

AMENDED IN SENATE AUGUST 17, 2016

AMENDED IN ASSEMBLY MAY 27, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1863**

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**Introduced by Assembly Member Wood**

February 10, 2016

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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 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 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 and bill these services as a separate visit, to process the addition of these services as a change in scope of service.

*This bill would incorporate additional changes in Section 14132.100 of the Welfare and Institutions Code proposed by SB 1335, that would become operative only if SB 1335 and this bill are both chaptered and become effective on or before January 1, 2017, and this bill is chaptered last.*

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~~, *1*  
 14 thereafter, until no longer required by federal law, federally  
 15 qualified health center (FQHC) and rural health clinic (RHC)  
 16 per-visit rates shall be increased by the Medicare Economic Index  
 17 applicable to primary care services in the manner provided for in  
 18 Section 1396a(bb)(3)(A) of Title 42 of the United States Code.  
 19 Prior to January 1, 2004, FQHC and RHC per-visit rates shall be

1 adjusted by the Medicare Economic Index in accordance with the  
2 methodology set forth in the state plan in effect on October 1,  
3 2001.

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

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

14 (A) The addition of a new FQHC or RHC service that is not  
15 incorporated in the baseline prospective payment system (PPS)  
16 rate, or a deletion of an FQHC or RHC service that is incorporated  
17 in the baseline PPS rate.

18 (B) A change in service due to amended regulatory requirements  
19 or rules.

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

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

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

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

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

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

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

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

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

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

10 (C) The change in the scope of services is a change in the type,  
11 intensity, duration, or amount of services, or any combination  
12 thereof.

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

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

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

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

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

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

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

36 (3) Requests for supplemental payments shall be submitted in  
37 writing to the department and shall set forth the reasons for the  
38 request. Each request shall be accompanied by sufficient  
39 documentation to enable the department to act upon the request.  
40 Documentation shall include the data necessary to demonstrate

1 that the circumstances for which supplemental payment is requested  
2 meet the requirements set forth in this section. Documentation  
3 shall include ~~all~~ *both* of the following:

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

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

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

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

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

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

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

39 (B) Notwithstanding subdivision (e), if an FQHC or RHC that  
40 currently includes the cost of the services of a dental hygienist in

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

27 (C) An FQHC or RHC that does not provide dental hygienist,  
28 dental hygienist in alternative practice, or marriage and family  
29 therapist services, and later elects to add these services and bill  
30 these services as a separate visit, shall process the addition of these  
31 services as a change in scope of service pursuant to subdivision  
32 (e).

33 (h) If FQHC or RHC services are partially reimbursed by a  
34 third-party payer, such as a managed care entity (as defined in  
35 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
36 the Medicare Program, or the Child Health and Disability  
37 Prevention (CHDP) ~~program~~, *Program*, the department shall  
38 reimburse an FQHC or RHC for the difference between its per-visit  
39 PPS rate and receipts from other plans or programs on a  
40 contract-by-contract basis and not in the aggregate, and may not

1 include managed care financial incentive payments that are required  
2 by federal law to be excluded from the calculation.

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

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

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

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

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

34 (2) In order for an FQHC or RHC to establish the comparability  
35 of its caseload for purposes of subparagraph (A) or (B) of paragraph  
36 (1), the department shall require that the FQHC or RHC submit  
37 its most recent annual utilization report as submitted to the Office  
38 of Statewide Health Planning and Development, unless the FQHC  
39 or RHC was not required to file an annual utilization report. FQHCs  
40 or RHCs that have experienced changes in their services or



1 caseload subsequent to the filing of the annual utilization report  
2 may submit to the department a completed report in the format  
3 applicable to the prior calendar year. FQHCs or RHCs that have  
4 not previously submitted an annual utilization report shall submit  
5 to the department a completed report in the format applicable to  
6 the prior calendar year. The FQHC or RHC shall not be required  
7 to submit the annual utilization report for the comparable FQHCs  
8 or RHCs to the department, but shall be required to identify the  
9 comparable FQHCs or RHCs.

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

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

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

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

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

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

16 *SEC. 1.5. Section 14132.100 of the Welfare and Institutions*  
17 *Code is amended to read:*

18 14132.100. (a) The federally qualified health center services  
19 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
20 Code are covered benefits.

21 (b) The rural health clinic services described in Section  
22 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
23 benefits.

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

28 (d) Effective October 1, 2004, and on each October ~~1~~, *1*  
29 thereafter, until no longer required by federal law, federally  
30 qualified health center (FQHC) and rural health clinic (RHC)  
31 per-visit rates shall be increased by the Medicare Economic Index  
32 applicable to primary care services in the manner provided for in  
33 Section 1396a(bb)(3)(A) of Title 42 of the United States Code.  
34 Prior to January 1, 2004, FQHC and RHC per-visit rates shall be  
35 adjusted by the Medicare Economic Index in accordance with the  
36 methodology set forth in the state plan in effect on October 1,  
37 2001.

38 (e) (1) An FQHC or RHC may apply for an adjustment to its  
39 per-visit rate based on a change in the scope of services provided  
40 by the FQHC or RHC. Rate changes based on a change in the

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

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

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

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

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

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

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

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

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

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

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

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

37 (A) The increase or decrease in cost is attributable to an increase  
38 or decrease in the scope of services defined in subdivisions (a) and  
39 (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 ~~at~~ both 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, or a visiting  
16 nurse. For purposes of this section, “physician” shall be interpreted  
17 in a manner consistent with the Centers for Medicare and Medicaid  
18 Services’ Medicare Rural Health Clinic and Federally Qualified  
19 Health Center Manual (Publication 27), or its successor, only to  
20 the extent that it defines the professionals whose services are  
21 reimbursable on a per-visit basis and not as to the types of services  
22 that these professionals may render during these visits and shall  
23 include a physician and surgeon, *osteopath*, podiatrist, dentist,  
24 optometrist, and chiropractor. A visit shall also include a  
25 face-to-face encounter between an FQHC or RHC patient and a  
26 comprehensive perinatal services practitioner, as defined in Section  
27 ~~51179.1~~ 51179.7 of Title 22 of the California Code of Regulations,  
28 providing comprehensive perinatal services, a four-hour day of  
29 attendance at an adult day health care center, and any other provider  
30 identified in the state plan’s definition of an FQHC or RHC visit.

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

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

1 adjustment has been approved by the department, shall bill these  
2 services as a separate visit. However, multiple encounters with  
3 dental professionals *or marriage and family therapists* that take  
4 place on the same day shall constitute a single visit. The department  
5 shall develop the appropriate forms to determine which FQHC's  
6 ~~or RHC~~ *RHC's* rates shall be adjusted and to facilitate the  
7 calculation of the adjusted rates. An FQHC's or RHC's application  
8 for, or the department's approval of, a rate adjustment pursuant to  
9 this 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~~, *services and bill these services as a separate visit*, shall  
27 process the addition of these services as a change in scope of  
28 service pursuant to subdivision (e).

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

39 (i) (1) An entity that first qualifies as an FQHC or RHC in the  
40 year 2001 or later, a newly licensed facility at a new location added

1 to an existing FQHC or RHC, and any entity that is an existing  
2 FQHC or RHC that is relocated to a new site shall each have its  
3 reimbursement rate established in accordance with one of the  
4 following methods, as selected by the FQHC or RHC:

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

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

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

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

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



1 to the department a completed report in the format applicable to  
2 the prior calendar year. The FQHC or RHC shall not be required  
3 to submit the annual utilization report for the comparable FQHCs  
4 or RHCs to the department, but shall be required to identify the  
5 comparable FQHCs or RHCs.

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

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

26 (k) (1) *Notwithstanding any other provision of this section*  
27 *requiring the use of a per-visit reimbursement rate, as described*  
28 *in subdivision (c), this subdivision shall govern reimbursement for*  
29 *services identified in this subdivision.*

30 (2) *An FQHC or RHC may elect to have pharmacy services or*  
31 *dental services reimbursed on a fee-for-services basis, utilizing*  
32 *the current fee schedules established for those services.*

33 (3) *An FQHC or RHC may elect to enroll as a Drug Medi-Cal*  
34 *certified provider. If an FQHC or RHC elects to enroll as a Drug*  
35 *Medi-Cal certified provider, the costs associated with the Drug*  
36 *Medi-Cal services shall not be included in the FQHC's or RHC's*  
37 *per-visit PPS rate and the reimbursement for those services shall*  
38 *be governed by subparagraph (A) or (B).*

39 (A) *If the FQHC or RHC elects to provide Drug Medi-Cal*  
40 *services in a county that has elected to participate in the Drug*

1 *Medi-Cal organized delivery system, the FQHC or RHC shall*  
2 *receive reimbursement pursuant to a mutually agreed upon*  
3 *contract between the county and the FQHC or RHC. If an FQHC*  
4 *or RHC is denied a contract by the county, the FQHC or RHC*  
5 *may follow the contract denial process set forth in the Special*  
6 *Terms and Conditions.*

7 *(B) If the FQHC or RHC elects to provide Drug Medi-Cal*  
8 *services in a county that does not elect to participate in the Drug*  
9 *Medi-Cal organized delivery system, the FQHC or RHC shall*  
10 *receive reimbursement pursuant to a mutually agreed upon*  
11 *contract between the county and the FQHC or RHC. If the county*  
12 *refuses to contract with the FQHC or RHC, the FQHC or RHC*  
13 *may request to contract directly with the department and shall be*  
14 *reimbursed for those services at the fee-for-service rate.*

15 *(4) (A) If an FQHC or RHC elects reimbursement pursuant to*  
16 *paragraph (2) or (3), pursuant to which the costs associated with*  
17 *providing the services are part of the FQHC's or RHC's clinic*  
18 *base rate, those costs shall be adjusted out of the FQHC's or*  
19 *RHC's clinic base rate as scope-of-service changes and payment*  
20 *pursuant to subdivision (h) shall not apply.*

21 ~~(A)~~

22 ~~(B) An FQHC or RHC may elect to have pharmacy or dental~~  
23 ~~services reimbursed on a fee-for-service basis, utilizing the current~~  
24 ~~fee schedules established for those services. These costs shall be~~  
25 ~~adjusted out of the FQHC's or RHC's clinic base rate as~~  
26 ~~scope-of-service changes. An FQHC or RHC that reverses its~~  
27 ~~election under this subdivision paragraph (2) or (3) shall revert~~  
28 ~~to its prior rate, subject to an increase to account for all-MEI~~  
29 ~~Medicare Economic Index increases occurring during the~~  
30 ~~intervening time period, and subject to any increase or decrease~~  
31 ~~increases or decreases associated with applicable scope-of-services~~  
32 ~~scope-of-service adjustments as provided in subdivision (e).~~

33 *(5) (A) An FQHC or RHC shall submit a scope-of-service rate*  
34 *change request within 90 days of the beginning of any FQHC or*  
35 *RHC fiscal year occurring after January 1, 2017, if, during the*  
36 *FQHC's or RHC's prior fiscal year, both of the following*  
37 *occurred:*

38 *(i) The FQHC or RHC elected reimbursement pursuant to*  
39 *paragraph (3).*

1 (ii) *The costs of providing Drug Medi-Cal services were*  
2 *included in the per-visit PPS rate and the removal of those costs*  
3 *would have resulted in a significantly lower per-visit PPS rate.*  
4 *For purposes of this subparagraph, “significantly lower” means*  
5 *an average per-visit PPS rate decrease in excess of 2.5 percent.*

6 (B) *Within 90 days of receipt of the request for a*  
7 *scope-of-service change, the department shall issue the FQHC or*  
8 *RHC an interim rate equal to 90 percent of the FQHC’s or RHC’s*  
9 *projected allowable cost as determined by the department. The*  
10 *audit performed to determine the final rate shall be performed in*  
11 *accordance with Section 14170.*

12 (6) *If an FQHC or RHC makes an election pursuant to*  
13 *paragraph (3) and a scope-of-service change is necessary pursuant*  
14 *to paragraphs (4) and (5), the FQHC or RHC shall comply with*  
15 *both of the following:*

16 (A) *After the department approves the request for a*  
17 *scope-of-service change and adjusts the per-visit PPS rate pursuant*  
18 *to paragraph (4), the FQHC or RHC shall not bill the per-visit*  
19 *PPS rate for services reimbursed by the Drug Medi-Cal organized*  
20 *delivery system.*

21 (B) *For the purpose of calculating a per-visit PPS rate, the*  
22 *FQHC or RHC shall provide verifiable documentation of the costs*  
23 *of an employee who provides both FQHC services and Drug*  
24 *Medi-Cal services. Documentation shall attribute costs*  
25 *proportionally between FQHC services and Drug Medi-Cal*  
26 *services. Only the costs attributable to FQHC services shall be*  
27 *included in the per-visit PPS rate.*

28 (7) *If an FQHC or RHC was enrolled as a Drug Medi-Cal*  
29 *certified provider on or before January 1, 2017, the FQHC or*  
30 *RHC may continue to provide, and be reimbursed for, Drug*  
31 *Medi-Cal services pursuant to the terms of the contract if the costs*  
32 *of providing Drug Medi-Cal services are reimbursed outside of*  
33 *the per-visit PPS rate described in subdivision (c).*

34 (8) (A) *If an FQHC or RHC entered into a contract on or before*  
35 *January 1, 2017, with a mental health plan to provide specialty*  
36 *mental health services to Medi-Cal beneficiaries as part of the*  
37 *mental health plan’s network, the FQHC or RHC may continue*  
38 *to provide, and be reimbursed for, those specialty mental health*  
39 *services pursuant to the terms of the contract with the mental health*  
40 *plan if the costs of providing specialty mental health services are*

1 *reimbursed outside of the per-visit PPS rate described in*  
2 *subdivision (c).*

3 *(B) For purposes of this paragraph, “mental health plan” means*  
4 *any mental health plan contracting with the department to provide*  
5 *specialty mental health services to enrolled Medi-Cal beneficiaries*  
6 *under Article 5 (commencing with Section 14680) of Chapter 8.8*  
7 *or Chapter 8.9 (commencing with Section 14700).*

8 *(9) Nothing in this subdivision shall be construed to alter or*  
9 *otherwise change the process applicable to an FQHC or RHC*  
10 *making an election pursuant to paragraph (2).*

11 *(10) For purposes of this subdivision, the following definitions*  
12 *shall apply:*

13 *(A) “Drug Medi-Cal organized delivery system” means the*  
14 *Drug Medi-Cal organized delivery system authorized under the*  
15 *California Medi-Cal 2020 Demonstration, Number 11-W-00193/9,*  
16 *as approved by the federal Centers for Medicare and Medicaid*  
17 *Services and described in the Special Terms and Conditions.*

18 *(B) “Special Terms and Conditions” shall have the same*  
19 *meaning as set forth in subdivision (o) of Section 14184.10.*

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

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

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

35 *SEC. 2. Section 1.5 of this bill incorporates amendments to*  
36 *Section 14132.100 of the Welfare and Institutions Code proposed*  
37 *by both this bill and Senate Bill 1335. It shall only become*  
38 *operative if (1) both bills are enacted and become effective on or*  
39 *before January 1, 2017, (2) each bill amends Section 14132.100*  
40 *of the Welfare and Institutions Code, and (3) this bill is enacted*

1 *after Senate Bill 1335, in which case Section 1 of this bill shall*  
2 *not become operative.*

O