that take place on the same day at a single location as constituting a single visit for purposes of establishing its FQHC or RHC rate to, by January 1, 2017, apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, require the FQHC or RHC to bill a medical visit and another health visit that take place on the same day at a single location as separate visits. The bill would make other conforming changes.

This bill would require the department, no later than March 30, 2016, to seek all necessary federal approvals to implement the changes described above.

This bill would also include a marriage and family therapist within those health care professionals covered under the definition of “visit.” The bill would require an FQHC or RHC that currently includes the cost of services of a marriage and family therapist for the purposes of establishing its FQHC or RHC rate to apply to the department for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, would require the FQHC or RHC to bill these services as a separate visit. The bill would require an FQHC or RHC that does not provide the services of a marriage and family therapist, and later elects to add these services, to process the addition of these services as a change in scope of service.

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

1 accordance with the definition of “visit” set forth in subdivision
2 (g).

3 (d) Effective October 1, 2004, and on each October 1, thereafter,
4 until no longer required by federal law, federally qualified health
5 center (FQHC) and rural health clinic (RHC) per-visit rates shall
6 be increased by the Medicare Economic Index applicable to
7 primary care services in the manner provided for in Section
8 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
9 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
10 by the Medicare Economic Index in accordance with the
11 methodology set forth in the state plan in effect on October 1,
12 2001.

13 (e) (1) An FQHC or RHC may apply for an adjustment to its
14 per-visit rate based on a change in the scope of services provided
15 by the FQHC or RHC. Rate changes based on a change in the
16 scope of services provided by an FQHC or RHC shall be evaluated
17 in accordance with Medicare reasonable cost principles, as set
18 forth in Part 413 (commencing with Section 413.1) of Title 42 of
19 the Code of Federal Regulations, or its successor.

20 (2) Subject to the conditions set forth in subparagraphs (A) to
21 (D), inclusive, of paragraph (3), a change in scope of service means
22 any of the following:

23 (A) The addition of a new FQHC or RHC service that is not
24 incorporated in the baseline prospective payment system (PPS)
25 rate, or a deletion of an FQHC or RHC service that is incorporated
26 in the baseline PPS rate.

27 (B) A change in service due to amended regulatory requirements
28 or rules.

29 (C) A change in service resulting from relocating or remodeling
30 an FQHC or RHC.

31 (D) A change in types of services due to a change in applicable
32 technology and medical practice utilized by the center or clinic.

33 (E) An increase in service intensity attributable to changes in
34 the types of patients served, including, but not limited to,
35 populations with HIV or AIDS, or other chronic diseases, or
36 homeless, elderly, migrant, or other special populations.

37 (F) Any changes in any of the services described in subdivision
38 (a) or (b), or in the provider mix of an FQHC or RHC or one of
39 its sites.

1 (G) Changes in operating costs attributable to capital
2 expenditures associated with a modification of the scope of any
3 of the services described in subdivision (a) or (b), including new
4 or expanded service facilities, regulatory compliance, or changes
5 in technology or medical practices at the center or clinic.

6 (H) Indirect medical education adjustments and a direct graduate
7 medical education payment that reflects the costs of providing
8 teaching services to interns and residents.

9 (I) Any changes in the scope of a project approved by the federal
10 Health Resources and ~~Service Services~~ Administration (HRSA).

11 (3) No change in costs shall, in and of itself, be considered a
12 scope-of-service change unless all of the following apply:

13 (A) The increase or decrease in cost is attributable to an increase
14 or decrease in the scope of services defined in subdivisions (a) and
15 (b), as applicable.

16 (B) The cost is allowable under Medicare reasonable cost
17 principles set forth in Part 413 (commencing with Section 413) of
18 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
19 Regulations, or its successor.

20 (C) The change in the scope of services is a change in the type,
21 intensity, duration, or amount of services, or any combination
22 thereof.

23 (D) The net change in the FQHC's or RHC's rate equals or
24 exceeds 1.75 percent for the affected FQHC or RHC site. For
25 FQHCs and RHCs that filed consolidated cost reports for multiple
26 sites to establish the initial prospective payment reimbursement
27 rate, the 1.75-percent threshold shall be applied to the average
28 per-visit rate of all sites for the purposes of calculating the cost
29 associated with a scope-of-service change. "Net change" means
30 the per-visit rate change attributable to the cumulative effect of all
31 increases and decreases for a particular fiscal year.

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

38 (5) An FQHC or RHC shall submit a scope-of-service rate
39 change request within 90 days of the beginning of any FQHC or
40 RHC fiscal year occurring after the effective date of this section,

1 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
2 RHC experienced a decrease in the scope of services provided that
3 the FQHC or RHC either knew or should have known would have
4 resulted in a significantly lower per-visit rate. If an FQHC or RHC
5 discontinues providing onsite pharmacy or dental services, it shall
6 submit a scope-of-service rate change request within 90 days of
7 the beginning of the following fiscal year. The rate change shall
8 be effective as provided for in paragraph (4). As used in this
9 paragraph, "significantly lower" means an average per-visit rate
10 decrease in excess of 2.5 percent.

11 (6) Notwithstanding paragraph (4), if the approved
12 scope-of-service change or changes were initially implemented
13 on or after the first day of an FQHC's or RHC's fiscal year ending
14 in calendar year 2001, but before the adoption and issuance of
15 written instructions for applying for a scope-of-service change,
16 the adjusted reimbursement rate for that scope-of-service change
17 shall be made retroactive to the date the scope-of-service change
18 was initially implemented. Scope-of-service changes under this
19 paragraph shall be required to be submitted within the later of 150
20 days after the adoption and issuance of the written instructions by
21 the department, or 150 days after the end of the FQHC's or RHC's
22 fiscal year ending in 2003.

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

26 (f) (1) An FQHC or RHC may request a supplemental payment
27 if extraordinary circumstances beyond the control of the FQHC
28 or RHC occur after December 31, 2001, and PPS payments are
29 insufficient due to these extraordinary circumstances. Supplemental
30 payments arising from extraordinary circumstances under this
31 subdivision shall be solely and exclusively within the discretion
32 of the department and shall not be subject to subdivision (m). These
33 supplemental payments shall be determined separately from the
34 scope-of-service adjustments described in subdivision (e).
35 Extraordinary circumstances include, but are not limited to, acts
36 of nature, changes in applicable requirements in the Health and
37 Safety Code, changes in applicable licensure requirements, and
38 changes in applicable rules or regulations. Mere inflation of costs
39 alone, absent extraordinary circumstances, shall not be grounds
40 for supplemental payment. If an FQHC's or RHC's PPS rate is

1 sufficient to cover its overall costs, including those associated with
2 the extraordinary circumstances, then a supplemental payment is
3 not warranted.

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

6 (3) Requests for supplemental payments shall be submitted in
7 writing to the department and shall set forth the reasons for the
8 request. Each request shall be accompanied by sufficient
9 documentation to enable the department to act upon the request.
10 Documentation shall include the data necessary to demonstrate
11 that the circumstances for which supplemental payment is requested
12 meet the requirements set forth in this section. Documentation
13 shall include all of the following:

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

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

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

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

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

27 (g) (1) An FQHC or RHC "visit" means a face-to-face
28 encounter between an FQHC or RHC patient and a physician,
29 physician assistant, nurse practitioner, certified nurse-midwife,
30 clinical psychologist, licensed clinical social worker, *marriage*
31 *and family therapist*, or a visiting nurse. For purposes of this
32 section, "physician" shall be interpreted in a manner consistent
33 with the Centers for Medicare and Medicaid Services' Medicare
34 Rural Health Clinic and Federally Qualified Health Center Manual
35 (Publication 27), or its successor, only to the extent that it defines
36 the professionals whose services are reimbursable on a per-visit
37 basis and not as to the types of services that these professionals
38 may render during these visits and shall include a medical doctor,
39 osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit
40 shall also include a face-to-face encounter between an FQHC or

1 RHC patient and a comprehensive perinatal practitioner, as defined
2 in Section 51179.7 of Title 22 of the California Code of
3 Regulations, providing comprehensive perinatal services, a
4 four-hour day of attendance at an adult day health care center, and
5 any other provider identified in the state plan's definition of an
6 FQHC or RHC visit.

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

10 (B) Notwithstanding subdivision (e), an FQHC or RHC that
11 currently includes the cost of the services of a dental hygienist in
12 alternative practice for the purposes of establishing its FQHC or
13 RHC rate shall apply for an adjustment to its per-visit rate, and,
14 after the rate adjustment has been approved by the department,
15 shall bill these services as a separate visit. However, multiple
16 encounters with dental professionals that take place on the same
17 day shall constitute a single visit. The department shall develop
18 the appropriate forms to determine which FQHC's or RHC's rates
19 shall be adjusted and to facilitate the calculation of the adjusted
20 rates. An FQHC's or RHC's application for, or the department's
21 approval of, a rate adjustment pursuant to this subparagraph shall
22 not constitute a change in scope of service within the meaning of
23 subdivision (e). An FQHC or RHC that applies for an adjustment
24 to its rate pursuant to this subparagraph may continue to bill for
25 all other FQHC or RHC visits at its existing per-visit rate, subject
26 to reconciliation, until the rate adjustment for visits between an
27 FQHC or RHC patient and a dental hygienist or a dental hygienist
28 in alternative practice has been approved. Any approved increase
29 or decrease in the provider's rate shall be made within six months
30 after the date of receipt of the department's rate adjustment forms
31 pursuant to this subparagraph and shall be retroactive to the
32 beginning of the fiscal year in which the FQHC or RHC submits
33 the request, but in no case shall the effective date be earlier than
34 January 1, 2008.

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

39 (3) (A) *Notwithstanding subdivision (e), an FQHC or RHC that*
40 *currently includes the cost of services of a marriage and family*

1 *therapist for the purposes of establishing its FQHC or RHC rate*
2 *shall apply for an adjustment to its per-visit rate, and, after the*
3 *rate adjustment has been approved by the department, shall bill*
4 *these services as a separate visit.*

5 (B) *An FQHC or RHC that does not provide the services of a*
6 *marriage and family therapist, and later elects to add these*
7 *services, shall process the addition of these services as a change*
8 *in scope of service pursuant to subdivision (e).*

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

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

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

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

36 (C) At a new entity's one-time election, the department shall
37 establish a reimbursement rate, calculated on a per-visit basis, that
38 is equal to 100 percent of the projected allowable costs to the
39 FQHC or RHC of furnishing FQHC or RHC services during the
40 first 12 months of operation as an FQHC or RHC. After the first

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

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

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

26 (3) The rate for any newly qualified entity set forth under this
27 subdivision shall be effective retroactively to the later of the date
28 that the entity was first qualified by the applicable federal agency
29 as an FQHC or RHC, the date a new facility at a new location was
30 added to an existing FQHC or RHC, or the date on which an
31 existing FQHC or RHC was relocated to a new site. The FQHC
32 or RHC shall be permitted to continue billing for Medi-Cal covered
33 benefits on a fee-for-service basis under its existing provider
34 number until it is informed of its new FQHC or RHC provider
35 number, and the department shall reconcile the difference between
36 the fee-for-service payments and the FQHC's or RHC's prospective
37 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 Medicare Economic Index
13 increases occurring during the intervening time period, and subject
14 to any increase or decrease associated with applicable
15 scope-of-service adjustments as provided in subdivision (e).

16 (l) (1) For purposes of this subdivision, the following definitions
17 shall apply:

18 (A) "Another health visit" means a face-to-face encounter
19 between an FQHC or RHC patient and a clinical psychologist,
20 licensed clinical social worker, *marriage and family therapist*,
21 dentist, dental hygienist, or registered dental hygienist in alternative
22 practice.

23 (B) "Medical visit" means a face-to-face encounter between an
24 FQHC or RHC patient and a physician, physician assistant, nurse
25 practitioner, certified nurse-midwife, visiting nurse, or a
26 comprehensive perinatal practitioner, as defined in Section 51179.7
27 of Title 22 of the California Code of Regulations, providing
28 comprehensive perinatal services.

29 (2) A maximum of two visits, as defined in subdivision (g),
30 taking place on the same day at a single location shall be
31 reimbursed when one or more of the following conditions exist:

32 (A) After the first visit the patient suffers illness or injury
33 requiring additional diagnosis or treatment.

34 (B) The patient has a medical visit and another health visit.

35 (3) (A) Notwithstanding subdivision (e), an FQHC or RHC
36 that currently includes the cost of encounters with more than one
37 health professional that take place on the same day at a single
38 location as constituting a single visit for purposes of establishing
39 its FQHC or RHC rate shall, by January 1, 2017, apply for an
40 adjustment to its per-visit rate, and, after the rate adjustment has

1 been approved by the department, the FQHC or RHC shall bill a
2 medical visit and another health visit that take place on the same
3 day at a single location as separate visits.

4 (B) The department shall, by July 1, 2016, develop and adjust
5 all appropriate forms to determine which FQHC's or RHC's rates
6 shall be adjusted and to facilitate the calculation of the adjusted
7 rates.

8 (C) An FQHC's or RHC's application for, or the department's
9 approval of, a rate adjustment pursuant to this paragraph shall not
10 constitute a change in scope of service within the meaning of
11 subdivision (e).

12 (D) An FQHC or RHC that applies for an adjustment to its rate
13 pursuant to this paragraph may continue to bill for all other FQHC
14 or RHC visits at its existing per-visit rate, *and shall be reimbursed*
15 *on a per-visit basis in accordance with the definition of "visit" set*
16 *forth in subdivision (g)*, subject to reconciliation, until the rate
17 adjustment has been approved.

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

24 (n) (1) The department shall, no later than March 30, 2008,
25 promptly seek all necessary federal approvals in order to implement
26 this section, including any amendments to the state plan.

27 (2) The department, no later than March 30, 2016, shall promptly
28 seek all necessary federal approvals in order to implement
29 subdivision (l), including any necessary amendments to the state
30 plan.

31 (3) To the extent that any element or requirement of this section
32 is not approved, the department shall submit a request to the federal
33 Centers for Medicare and Medicaid Services for any waivers that
34 would be necessary to implement this section.

35 (o) The department shall implement this section only to the
36 extent that federal financial participation is obtained.

O