AMENDED IN ASSEMBLY AUGUST 18, 2016

AMENDED IN ASSEMBLY AUGUST 1, 2016

AMENDED IN SENATE APRIL 20, 2016

AMENDED IN SENATE APRIL 5, 2016

SENATE BILL No. 1335

Introduced by Senator Mitchell
(Coauthor: Assembly Member Gonzalez)

February 19, 2016

An act to amend Section 14132.100 of, and to add Section 14124.28 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. Under existing law, specialty mental health services are generally provided by mental health plans that contract with the department.

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, or the department is required to directly arrange for these services if a county elects not to do so.

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 services under 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.~~ *enroll as a Drug Medi-Cal certified provider under Drug Medi-Cal to provide Drug Medi-Cal services and would set forth the reimbursement requirements for these services. The bill would require the costs of providing Drug Medi-Cal services to be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes, as specified, and would prohibit the FQHC or RHC from billing the per-visit prospective payment system (PPS) rate for services reimbursed by Drug Medi-Cal.* The bill would authorize a county to contract with the FQHCs and RHCs for these Drug Medi-Cal services. The bill would authorize an FQHC or RHC that entered into a contract on or before January 1, 2017, with a mental health plan to provide specialty mental health services to continue to provide, and be reimbursed for, those specialty mental health services if the costs of providing specialty mental health services are reimbursed outside of the per-visit rate.

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

This bill would incorporate additional changes in Section 14132.100 of the Welfare and Institutions Code proposed by AB 1863, that would become operative only if AB 1863 and this bill are both chaptered and become effective on or before January 1, 2017, and this bill is chaptered last.

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

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

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means

the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

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

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

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

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

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental

payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental 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~~ *both* 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.

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

(B) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice for the purposes of establishing its FQHC or RHC rate shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms

pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

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

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

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

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

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

(C) At a new entity’s one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first

12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

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

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs 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 (c), 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) An FQHC or RHC may elect to ~~become certified to provide services in the Drug Medi-Cal program, and reimbursement for those services shall be governed by this paragraph.~~ *enroll as a Drug Medi-Cal certified provider. If an FQHC or RHC elects to enroll as a Drug Medi-Cal certified provider, the costs associated with the Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate and the reimbursement for those services shall be governed by subparagraph (A) or (B).*

(A) If the FQHC ~~is located~~ *or RHC elects to provide Drug Medi-Cal services* in a county that has elected to participate in the Drug Medi-Cal organized delivery system, the FQHC or RHC ~~may elect to~~ *shall* receive reimbursement pursuant to a mutually agreed upon contract between the county and the FQHC or RHC. *If an FQHC or RHC is denied a contract by the county, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.*

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

(4) (A) If an FQHC or RHC elects reimbursement pursuant to paragraph (2) or (3), pursuant to which the costs associated with providing the services are part of the FQHC's or RHC's clinic base rate, those costs shall be adjusted out of the FQHC's or RHC's

clinic base rate as scope-of-service changes and payment pursuant to subdivision (h) shall not apply.

(B) An FQHC or RHC that reverses its election under paragraph (2) or (3) shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increases or decreases associated with applicable scope-of-service adjustments as provided in subdivision (e).

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

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

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

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

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

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

(B) For the purpose of calculating a per-visit PPS rate, the FQHC or RHC shall provide verifiable documentation of the costs of an employee who provides both FQHC services and Drug Medi-Cal services. Documentation shall attribute costs proportionally between FQHC services and Drug Medi-Cal

services. Only the costs attributable to FQHC services shall be included in the per-visit PPS rate.

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

~~(5)~~

(8) (A) If an FQHC or RHC entered into a contract on or before January 1, 2017, with a mental health plan to provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network, the FQHC or RHC may continue to provide, and be reimbursed for, those specialty mental health services pursuant to the terms of the contract with the mental health plan if the costs of providing specialty mental health services are reimbursed outside of the per-visit PPS rate described in subdivision (c).

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

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

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

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

(B) "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(*l*) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are

cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that 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. 1.5. Section 14132.100 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

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

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

(2) The department shall accept requests for supplemental 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~~ *both* 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, osteopath, 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 practitioner, as defined in Section 51179.7 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.

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

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or

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

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

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

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

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

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

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

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

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs 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 under its existing provider number until it is informed of its FQHC or RHC enrollment approval, 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 (c), 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) An FQHC or RHC may elect to ~~become certified to provide services in the Drug Medi-Cal program, and reimbursement for those services shall be governed by this paragraph.~~ *enroll as a Drug Medi-Cal certified provider. If an FQHC or RHC elects to enroll as a Drug Medi-Cal certified provider, the costs associated with the Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate and the reimbursement for those services shall be governed by subparagraph (A) or (B).*

(A) If the FQHC ~~is located~~ *or RHC elects to provide Drug Medi-Cal services* in a county that has elected to participate in the Drug Medi-Cal organized delivery system, the FQHC or RHC

~~may elect to~~ *shall* receive reimbursement pursuant to a mutually agreed upon contract between the county and the FQHC or RHC. *If an FQHC or RHC is denied a contract by the county, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.*

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

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

(B) An FQHC or RHC that reverses its election under paragraph (2) or (3) shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increases or decreases associated with applicable scope-of-service adjustments as provided in subdivision (e).

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

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

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

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

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

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

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

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

~~(5)~~

(8) (A) If an FQHC or RHC entered into a contract on or before January 1, 2017, with a mental health plan to provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network, the FQHC or RHC may continue to provide, and be reimbursed for, those specialty mental health services pursuant to the terms of the contract with the mental health plan if the costs of providing specialty mental health services are reimbursed outside of the per-visit PPS rate described in subdivision (c).

(B) For purposes of this paragraph, "mental health plan" means any mental health plan contracting with the department to provide

specialty mental health services to enrolled Medi-Cal beneficiaries under Article 5 (commencing with Section 14680) of Chapter 8.8 or Chapter 8.9 (commencing with Section 14700).

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

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

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

(B) "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

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

(m) The department shall, no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that 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. The amendments made by this act to subdivision (k) of Section 14132.100 of, and the changes made by this act by the addition of Section 14124.28 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.

SEC. 4. Section 1.5 of this bill incorporates amendments to Section 14132.100 of the Welfare and Institutions Code proposed by both this bill and Assembly Bill 1863. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2017, (2) each bill amends Section 14132.100 of the Welfare and Institutions Code, and (3) this bill is enacted after Assembly Bill 1863, in which case Section 1 of this bill shall not become operative.

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