

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL

No. 610

Introduced by Senator Pan

February 27, 2015

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 amended, 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 conduct an initial review of a scope-of-service rate change request within 30 days after submission by the FQHC or RHC, and notify the FQHC or RHC by the 31st day after submission if the department determines that additional information is necessary, as prescribed.* The bill would require the department to finalize ~~a new entity's~~ *the FQHC's or RHC's* rate within 90 days after receiving a submission the department determines to be ~~comparable~~. *complete.*

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 Section 53810 of Title 22 of the California Code of
6 Regulations, offer a subcontract to any entity defined in Section
7 1396d(l)(2)(B) of Title 42 of the United States Code providing
8 services as defined in Section 1396d(a)(2)(C) of Title 42 of the
9 United States Code and operating in the service area covered by
10 the local initiative's contract with the department. These entities
11 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 Section 53810 of Title 22 of the
18 California Code of Regulations, or a health plan contracting with
19 a geographic managed care program, as defined in subdivision (g)
20 of Section 53902 of Title 22 of the California Code of Regulations,
21 shall be on the same terms and conditions offered to other
22 subcontractors providing a similar scope of service. Any
23 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

1 rural health clinic, shall be assigned directly to the federally
2 qualified health center or rural health clinic, and not to any
3 individual provider performing services on behalf of the federally
4 qualified health center or rural health clinic.

5 (c) The department shall provide incentives in the competitive
6 application process described in paragraph (1) of subdivision (b)
7 of Section 53800 of Title 22 of the California Code of Regulations,
8 to encourage potential commercial plans as defined in Section
9 53810 of Title 22 of the California Code of Regulations to offer
10 subcontracts to these federally qualified health centers.

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

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

1 to minimize the difference between the center's or clinic's revenue
2 from the plan and the center's or clinic's cost-based reimbursement
3 or the center's or clinic's prospective payment rate.

4 (2) In addition, to the extent feasible, within six months of the
5 end of the center's or clinic's fiscal year, the department shall
6 perform an annual reconciliation to reasonable cost, and make
7 payments to, or obtain a recovery from, the center or clinic.
8 Reconciliation shall be based upon the reconciliation filing
9 submitted to the department by the center or clinic. The department
10 shall perform an initial review of the reconciliation filing within
11 30 days of receipt. If the department determines during the initial
12 review that a payment is owed to the center or clinic, the
13 department shall pay to the center or clinic at least 80 percent of
14 the amount owed within 30 days of completion of the initial review
15 or in any event within 60 days of receipt of the reconciliation filing.
16 The department shall complete the final reconciliation review and
17 shall pay to the center or clinic the remaining amount owed within
18 15 months of the last date of the fiscal year for which the
19 department is conducting the review.

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

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

1 (h) The department shall approve all contracts between federally
2 qualified health centers or rural health clinics and any local
3 initiative, commercial plan, geographic managed care program
4 health plan, or county organized health system in order to ensure
5 compliance with this section.

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

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

10 14132.100. (a) The federally qualified health center services
11 described in Section 1396d(a)(2)(C) of Title 42 of the United States
12 Code are covered benefits.

13 (b) The rural health clinic services described in Section
14 1396d(a)(2)(B) of Title 42 of the United States Code are covered
15 benefits.

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

20 (d) Effective October 1, 2004, and on each October 1, thereafter,
21 until no longer required by federal law, federally qualified health
22 center (FQHC) and rural health clinic (RHC) per-visit rates shall
23 be increased by the Medicare Economic Index applicable to
24 primary care services in the manner provided for in Section
25 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
26 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
27 by the Medicare Economic Index in accordance with the
28 methodology set forth in the state plan in effect on October 1,
29 2001.

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

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

- 1 (A) The addition of a new FQHC or RHC service that is not
2 incorporated in the baseline prospective payment system (PPS)
3 rate, or a deletion of an FQHC or RHC service that is incorporated
4 in the baseline PPS rate.
- 5 (B) A change in service due to amended regulatory requirements
6 or rules.
- 7 (C) A change in service resulting from relocating or remodeling
8 an FQHC or RHC.
- 9 (D) A change in types of services due to a change in applicable
10 technology and medical practice utilized by the center or clinic.
- 11 (E) An increase in service intensity attributable to changes in
12 the types of patients served, including, but not limited to,
13 populations with HIV or AIDS, or other chronic diseases, or
14 homeless, elderly, migrant, or other special populations.
- 15 (F) Any changes in any of the services described in subdivision
16 (a) or (b), or in the provider mix of an FQHC or RHC or one of
17 its sites.
- 18 (G) Changes in operating costs attributable to capital
19 expenditures associated with a modification of the scope of any
20 of the services described in subdivision (a) or (b), including new
21 or expanded service facilities, regulatory compliance, or changes
22 in technology or medical practices at the center or clinic.
- 23 (H) Indirect medical education adjustments and a direct graduate
24 medical education payment that reflects the costs of providing
25 teaching services to interns and residents.
- 26 (I) Any changes in the scope of a project approved by the federal
27 Health Resources and Service Administration (HRSA).
- 28 (3) No change in costs shall, in and of itself, be considered a
29 scope-of-service change unless all of the following apply:
- 30 (A) The increase or decrease in cost is attributable to an increase
31 or decrease in the scope of services defined in subdivisions (a) and
32 (b), as applicable.
- 33 (B) The cost is allowable under Medicare reasonable cost
34 principles set forth in Part 413 (commencing with Section 413) of
35 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
36 Regulations, or its successor.
- 37 (C) The change in the scope of services is a change in the type,
38 intensity, duration, or amount of services, or any combination
39 thereof.

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

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

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

29 ~~(6) The department shall finalize a new rate within 90 days after~~
30 ~~the submission by an FQHC or RHC of a scope-of-service rate~~
31 ~~change request and shall update the provider master file within 10~~
32 ~~business days of finalizing the rate.~~

33 (6) (A) *The department shall conduct an initial review of a*
34 *scope-of-service rate change request within 30 days after*
35 *submission by an FQHC or RHC.*

36 (B) *If the department determines that additional information*
37 *is necessary to finalize a new rate, the department shall notify the*
38 *FQHC or RHC, no later than the 31st day after submission. The*
39 *notification shall state the reason or reasons the submitted*

1 *information is insufficient and shall request submission of*
2 *supplemental information from the FQHC or RHC.*

3 *(C) Within 90 days after receiving a submission that it*
4 *determines to be complete, the department shall finalize the*
5 *FQHC's or RHC's rate and shall update the provider master file*
6 *within 10 business days.*

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

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

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

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

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

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

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

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

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

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

24 (g) (1) An FQHC or RHC "visit" means a face-to-face
25 encounter between an FQHC or RHC patient and a physician,
26 physician assistant, nurse practitioner, certified nurse-midwife,
27 clinical psychologist, licensed clinical social worker, or a visiting
28 nurse. For purposes of this section, "physician" shall be interpreted
29 in a manner consistent with the Centers for Medicare and Medicaid
30 Services' Medicare Rural Health Clinic and Federally Qualified
31 Health Center Manual (Publication 27), or its successor, only to
32 the extent that it defines the professionals whose services are
33 reimbursable on a per-visit basis and not as to the types of services
34 that these professionals may render during these visits and shall
35 include a physician and surgeon, podiatrist, dentist, optometrist,
36 and chiropractor. A visit shall also include a face-to-face encounter
37 between an FQHC or RHC patient and a comprehensive perinatal
38 services practitioner, as defined in Section 51179.1 of Title 22 of
39 the California Code of Regulations, providing comprehensive
40 perinatal services, a four-hour day of attendance at an adult day

1 health care center, and any other provider identified in the state
2 plan's definition of an FQHC or RHC visit.

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

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

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

35 (h) If FQHC or RHC services are partially reimbursed by a
36 third-party payer, such as a managed care entity (as defined in
37 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),
38 the Medicare Program, or the Child Health and Disability
39 Prevention (CHDP) program, the department shall reimburse an
40 FQHC or RHC for the difference between its per-visit PPS rate

1 and receipts from other plans or programs on a contract-by-contract
2 basis and not in the aggregate, and may not include managed care
3 financial incentive payments that are required by federal law to
4 be excluded from the calculation.

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

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

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

22 (C) At a new entity's one-time election, the department shall
23 establish a reimbursement rate, calculated on a per-visit basis, that
24 is equal to 100 percent of the projected allowable costs to the
25 FQHC or RHC of furnishing FQHC or RHC services during the
26 first 12 months of operation as an FQHC or RHC. After the first
27 12-month period, the projected per-visit rate shall be increased by
28 the Medicare Economic Index then in effect. The projected
29 allowable costs for the first 12 months shall be cost settled and the
30 prospective payment reimbursement rate shall be adjusted based
31 on actual and allowable cost per visit. The department shall finalize
32 a new rate within 90 days after the submission of the actual cost
33 report from the first full 12 months of operation and shall update
34 the department provider master file within 10 business days of
35 finalizing the rate.

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

1 (2) (A) In order for an FQHC or RHC to establish the
2 comparability of its caseload, the department shall require that the
3 FQHC or RHC submit its most recent annual utilization report as
4 submitted to the Office of Statewide Health Planning and
5 Development, unless the FQHC or RHC was not required to file
6 an annual utilization report. FQHCs or RHCs that have experienced
7 changes in their services or caseload subsequent to the filing of
8 the annual utilization report may submit to the department a
9 completed report in the format applicable to the prior calendar
10 year. FQHCs or RHCs that have not previously submitted an annual
11 utilization report shall submit to the department a completed report
12 in the format applicable to the prior calendar year. The FQHC or
13 RHC shall not be required to submit the annual utilization report
14 for the comparable FQHCs or RHCs to the department, but shall
15 be required to identify the comparable FQHCs or RHCs. This
16 paragraph shall apply only to a facility that selects the
17 comparability approach described in subparagraph (A) or (B) of
18 paragraph (1).

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

25 (C) The notification shall state the reason or reasons for the
26 finding of noncomparability and shall request a supplemental
27 submission from the new entity. The request shall clearly state
28 whether the new entity shall submit data from one, two, or three
29 FQHCs or RHCs to meet the comparability threshold. Once the
30 new entity submits its supplemental information, the initial review
31 process described in subparagraph (B) shall apply.

32 (D) Within 90 days after receiving a submission determined by
33 the department to be comparable, the department shall finalize the
34 new entity's rate and shall update the provider master file within
35 10 business days.

36 (3) The rate for any newly qualified entity set forth under this
37 subdivision shall be effective retroactively to the later of the date
38 that the entity was first qualified by the applicable federal agency
39 as an FQHC or RHC, the date a new facility at a new location was
40 added to an existing FQHC or RHC, or the date on which an

1 existing FQHC or RHC was relocated to a new site. The FQHC
2 or RHC shall be permitted to continue billing for Medi-Cal covered
3 benefits on a fee-for-service basis until it is informed of its
4 enrollment as an FQHC or RHC, and the department shall reconcile
5 the difference between the fee-for-service payments and the
6 FQHC's or RHC's prospective payment rate at that time.

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

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

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

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

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

- 1 (o) The department shall correct erroneous payments at least
- 2 quarterly to reprocess past claims and ensure all claims are
- 3 reimbursed at the finalized new rate determined pursuant to either
- 4 subdivision (e) or (i).

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