

AMENDED IN SENATE APRIL 20, 2016

AMENDED IN SENATE APRIL 5, 2016

**SENATE BILL**

**No. 1335**

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**Introduced by Senator Mitchell**

February 19, 2016

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An act to amend Section 14132.100 ~~of~~ *of, and to add Sections 14124.28 and 14687 to*, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1335, as amended, Mitchell. Medi-Cal benefits: federally qualified health centers and rural health centers: Drug Medi-Cal and specialty mental health services.

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, including specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county for various alcohol and drug treatment services, including substance use disorder services, narcotic treatment program services, naltrexone services, and outpatient drug-free services, to Medi-Cal beneficiaries. Specialty mental health services and Drug Medi-Cal Services are provided pursuant to waivers from the federal Centers for Medicare and Medicaid Services.

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 FQHCs and RHCs to elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services and requires those costs to be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes.

This bill additionally would authorize FQHCs and RHCs to elect to provide Drug Medi-Cal and to receive reimbursement for those services pursuant to the terms of a contract or contracts mutually agreed upon by the FQHC or RHC and the county or the department, pursuant to specified requirements. The bill also would authorize FQHCs and RHCs to elect to provide specialty mental health services and to receive reimbursement for those services pursuant to the terms of a contract or contracts mutually agreed upon by the FQHC or RHC and mental health plans that contract with the state. *The bill would authorize the counties and the mental health plans to contract with the FQHCs and RHCs for these services.*

The bill's requirements would be implemented only to the extent that federal financial participation is available and any federal approvals have been obtained.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 14132.100 of the Welfare and Institutions
- 2 Code is amended to read:
- 3 14132.100. (a) The federally qualified health center services
- 4 described in Section 1396d(a)(2)(C) of Title 42 of the United States
- 5 Code are covered benefits.
- 6 (b) The rural health clinic services described in Section
- 7 1396d(a)(2)(B) of Title 42 of the United States Code are covered
- 8 benefits.
- 9 (c) Federally qualified health center services and rural health
- 10 clinic services shall be reimbursed on a per-visit basis in
- 11 accordance with the definition of "visit" set forth in subdivision
- 12 (g).
- 13 (d) Effective October 1, 2004, and on each October 1, thereafter,
- 14 until no longer required by federal law, federally qualified health
- 15 center (FQHC) and rural health clinic (RHC) per-visit rates shall

1 be increased by the Medicare Economic Index applicable to  
2 primary care services in the manner provided for in Section  
3 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
4 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted  
5 by the Medicare Economic Index in accordance with the  
6 methodology set forth in the state plan in effect on October 1,  
7 2001.

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

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

18 (A) The addition of a new FQHC or RHC service that is not  
19 incorporated in the baseline prospective payment system (PPS)  
20 rate, or a deletion of an FQHC or RHC service that is incorporated  
21 in the baseline PPS rate.

22 (B) A change in service due to amended regulatory requirements  
23 or rules.

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

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

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

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

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

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

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

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

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

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

15 (C) The change in the scope of services is a change in the type,  
16 intensity, duration, or amount of services, or any combination  
17 thereof.

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

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

33 (5) 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 the effective date of this section,  
36 if, during the FQHC's or RHC's prior fiscal year, the FQHC or  
37 RHC experienced a decrease in the scope of services provided that  
38 the FQHC or RHC either knew or should have known would have  
39 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
40 discontinues providing onsite pharmacy or dental services, it shall

1 submit a scope-of-service rate change request within 90 days of  
2 the beginning of the following fiscal year. The rate change shall  
3 be effective as provided for in paragraph (4). As used in this  
4 paragraph, “significantly lower” means an average per-visit rate  
5 decrease in excess of 2.5 percent.

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

18 (7) All references in this subdivision to “fiscal year” shall be  
19 construed to be references to the fiscal year of the individual FQHC  
20 or RHC, as the case may be.

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

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

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

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

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

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

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

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

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

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

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

29 (C) An FQHC or RHC that does not provide dental hygienist  
30 or dental hygienist in alternative practice services, and later elects  
31 to add these services, shall process the addition of these services  
32 as a change in scope of service pursuant to subdivision (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, the department shall reimburse an  
38 FQHC or RHC for the difference between its per-visit PPS rate  
39 and receipts from other plans or programs on a contract-by-contract  
40 basis and not in the aggregate, and may not include managed care

1 financial incentive payments that are required by federal law to  
2 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



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

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

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

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

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

(3) If an FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 mutually agree to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network, the FQHC or RHC

1 shall elect to have specialty mental health services reimbursed  
2 pursuant to the terms of the contract or contracts and outside of  
3 the per-visit PPS rate.

4 (4) An FQHC or RHC may elect to become certified to provide  
5 services in the Drug Medi-Cal program, and reimbursement for  
6 those services shall be governed by this paragraph.

7 (A) If the FQHC is located in a county that has elected to  
8 participate in the Drug Medi-Cal organized delivery system, the  
9 FQHC or RHC may elect to receive reimbursement pursuant to a  
10 mutually agreed upon contract between the county and the FQHC  
11 or RHC.

12 (B) If the county does not elect to participate in the Drug  
13 Medi-Cal organized delivery system, an FQHC or RHC may elect  
14 to contract through the department as a Drug Medi-Cal provider.

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

21 (B) An FQHC or RHC that reverses its election under this  
22 subdivision shall revert to its prior rate, subject to an increase to  
23 account for all MEI increases occurring during the intervening  
24 time period, and subject to any increases or decreases associated  
25 with applicable scope-of-services adjustments as provided in  
26 subdivision (e).

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

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

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

*SEC. 2. Section 14124.28 is added to the Welfare and Institutions Code, immediately following Section 14124.26, to read:*

*14124.28. Notwithstanding any other provision of this article or regulation adopted thereunder, a county may contract with a federally qualified health center (FQHC) or rural health center (RHC), in accordance with subdivision (k) of Section 14132.100, for the provision of alcohol and drug use services within the county service area.*

*SEC. 3. Section 14687 is added to the Welfare and Institutions Code, to read:*

*14687. Notwithstanding any other provision of this article or regulation adopted thereunder, a mental health plan may contract with a federally qualified health center (FQHC) or rural health center (RHC), in accordance with subdivision (k) of Section 14132.100, for the provision of specialty mental health services.*

~~SEC. 2.~~

*SEC. 4. The amendments made by this act to subdivision (k) of Section 14132.100 of of, and the changes made by this act by the addition of Sections 14124.28 and 14687 to, the Welfare and Institutions Code shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.*