

AMENDED IN ASSEMBLY MAY 27, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1863

Introduced by Assembly Member Wood

February 10, 2016

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1863, as amended, Wood. Medi-Cal: federally qualified health centers: rural health centers.

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~~ *program* provisions. 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 include a marriage and family therapist within those health care professionals covered under that definition. The bill would require an FQHC or RHC that currently includes the cost of services of a *dental hygienist in alternative practice, or 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~~, *rate if the FQHC or RHC chooses to bill these services as a separate visit*, 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, as specified. The bill would require an FQHC or RHC that does not provide the services of a *dental hygienist, dental hygienist in alternative practice, or a marriage and family therapist*, and later elects to add these ~~services~~, *services and bill these services as a separate visit*, 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
 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

1 in accordance with Medicare reasonable cost principles, as set
2 forth in Part 413 (commencing with Section 413.1) of Title 42 of
3 the Code of Federal Regulations, or its successor.

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

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

11 (B) A change in service due to amended regulatory requirements
12 or rules.

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

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

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

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

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

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

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

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

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

39 (B) The cost is allowable under Medicare reasonable cost
40 principles set forth in Part 413 (commencing with Section 413) of

1 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
2 Regulations, or its successor.

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

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

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

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

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

1 was initially implemented. Scope-of-service changes under this
2 paragraph shall be required to be submitted within the later of 150
3 days after the adoption and issuance of the written instructions by
4 the department, or 150 days after the end of the FQHC's or RHC's
5 fiscal year ending in 2003.

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

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

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

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

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

39 (B) Documentation showing the cost implications. The cost
40 impact shall be material and significant, two hundred thousand

1 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
2 is less.

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

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

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

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

29 (2) (A) A visit shall also include a face-to-face encounter
30 between an FQHC or RHC patient and a dental hygienist, a dental
31 hygienist in alternative practice, or a marriage and family therapist.

32 (B) Notwithstanding subdivision (e), *if* an FQHC or RHC that
33 currently includes the cost of the services of a dental hygienist in
34 alternative practice, or a marriage and family therapist for the
35 purposes of establishing its FQHC or RHC rate *chooses to bill*
36 *these services as a separate visit, the FQHC or RHC shall apply*
37 *for an adjustment to its per-visit rate, and, after the rate adjustment*
38 *has been approved by the department, shall bill these services as*
39 *a separate visit. However, multiple encounters with dental*
40 *professionals or marriage and family therapists that take place on*

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

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

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

36 (i) (1) An entity that first qualifies as an FQHC or RHC in the
37 year 2001 or later, a newly licensed facility at a new location added
38 to an existing FQHC or RHC, and any entity that is an existing
39 FQHC or RHC that is relocated to a new site shall each have its

1 reimbursement rate established in accordance with one of the
2 following methods, as selected by the FQHC or RHC:

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

7 (B) In the absence of three comparable FQHCs or RHCs with
8 a similar caseload, the rate may be calculated on a per-visit basis
9 in an amount that is equal to the average of the per-visit rates of
10 three comparable FQHCs or RHCs located in the same or an
11 adjacent service area, or in a reasonably similar geographic area
12 with respect to relevant social, health care, and economic
13 characteristics.

14 (C) At a new entity's one-time election, the department shall
15 establish a reimbursement rate, calculated on a per-visit basis, that
16 is equal to 100 percent of the projected allowable costs to the
17 FQHC or RHC of furnishing FQHC or RHC services during the
18 first 12 months of operation as an FQHC or RHC. After the first
19 12-month period, the projected per-visit rate shall be increased by
20 the Medicare Economic Index then in effect. The projected
21 allowable costs for the first 12 months shall be cost settled and the
22 prospective payment reimbursement rate shall be adjusted based
23 on actual and allowable cost per visit.

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

28 (2) In order for an FQHC or RHC to establish the comparability
29 of its caseload for purposes of subparagraph (A) or (B) of paragraph
30 (1), the department shall require that the FQHC or RHC submit
31 its most recent annual utilization report as submitted to the Office
32 of Statewide Health Planning and Development, unless the FQHC
33 or RHC was not required to file an annual utilization report. FQHCs
34 or RHCs that have experienced changes in their services or
35 caseload subsequent to the filing of the annual utilization report
36 may submit to the department a completed report in the format
37 applicable to the prior calendar year. FQHCs or RHCs that have
38 not previously submitted an annual utilization report shall submit
39 to the department a completed report in the format applicable to
40 the prior calendar year. The FQHC or RHC shall not be required

1 to submit the annual utilization report for the comparable FQHCs
2 or RHCs to the department, but shall be required to identify the
3 comparable FQHCs or RHCs.

4 (3) The rate for any newly qualified entity set forth under this
5 subdivision shall be effective retroactively to the later of the date
6 that the entity was first qualified by the applicable federal agency
7 as an FQHC or RHC, the date a new facility at a new location was
8 added to an existing FQHC or RHC, or the date on which an
9 existing FQHC or RHC was relocated to a new site. The FQHC
10 or RHC shall be permitted to continue billing for Medi-Cal covered
11 benefits on a fee-for-service basis under its existing provider
12 number until it is informed of its FQHC or RHC enrollment
13 approval, and the department shall reconcile the difference between
14 the fee-for-service payments and the FQHC's or RHC's prospective
15 payment rate at that time.

16 (j) Visits occurring at an intermittent clinic site, as defined in
17 subdivision (h) of Section 1206 of the Health and Safety Code, of
18 an existing FQHC or RHC, or in a mobile unit as defined by
19 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
20 and Safety Code, shall be billed by and reimbursed at the same
21 rate as the FQHC or RHC establishing the intermittent clinic site
22 or the mobile unit, subject to the right of the FQHC or RHC to
23 request a scope-of-service adjustment to the rate.

24 (k) An FQHC or RHC may elect to have pharmacy or dental
25 services reimbursed on a fee-for-service basis, utilizing the current
26 fee schedules established for those services. These costs shall be
27 adjusted out of the FQHC's or RHC's clinic base rate as
28 scope-of-service changes. An FQHC or RHC that reverses its
29 election under this subdivision shall revert to its prior rate, subject
30 to an increase to account for all Medicare Economic Index
31 increases occurring during the intervening time period, and subject
32 to any increase or decrease associated with applicable
33 scope-of-service adjustments as provided in subdivision (e).

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

1 (m) The department shall, no later than March 30, 2008,
2 promptly seek all necessary federal approvals in order to implement
3 this section, including any amendments to the state plan. To the
4 extent that any element or requirement of this section is not
5 approved, the department shall submit a request to the federal
6 Centers for Medicare and Medicaid Services for any waivers that
7 would be necessary to implement this section.

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

O