

AMENDED IN SENATE AUGUST 31, 2015

AMENDED IN SENATE JULY 1, 2015

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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 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~~: *visit, as specified*. 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
 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

1 by the FQHC or RHC. Rate changes based on a change in the
2 scope of services provided by an FQHC or RHC shall be evaluated
3 in accordance with Medicare reasonable cost principles, as set
4 forth in Part 413 (commencing with Section 413.1) of Title 42 of
5 the Code of Federal Regulations, or its successor.

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

9 (A) The addition of a new FQHC or RHC service that is not
10 incorporated in the baseline prospective payment system (PPS)
11 rate, or a deletion of an FQHC or RHC service that is incorporated
12 in the baseline PPS rate.

13 (B) A change in service due to amended regulatory requirements
14 or rules.

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

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

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

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

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

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

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

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

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

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

5 (C) The change in the scope of services is a change in the type,
6 intensity, duration, or amount of services, or any combination
7 thereof.

8 (D) The net change in the FQHC's or RHC's rate equals or
9 exceeds 1.75 percent for the affected FQHC or RHC site. For
10 FQHCs and RHCs that filed consolidated cost reports for multiple
11 sites to establish the initial prospective payment reimbursement
12 rate, the 1.75-percent threshold shall be applied to the average
13 per-visit rate of all sites for the purposes of calculating the cost
14 associated with a scope-of-service change. "Net change" means
15 the per-visit rate change attributable to the cumulative effect of all
16 increases and decreases for a particular fiscal year.

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

23 (5) An FQHC or RHC shall submit a scope-of-service rate
24 change request within 90 days of the beginning of any FQHC or
25 RHC fiscal year occurring after the effective date of this section,
26 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
27 RHC experienced a decrease in the scope of services provided that
28 the FQHC or RHC either knew or should have known would have
29 resulted in a significantly lower per-visit rate. If an FQHC or RHC
30 discontinues providing onsite pharmacy or dental services, it shall
31 submit a scope-of-service rate change request within 90 days of
32 the beginning of the following fiscal year. The rate change shall
33 be effective as provided for in paragraph (4). As used in this
34 paragraph, "significantly lower" means an average per-visit rate
35 decrease in excess of 2.5 percent.

36 (6) Notwithstanding paragraph (4), if the approved
37 scope-of-service change or changes were initially implemented
38 on or after the first day of an FQHC's or RHC's fiscal year ending
39 in calendar year 2001, but before the adoption and issuance of
40 written instructions for applying for a scope-of-service change,

1 the adjusted reimbursement rate for that scope-of-service change
2 shall be made retroactive to the date the scope-of-service change
3 was initially implemented. Scope-of-service changes under this
4 paragraph shall be required to be submitted within the later of 150
5 days after the adoption and issuance of the written instructions by
6 the department, or 150 days after the end of the FQHC's or RHC's
7 fiscal year ending in 2003.

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

11 (f) (1) An FQHC or RHC may request a supplemental payment
12 if extraordinary circumstances beyond the control of the FQHC
13 or RHC occur after December 31, 2001, and PPS payments are
14 insufficient due to these extraordinary circumstances. Supplemental
15 payments arising from extraordinary circumstances under this
16 subdivision shall be solely and exclusively within the discretion
17 of the department and shall not be subject to subdivision (l). These
18 supplemental payments shall be determined separately from the
19 scope-of-service adjustments described in subdivision (e).
20 Extraordinary circumstances include, but are not limited to, acts
21 of nature, changes in applicable requirements in the Health and
22 Safety Code, changes in applicable licensure requirements, and
23 changes in applicable rules or regulations. Mere inflation of costs
24 alone, absent extraordinary circumstances, shall not be grounds
25 for supplemental payment. If an FQHC's or RHC's PPS rate is
26 sufficient to cover its overall costs, including those associated with
27 the extraordinary circumstances, then a supplemental payment is
28 not warranted.

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

31 (3) Requests for supplemental payments shall be submitted in
32 writing to the department and shall set forth the reasons for the
33 request. Each request shall be accompanied by sufficient
34 documentation to enable the department to act upon the request.
35 Documentation shall include the data necessary to demonstrate
36 that the circumstances for which supplemental payment is requested
37 meet the requirements set forth in this section. Documentation
38 shall include all of the following:

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

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

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

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

10 (6) The department shall notify the provider of the department’s
 11 discretionary decision in writing.

12 (g) (1) An FQHC or RHC “visit” means a face-to-face
 13 encounter between an FQHC or RHC patient and a physician,
 14 physician assistant, nurse practitioner, certified nurse-midwife,
 15 clinical psychologist, licensed clinical social worker, ~~marriage and~~
 16 ~~family therapist~~, or a visiting nurse. For purposes of this section,
 17 “physician” shall be interpreted in a manner consistent with the
 18 Centers for Medicare and Medicaid Services’ Medicare Rural
 19 Health Clinic and Federally Qualified Health Center Manual
 20 (Publication 27), or its successor, only to the extent that it defines
 21 the professionals whose services are reimbursable on a per-visit
 22 basis and not as to the types of services that these professionals
 23 may render during these visits and shall include a medical doctor,
 24 osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit
 25 shall also include a face-to-face encounter between an FQHC or
 26 RHC patient and a comprehensive perinatal practitioner, as defined
 27 in Section 51179.7 of Title 22 of the California Code of
 28 Regulations, providing comprehensive perinatal services, a
 29 four-hour day of attendance at an adult day health care center, and
 30 any other provider identified in the state plan’s definition of an
 31 FQHC or RHC visit.

32 (2) (A) A visit shall also include a face-to-face encounter
 33 between an FQHC or RHC patient and a dental ~~hygienist or~~
 34 ~~hygienist~~, a dental hygienist in alternative ~~practice~~, *practice*, or a
 35 *marriage and family therapist*.

36 (B) Notwithstanding subdivision (e), an FQHC or RHC that
 37 currently includes the cost of the services of a dental hygienist in
 38 alternative ~~practice~~ *practice*, or a *marriage and family therapist*,
 39 for the purposes of establishing its FQHC or RHC rate shall apply
 40 for an adjustment to its per-visit rate, and, after the rate adjustment

1 has been approved by the department, shall bill these services as
2 a separate visit. However, multiple encounters with dental
3 professionals *or marriage and family therapists* that take place on
4 the same day shall constitute a single visit. The department shall
5 develop the appropriate forms to determine which FQHC's or
6 RHC's rates shall be adjusted and to facilitate the calculation of
7 the adjusted rates. An FQHC's or RHC's application for, or the
8 department's approval of, a rate adjustment pursuant to this
9 subparagraph shall not constitute a change in scope of service
10 within the meaning of subdivision (e). An FQHC or RHC that
11 applies for an adjustment to its rate pursuant to this subparagraph
12 may continue to bill for all other FQHC or RHC visits at its existing
13 per-visit rate, subject to reconciliation, until the rate adjustment
14 for visits between an FQHC or RHC patient and a dental ~~hygienist~~
15 ~~or hygienist~~, a dental hygienist in alternative ~~practice~~ *practice, or*
16 *a marriage and family therapist* has been approved. Any approved
17 increase or decrease in the provider's rate shall be made within
18 six months after the date of receipt of the department's rate
19 adjustment forms pursuant to this subparagraph and shall be
20 retroactive to the beginning of the fiscal year in which the FQHC
21 or RHC submits the request, but in no case shall the effective date
22 be earlier than January 1, 2008.

23 (C) An FQHC or RHC that does not provide dental ~~hygienist~~
24 ~~or hygienist~~, dental hygienist in alternative ~~practice~~ *practice, or*
25 *marriage and family therapist* services, and later elects to add these
26 services, shall process the addition of these services as a change
27 in scope of service pursuant to subdivision (e).

28 ~~(3) (A) Notwithstanding subdivision (e), an FQHC or RHC~~
29 ~~that currently includes the cost of services of a marriage and family~~
30 ~~therapist for the purposes of establishing its FQHC or RHC rate~~
31 ~~shall apply for an adjustment to its per-visit rate, and, after the rate~~
32 ~~adjustment has been approved by the department, shall bill these~~
33 ~~services as a separate visit.~~

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

38 (h) If FQHC or RHC services are partially reimbursed by a
39 third-party payer, such as a managed care entity (as defined in
40 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),

1 the Medicare program, or the Child Health and Disability
2 Prevention (CHDP) program, the department shall reimburse an
3 FQHC or RHC for the difference between its per-visit PPS rate
4 and receipts from other plans or programs on a contract-by-contract
5 basis and not in the aggregate, and may not include managed care
6 financial incentive payments that are required by federal law to
7 be excluded from the calculation.

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

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

18 (B) In the absence of three comparable FQHCs or RHCs with
19 a similar caseload, the rate may be calculated on a per-visit basis
20 in an amount that is equal to the average of the per-visit rates of
21 three comparable FQHCs or RHCs located in the same or an
22 adjacent service area, or in a reasonably similar geographic area
23 with respect to relevant social, health care, and economic
24 characteristics.

25 (C) At a new entity's one-time election, the department shall
26 establish a reimbursement rate, calculated on a per-visit basis, that
27 is equal to 100 percent of the projected allowable costs to the
28 FQHC or RHC of furnishing FQHC or RHC services during the
29 first 12 months of operation as an FQHC or RHC. After the first
30 12-month period, the projected per-visit rate shall be increased by
31 the Medicare Economic Index then in effect. The projected
32 allowable costs for the first 12 months shall be cost settled and the
33 prospective payment reimbursement rate shall be adjusted based
34 on actual and allowable cost per visit.

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

39 (2) In order for an FQHC or RHC to establish the comparability
40 of its caseload for purposes of subparagraph (A) or (B) of paragraph

1 (1), the department shall require that the FQHC or RHC submit
2 its most recent annual utilization report as submitted to the Office
3 of Statewide Health Planning and Development, unless the FQHC
4 or RHC was not required to file an annual utilization report. FQHCs
5 or RHCs that have experienced changes in their services or
6 caseload subsequent to the filing of the annual utilization report
7 may submit to the department a completed report in the format
8 applicable to the prior calendar year. FQHCs or RHCs that have
9 not previously submitted an annual utilization report shall submit
10 to the department a completed report in the format applicable to
11 the prior calendar year. The FQHC or RHC shall not be required
12 to submit the annual utilization report for the comparable FQHCs
13 or RHCs to the department, but shall be required to identify the
14 comparable FQHCs or RHCs.

15 (3) The rate for any newly qualified entity set forth under this
16 subdivision shall be effective retroactively to the later of the date
17 that the entity was first qualified by the applicable federal agency
18 as an FQHC or RHC, the date a new facility at a new location was
19 added to an existing FQHC or RHC, or the date on which an
20 existing FQHC or RHC was relocated to a new site. The FQHC
21 or RHC shall be permitted to continue billing for Medi-Cal covered
22 benefits on a fee-for-service basis under its existing provider
23 number until it is informed of its ~~new FQHC or RHC provider~~
24 ~~number~~, *enrollment approval*, and the department shall reconcile
25 the difference between the fee-for-service payments and the
26 FQHC's or RHC's prospective payment rate at that time.

27 (j) Visits occurring at an intermittent clinic site, as defined in
28 subdivision (h) of Section 1206 of the Health and Safety Code, of
29 an existing FQHC or RHC, or in a mobile unit as defined by
30 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
31 and Safety Code, shall be billed by and reimbursed at the same
32 rate as the FQHC or RHC establishing the intermittent clinic site
33 or the mobile unit, subject to the right of the FQHC or RHC to
34 request a scope-of-service adjustment to the rate.

35 (k) An FQHC or RHC may elect to have pharmacy or dental
36 services reimbursed on a fee-for-service basis, utilizing the current
37 fee schedules established for those services. These costs shall be
38 adjusted out of the FQHC's or RHC's clinic base rate as
39 scope-of-service changes. An FQHC or RHC that reverses its
40 election under this subdivision shall revert to its prior rate, subject

1 to an increase to account for all Medicare Economic Index
2 increases occurring during the intervening time period, and subject
3 to any increase or decrease associated with applicable
4 scope-of-service adjustments as provided in subdivision (e).

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

11 (m) The department shall, no later than March 30, 2008,
12 promptly seek all necessary federal approvals in order to implement
13 this section, including any amendments to the state plan. To the
14 extent that any element or requirement of this section is not
15 approved, the department shall submit a request to the federal
16 Centers for Medicare and Medicaid Services for any waivers that
17 would be necessary to implement this section.

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