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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 ~~FHQH~~ 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.

1 (c) Federally qualified health center services and rural health
2 clinic services shall be reimbursed on a per-visit basis in
3 accordance with the definition of “visit” set forth in subdivision
4 (g).

5 (d) Effective October 1, 2004, and on each October 1, thereafter,
6 until no longer required by federal law, federally qualified health
7 center (FQHC) and rural health clinic (RHC) per-visit rates shall
8 be increased by the Medicare Economic Index applicable to
9 primary care services in the manner provided for in Section
10 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
11 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
12 by the Medicare Economic Index in accordance with the
13 methodology set forth in the state plan in effect on October 1,
14 2001.

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

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

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

29 (B) A change in service due to amended regulatory requirements
30 or rules.

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

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

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

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

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

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

12 (I) Any changes in the scope of a project approved by the federal
13 Health Resources and Services Administration (HRSA).

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

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

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

23 (C) The change in the scope of services is a change in the type,
24 intensity, duration, or amount of services, or any combination
25 thereof.

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

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

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

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

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

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

1 changes in applicable rules or regulations. Mere inflation of costs
2 alone, absent extraordinary circumstances, shall not be grounds
3 for supplemental payment. If an FQHC's or RHC's PPS rate is
4 sufficient to cover its overall costs, including those associated with
5 the extraordinary circumstances, then a supplemental payment is
6 not warranted.

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

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

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

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

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

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

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

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

1 may render during these visits and shall include a medical doctor,
2 osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit
3 shall also include a face-to-face encounter between an FQHC or
4 RHC patient and a comprehensive perinatal practitioner, as defined
5 in Section 51179.7 of Title 22 of the California Code of
6 Regulations, providing comprehensive perinatal services, a
7 four-hour day of attendance at an adult day health care center, and
8 any other provider identified in the state plan's definition of an
9 FQHC or RHC visit.

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

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

38 (C) An FQHC or RHC that does not provide dental hygienist
39 or dental hygienist in alternative practice services, and later elects

1 to add these services, shall process the addition of these services
2 as a change in scope of service pursuant to subdivision (e).

3 (3) (A) Notwithstanding subdivision (e), an FQHC or RHC
4 that currently includes the cost of services of a marriage and family
5 therapist for the purposes of establishing its FQHC or RHC rate
6 shall apply for an adjustment to its per-visit rate, and, after the rate
7 adjustment has been approved by the department, shall bill these
8 services as a separate visit.

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

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

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

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

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

1 (C) At a new entity's one-time election, the department shall
2 establish a reimbursement rate, calculated on a per-visit basis, that
3 is equal to 100 percent of the projected allowable costs to the
4 FQHC or RHC of furnishing FQHC or RHC services during the
5 first 12 months of operation as an FQHC or RHC. After the first
6 12-month period, the projected per-visit rate shall be increased by
7 the Medicare Economic Index then in effect. The projected
8 allowable costs for the first 12 months shall be cost settled and the
9 prospective payment reimbursement rate shall be adjusted based
10 on actual and allowable cost per visit.

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

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

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

1 the fee-for-service payments and the FQHC’s or RHC’s prospective
2 payment rate at that time.

3 (j) Visits occurring at an intermittent clinic site, as defined in
4 subdivision (h) of Section 1206 of the Health and Safety Code, of
5 an existing FQHC or RHC, or in a mobile unit as defined by
6 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
7 and Safety Code, shall be billed by and reimbursed at the same
8 rate as the FQHC or RHC establishing the intermittent clinic site
9 or the mobile unit, subject to the right of the FQHC or RHC to
10 request a scope-of-service adjustment to the rate.

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

21 ~~(l) (1) For purposes of this subdivision, the following definitions~~
22 ~~shall apply:~~

23 ~~(A) “Another health visit” means a face-to-face encounter~~
24 ~~between an FQHC or RHC patient and a clinical psychologist,~~
25 ~~licensed clinical social worker, marriage and family therapist,~~
26 ~~dentist, dental hygienist, or registered dental hygienist in alternative~~
27 ~~practice.~~

28 ~~(B) “Medical visit” means a face-to-face encounter between an~~
29 ~~FQHC or RHC patient and a physician, physician assistant, nurse~~
30 ~~practitioner, certified nurse-midwife, visiting nurse, or a~~
31 ~~comprehensive perinatal practitioner, as defined in Section 51179.7~~
32 ~~of Title 22 of the California Code of Regulations, providing~~
33 ~~comprehensive perinatal services.~~

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

37 ~~(A) After the first visit the patient suffers illness or injury~~
38 ~~requiring additional diagnosis or treatment.~~

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

1 ~~(3) (A) Notwithstanding subdivision (c), an FQHC or RHC~~
2 ~~that currently includes the cost of encounters with more than one~~
3 ~~health professional that take place on the same day at a single~~
4 ~~location as constituting a single visit for purposes of establishing~~
5 ~~its FQHC or RHC rate shall, by January 1, 2017, apply for an~~
6 ~~adjustment to its per-visit rate, and, after the rate adjustment has~~
7 ~~been approved by the department, the FQHC or RHC shall bill a~~
8 ~~medical visit and another health visit that take place on the same~~
9 ~~day at a single location as separate visits.~~

10 ~~(B) The department shall, by July 1, 2016, develop and adjust~~
11 ~~all appropriate forms to determine which FQHC's or RHC's rates~~
12 ~~shall be adjusted and to facilitate the calculation of the adjusted~~
13 ~~rates.~~

14 ~~(C) An FQHC's or RHC's application for, or the department's~~
15 ~~approval of, a rate adjustment pursuant to this paragraph shall not~~
16 ~~constitute a change in scope of service within the meaning of~~
17 ~~subdivision (e).~~

18 ~~(D) An FQHC or RHC that applies for an adjustment to its rate~~
19 ~~pursuant to this paragraph may continue to bill for all other FQHC~~
20 ~~or RHC visits at its existing per-visit rate, and shall be reimbursed~~
21 ~~on a per-visit basis in accordance with the definition of "visit" set~~
22 ~~forth in subdivision (g), subject to reconciliation, until the rate~~
23 ~~adjustment has been approved.~~

24 ~~(m)~~
25 ~~(l) FQHCs and RHCs may appeal a grievance or complaint~~
26 ~~concerning ratesetting, scope-of-service changes, and settlement~~
27 ~~of cost report audits, in the manner prescribed by Section 14171.~~
28 ~~The rights and remedies provided under this subdivision are~~
29 ~~cumulative to the rights and remedies available under all other~~
30 ~~provisions of law of this state.~~

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

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

38 ~~(3)~~
39 ~~(m) The department shall, no later than March 30, 2008,~~
40 ~~promptly seek all necessary federal approvals in order to~~

1 *implement this section, including any amendments to the state*
2 *plan.* To the extent that any element or requirement of this section
3 is not approved, the department shall submit a request to the federal
4 Centers for Medicare and Medicaid Services for any waivers that
5 would be necessary to implement this section.

6 ~~(e)~~

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

O