

**Introduced by Senator Pan**February 27, 2015

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An act to amend Sections 14087.325 and 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

## LEGISLATIVE COUNSEL'S DIGEST

SB 610, as introduced, Pan. Medi-Cal: federally qualified health centers and rural health clinics: managed care contracts.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid 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.

Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate, based on a change in the scope of services provided, as prescribed. Existing law establishes alternative ratesetting procedures with respect to a new entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC or an existing FQHC or RHC that is relocated. Two of the procedures are referred to as comparability approaches, based on the rates of 3 similarly situated FQHCs and RHCs. The 3rd procedure requires, at a new entity's one-time election, that the department establish the reimbursement rate, calculated on a per-visit basis, that equals 100% of the projected allowable costs to the FQHC

or RHC of furnishing services during its first 12 months of operation as an FQHC or RHC.

This bill would require the department to finalize a new rate within 90 days after an FQHC's or RHC's submission of a scope-of-service rate change. With respect to a new FQHC or RHC that has elected for the department to establish its reimbursement rate based on projected allowable costs as described above, this bill would require the department to finalize that rate within 90 days after the submission of the actual cost report from the first full 12 months of operation, as specified.

This bill would revise the department's responsibilities with respect to a new entity or a relocated FQHC or RHC that selects either of the comparability approaches. The bill would require the department to review the comparable facilities to determine if any of them do not meet the comparability threshold and, if so, to notify the new entity, and request a supplemental submission, as prescribed. The bill would require the department to finalize a new entity's rate within 90 days after receiving a submission the department determines to be comparable.

This bill would require the department to correct erroneous payments at least quarterly to reprocess past claims and ensure all claims are reimbursed at the appropriate finalized new rate.

Existing law requires the department to administer a program to ensure that total payments to FQHCs and RHCs operating as managed care subcontractors comply with applicable federal law regarding payment for services provided by FQHCs and RHCs. Under the department's program, existing law requires FQHCs and RHCs subcontracting with specified managed care plans to seek supplemental reimbursement from the department through a per visit fee-for-service billing system. To be reimbursed under these provisions, existing law requires each FQHC and RHC to submit to the department for approval a rate differential based on the FQHC's or RHC's reasonable cost or the prospective payment rate. Within 6 months of the end of the FQHC's or RHC's fiscal year, existing law requires, to the extent feasible, the department to perform an annual reconciliation to reasonable cost, and make payments to, or obtain recovery from, the FQHC or RHC.

This bill would impose various requirements on the department regarding the reconciliation process described above. The bill would require the department to complete the final reconciliation review and pay to the center or clinic any remaining amount owed within 15 months

of the last date of the fiscal year for which the department is conducting the review.

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 14087.325 of the Welfare and Institutions  
2 Code is amended to read:

3 14087.325. (a) The department shall require, as a condition  
4 of obtaining a contract with the department, that any local initiative,  
5 as defined in ~~subdivision (v) of~~ Section 53810 of Title 22 of the  
6 California Code of Regulations, offer a subcontract to any entity  
7 defined in Section 1396d(l)(2)(B) of Title 42 of the United States  
8 Code providing services as defined in Section 1396d(a)(2)(C) of  
9 Title 42 of the United States Code and operating in the service  
10 area covered by the local initiative's contract with the department.  
11 These entities are also known as federally qualified health centers.

12 (b) Except as otherwise provided in this section, managed care  
13 subcontracts offered to a federally qualified health center or a rural  
14 health clinic, as defined in Section 1396d(l)(1) of Title 42 of the  
15 United States Code, by a local initiative, county organized health  
16 system, as defined in Section 12693.05 of the Insurance Code,  
17 commercial plan, as defined in ~~subdivision (h) of~~ Section 53810  
18 of Title 22 of the California Code of Regulations, or a health plan  
19 contracting with a geographic managed care program, as defined  
20 in subdivision (g) of Section 53902 of Title 22 of the California  
21 Code of Regulations, shall be on the same terms and conditions  
22 offered to other subcontractors providing a similar scope of service.  
23 Any beneficiary, subscriber, or enrollee of a program or plan who  
24 affirmatively selects, or is assigned by default to, a federally  
25 qualified health center or rural health clinic under the terms of a  
26 contract between a plan, government program, or any subcontractor  
27 of a plan or program, and a federally qualified health center or  
28 rural health clinic, shall be assigned directly to the federally  
29 qualified health center or rural health clinic, and not to any  
30 individual provider performing services on behalf of the federally  
31 qualified health center or rural health clinic.

32 (c) The department shall provide incentives in the competitive  
33 application process described in paragraph (1) of subdivision (b)

1 of Section 53800 of Title 22 of the California Code of Regulations,  
2 to encourage potential commercial plans as defined in ~~subdivision~~  
3 ~~(h)~~ of Section 53810 of Title 22 of the California Code of  
4 Regulations to offer subcontracts to these federally qualified health  
5 centers.

6 (d) Reimbursement to federally qualified health centers and  
7 rural health centers for services provided pursuant to a subcontract  
8 with a local initiative, a commercial plan, geographic managed  
9 care program health plan, or a county organized health system,  
10 shall be paid in a manner that is not less than the level and amount  
11 of payment that the plan would make for the same scope of services  
12 if the services were furnished by a provider that is not a federally  
13 qualified health center or rural health clinic.

14 (e) (1) The department shall administer a program to ensure  
15 that total payments to federally qualified health centers and rural  
16 health clinics operating as managed care subcontractors pursuant  
17 to subdivision (d) comply with applicable federal law pursuant to  
18 Sections ~~1902(aa)~~ 1902(bb) and 1903(m)(2)(A)(ix) of the Social  
19 Security Act (42 U.S.C.A. Secs. ~~1396a(aa)~~ U.S.C. Secs. 1396a  
20 (bb) and 1396b(m)(2)(A)(ix)). Under the department's program,  
21 federally qualified health centers and rural health clinics  
22 subcontracting with local initiatives, commercial plans, county  
23 organized health systems, and geographic managed care program  
24 health plans shall seek supplemental reimbursement from the  
25 department through a per visit fee-for-service billing system  
26 utilizing the state's Medi-Cal fee-for-service claims processing  
27 system contractor. To carry out this per visit payment process,  
28 each federally qualified health system and rural health clinic shall  
29 submit to the department for approval a rate differential calculated  
30 to reflect the amount necessary to reimburse the federally qualified  
31 health center or rural health clinic for the difference between the  
32 payment the center or clinic received from the managed care health  
33 plan and either the interim rate established by the department based  
34 on the center's or clinic's reasonable cost or the center's or clinic's  
35 prospective payment rate. The department shall adjust the  
36 computed rate differential as it deems necessary to minimize the  
37 difference between the center's or clinic's revenue from the plan  
38 and the center's or clinic's cost-based reimbursement or the center's  
39 or clinic's prospective payment rate.

1 (2) In addition, to the extent feasible, within six months of the  
2 end of the center's or clinic's fiscal year, the department shall  
3 perform an annual reconciliation to reasonable cost, and make  
4 payments to, or obtain a recovery from, the center or clinic.  
5 *Reconciliation shall be based upon the reconciliation filing*  
6 *submitted to the department by the center or clinic. The department*  
7 *shall perform an initial review of the reconciliation filing within*  
8 *30 days of receipt. If the department determines during the initial*  
9 *review that a payment is owed to the center or clinic, the*  
10 *department shall pay to the center or clinic at least 80 percent of*  
11 *the amount owed within 30 days of completion of the initial review*  
12 *or in any event within 60 days of receipt of the reconciliation filing.*  
13 *The department shall complete the final reconciliation review and*  
14 *shall pay to the center or clinic the remaining amount owed within*  
15 *15 months of the last date of the fiscal year for which the*  
16 *department is conducting the review.*

17 (f) In calculating the capitation rates to be paid to local  
18 initiatives, commercial plans, geographic managed care program  
19 health plans, and county organized health systems, the department  
20 shall not include the additional dollar amount applicable to  
21 cost-based reimbursement that would otherwise be paid, absent  
22 cost-based reimbursement, to federally qualified health centers  
23 and rural health clinics in the Medi-Cal fee-for-service program.

24 (g) On or before September 30, 2002, the director shall conduct  
25 a study of the actual and projected impact of the transition from a  
26 cost-based reimbursement system to a prospective payment system  
27 for federally qualified health centers and rural health clinics. In  
28 conducting the study, the director shall evaluate the extent to which  
29 the prospective payment system stimulates expansion of services,  
30 including new facilities to expand capacity of the centers, and the  
31 extent to which actual and estimated prospective payment rates of  
32 federally qualified health centers and rural health clinics for the  
33 first five years of the prospective payment system are reflective  
34 of the cost of providing services to Medi-Cal beneficiaries. Clinics  
35 may submit cost reporting information to the department to provide  
36 data for the study.

37 (h) The department shall approve all contracts between federally  
38 qualified health centers or rural health clinics and any local  
39 initiative, commercial plan, geographic managed care program

1 health plan, or county organized health system in order to ensure  
2 compliance with this section.

3 (i) This section shall not preclude the department from  
4 establishing pilot programs pursuant to Section 14087.329.

5 SEC. 2. Section 14132.100 of the Welfare and Institutions  
6 Code is amended to read:

7 14132.100. (a) The federally qualified health center services  
8 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
9 Code are covered benefits.

10 (b) The rural health clinic services described in Section  
11 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
12 benefits.

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

17 (d) Effective October 1, 2004, and on each October 1, thereafter,  
18 until no longer required by federal law, federally qualified health  
19 center (FQHC) and rural health clinic (RHC) per-visit rates shall  
20 be increased by the Medicare Economic Index applicable to  
21 primary care services in the manner provided for in Section  
22 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
23 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted  
24 by the Medicare Economic Index in accordance with the  
25 methodology set forth in the state plan in effect on October 1,  
26 2001.

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

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

37 (A) The addition of a new FQHC or RHC service that is not  
38 incorporated in the baseline prospective payment system (PPS)  
39 rate, or a deletion of an FQHC or RHC service that is incorporated  
40 in the baseline PPS rate.

1 (B) A change in service due to amended regulatory requirements  
2 or rules.

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

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

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

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

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

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

22 (I) Any changes in the scope of a project approved by the federal  
23 Health Resources and Service Administration (HRSA).

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

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

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

33 (C) The change in the scope of services is a change in the type,  
34 intensity, duration, or amount of services, or any combination  
35 thereof.

36 (D) The net change in the FQHC's or RHC's rate equals or  
37 exceeds 1.75 percent for the affected FQHC or RHC site. For  
38 FQHCs and RHCs that filed consolidated cost reports for multiple  
39 sites to establish the initial prospective payment reimbursement  
40 rate, the 1.75-percent threshold shall be applied to the average

1 per-visit rate of all sites for the purposes of calculating the cost  
2 associated with a scope-of-service change. “Net change” means  
3 the per-visit rate change attributable to the cumulative effect of all  
4 increases and decreases for a particular fiscal year.

5 (4) An FQHC or RHC may submit requests for scope-of-service  
6 changes once per fiscal year, only within 90 days following the  
7 beginning of the FQHC’s or RHC’s fiscal year. Any approved  
8 increase or decrease in the provider’s rate shall be retroactive to  
9 the beginning of the FQHC’s or RHC’s fiscal year in which the  
10 request is submitted.

11 (5) An FQHC or RHC shall submit a scope-of-service rate  
12 change request within 90 days ~~of~~ *after* the beginning of any FQHC  
13 or RHC fiscal year occurring after the effective date of this section,  
14 if, during the FQHC’s or RHC’s prior fiscal year, the FQHC or  
15 RHC experienced a decrease in the scope of services provided that  
16 the FQHC or RHC either knew or should have known would have  
17 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
18 discontinues providing onsite pharmacy or dental services, it shall  
19 submit a scope-of-service rate change request within 90 days ~~of~~  
20 *after* the beginning of the following fiscal year. The rate change  
21 shall be effective as provided for in paragraph (4). As used in this  
22 paragraph, “significantly lower” means an average per-visit rate  
23 decrease in excess of 2.5 percent.

24 (6) *The department shall finalize a new rate within 90 days after*  
25 *the submission by an FQHC or RHC of a scope-of-service rate*  
26 *change request and shall update the provider master file within*  
27 *10 business days of finalizing the rate.*

28 (6)

29 (7) Notwithstanding paragraph (4), if the approved  
30 scope-of-service change or changes were initially implemented  
31 on or after the first day of an FQHC’s or RHC’s fiscal year ending  
32 in calendar year 2001, but before the adoption and issuance of  
33 written instructions for applying for a scope-of-service change,  
34 the adjusted reimbursement rate for that scope-of-service change  
35 shall be made retroactive to the date the scope-of-service change  
36 was initially implemented. Scope-of-service changes under this  
37 paragraph shall be required to be submitted within the later of 150  
38 days after the adoption and issuance of the written instructions by  
39 the department, or 150 days after the end of the FQHC’s or RHC’s  
40 fiscal year ending in 2003.

1     ~~(7)~~

2     (8) All references in this subdivision to “fiscal year” shall be  
3 construed to be references to the fiscal year of the individual FQHC  
4 or RHC, as the case may be.

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

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

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

33     (A) A presentation of data to demonstrate reasons for the  
34 FQHC’s or RHC’s request for a supplemental payment.

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

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

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

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

7 (g) (1) An FQHC or RHC "visit" means a face-to-face  
8 encounter between an FQHC or RHC patient and a physician,  
9 physician assistant, nurse practitioner, certified nurse-midwife,  
10 clinical psychologist, licensed clinical social worker, or a visiting  
11 nurse. For purposes of this section, "physician" shall be interpreted  
12 in a manner consistent with the Centers for Medicare and Medicaid  
13 Services' Medicare Rural Health Clinic and Federally Qualified  
14 Health Center Manual (Publication 27), or its successor, only to  
15 the extent that it defines the professionals whose services are  
16 reimbursable on a per-visit basis and not as to the types of services  
17 that these professionals may render during these visits and shall  
18 include a physician and surgeon, podiatrist, dentist, optometrist,  
19 and chiropractor. A visit shall also include a face-to-face encounter  
20 between an FQHC or RHC patient and a comprehensive perinatal  
21 services practitioner, as defined in Section 51179.1 of Title 22 of  
22 the California Code of Regulations, providing comprehensive  
23 perinatal services, a four-hour day of attendance at an adult day  
24 health care center, and any other provider identified in the state  
25 plan's definition of an FQHC or RHC visit.

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

29 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
30 currently includes the cost of the services of a dental hygienist in  
31 alternative practice for the purposes of establishing its FQHC or  
32 RHC rate shall apply for an adjustment to its per-visit rate, and,  
33 after the rate adjustment has been approved by the department,  
34 shall bill these services as a separate visit. However, multiple  
35 encounters with dental professionals that take place on the same  
36 day shall constitute a single visit. The department shall develop  
37 the appropriate forms to determine which FQHC's or RHC rates  
38 shall be adjusted and to facilitate the calculation of the adjusted  
39 rates. An FQHC's or RHC's application for, or the department's  
40 approval of, a rate adjustment pursuant to this subparagraph shall

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

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

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

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

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

38 (B) In the absence of three comparable FQHCs or RHCs with  
39 a similar caseload, the rate may be calculated on a per-visit basis  
40 in an amount that is equal to the average of the per-visit rates of

1 three comparable FQHCs or RHCs located in the same or an  
2 adjacent service area, or in a reasonably similar geographic area  
3 with respect to relevant social, health care, and economic  
4 characteristics.

5 (C) At a new entity's one-time election, the department shall  
6 establish a reimbursement rate, calculated on a per-visit basis, that  
7 is equal to 100 percent of the projected allowable costs to the  
8 FQHC or RHC of furnishing FQHC or RHC services during the  
9 first 12 months of operation as an FQHC or RHC. After the first  
10 12-month period, the projected per-visit rate shall be increased by  
11 the Medicare Economic Index then in effect. The projected  
12 allowable costs for the first 12 months shall be cost settled and the  
13 prospective payment reimbursement rate shall be adjusted based  
14 on actual and allowable cost per visit. *The department shall finalize*  
15 *a new rate within 90 days after the submission of the actual cost*  
16 *report from the first full 12 months of operation and shall update*  
17 *the department provider master file within 10 business days of*  
18 *finalizing the rate.*

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

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

1 comparability approach described in subparagraph (A) or (B) of  
2 paragraph (1).

3 (B) The department shall conduct an initial review of the three  
4 FQHCs or RHCs for the purpose of determining comparability  
5 within 30 days of submission by the new entity. If the department  
6 determines one or more of the submitted centers or clinics do not  
7 meet the comparability threshold, the department shall notify the  
8 new entity no later than the 31st day after submission.

9 (C) The notification shall state the reason or reasons for the  
10 finding of noncomparability and shall request a supplemental  
11 submission from the new entity. The request shall clearly state  
12 whether the new entity shall submit data from one, two, or three  
13 FQHCs or RHCs to meet the comparability threshold. Once the  
14 new entity submits its supplemental information, the initial review  
15 process described in subparagraph (B) shall apply.

16 (D) Within 90 days after receiving a submission determined by  
17 the department to be comparable, the department shall finalize  
18 the new entity's rate and shall update the provider master file  
19 within 10 business days.

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

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

39 (k) An FQHC or RHC may elect to have pharmacy or dental  
40 services reimbursed on a fee-for-service basis, utilizing the current

1 fee schedules established for those services. These costs shall be  
2 adjusted out of the FQHC's or RHC's clinic base rate as  
3 scope-of-service changes. An FQHC or RHC that reverses its  
4 election under this subdivision shall revert to its prior rate, subject  
5 to an increase to account for all MEI increases occurring during  
6 the intervening time period, and subject to any increase or decrease  
7 associated with applicable scope-of-services adjustments as  
8 provided in subdivision (e).

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

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

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

24 (o) *The department shall correct erroneous payments at least*  
25 *quarterly to reprocess past claims and ensure all claims are*  
26 *reimbursed at the finalized new rate determined pursuant to either*  
27 *subdivision (e) or (i).*