

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (3) Requests for supplemental payments shall be submitted in
18 writing to the department and shall set forth the reasons for the
19 request. Each request shall be accompanied by sufficient
20 documentation to enable the department to act upon the request.
21 Documentation shall include the data necessary to demonstrate
22 that the circumstances for which supplemental payment is requested
23 meet the requirements set forth in this section. Documentation
24 shall include ~~at~~ both of the following:

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

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

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

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

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

38 (g) (1) An FQHC or RHC "visit" means a face-to-face
39 encounter between an FQHC or RHC patient and a physician,
40 physician assistant, nurse practitioner, certified nurse-midwife,

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

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

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

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

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

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

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

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

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

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

1 12-month period, the projected per-visit rate shall be increased by
2 the Medicare Economic Index then in effect. The projected
3 allowable costs for the first 12 months shall be cost settled and the
4 prospective payment reimbursement rate shall be adjusted based
5 on actual and allowable cost per visit.

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

10 (2) In order for an FQHC or RHC to establish the comparability
11 of its caseload for purposes of subparagraph (A) or (B) of paragraph
12 (1), the department shall require that the FQHC or RHC submit
13 its most recent annual utilization report as submitted to the Office
14 of Statewide Health Planning and Development, unless the FQHC
15 or RHC was not required to file an annual utilization report. FQHCs
16 or RHCs that have experienced changes in their services or
17 caseload subsequent to the filing of the annual utilization report
18 may submit to the department a completed report in the format
19 applicable to the prior calendar year. FQHCs or RHCs that have
20 not previously submitted an annual utilization report shall submit
21 to the department a completed report in the format applicable to
22 the prior calendar year. The FQHC or RHC shall not be required
23 to submit the annual utilization report for the comparable FQHCs
24 or RHCs to the department, but shall be required to identify the
25 comparable FQHCs or RHCs.

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

37 (j) Visits occurring at an intermittent clinic site, as defined in
38 subdivision (h) of Section 1206 of the Health and Safety Code, of
39 an existing FQHC or RHC, or in a mobile unit as defined by
40 paragraph (2) of subdivision (b) of Section 1765.105 of the Health

1 and Safety Code, shall be billed by and reimbursed at the same
2 rate as the FQHC or RHC establishing the intermittent clinic site
3 or the mobile unit, subject to the right of the FQHC or RHC to
4 request a scope-of-service adjustment to the rate.

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

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

12 (3) An FQHC or RHC may elect to ~~become certified to provide~~
13 ~~services in the Drug Medi-Cal program, and reimbursement for~~
14 ~~those services shall be governed by this paragraph.~~ *enroll as a*
15 *Drug Medi-Cal certified provider. If an FQHC or RHC elects to*
16 *enroll as a Drug Medi-Cal certified provider, the costs associated*
17 *with the Drug Medi-Cal services shall not be included in the*
18 *FQHC's or RHC's per-visit PPS rate and the reimbursement for*
19 *those services shall be governed by subparagraph (A) or (B).*

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

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

37 (4) (A) If an FQHC or RHC elects reimbursement pursuant to
38 paragraph (2) or (3), pursuant to which the costs associated with
39 providing the services are part of the FQHC's or RHC's clinic
40 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*

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

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

9 ~~(5)~~

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

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

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

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

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

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

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

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

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

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

12 SEC. 1.5. Section 14132.100 of the Welfare and Institutions
13 Code is amended to read:

14 14132.100. (a) The federally qualified health center services
15 described in Section 1396d(a)(2)(C) of Title 42 of the United States
16 Code are covered benefits.

17 (b) The rural health clinic services described in Section
18 1396d(a)(2)(B) of Title 42 of the United States Code are covered
19 benefits.

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

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

34 (e) (1) An FQHC or RHC may apply for an adjustment to its
35 per-visit rate based on a change in the scope of services provided
36 by the FQHC or RHC. Rate changes based on a change in the
37 scope of services provided by an FQHC or RHC shall be evaluated
38 in accordance with Medicare reasonable cost principles, as set
39 forth in Part 413 (commencing with Section 413.1) of Title 42 of
40 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (g) (1) An FQHC or RHC "visit" means a face-to-face
9 encounter between an FQHC or RHC patient and a physician,
10 physician assistant, nurse practitioner, certified nurse-midwife,
11 clinical psychologist, licensed clinical social worker, or a visiting
12 nurse. For purposes of this section, "physician" shall be interpreted
13 in a manner consistent with the Centers for Medicare and Medicaid
14 Services' Medicare Rural Health Clinic and Federally Qualified
15 Health Center Manual (Publication 27), or its successor, only to
16 the extent that it defines the professionals whose services are
17 reimbursable on a per-visit basis and not as to the types of services
18 that these professionals may render during these visits and shall
19 include a physician and surgeon, osteopath, podiatrist, dentist,
20 optometrist, and chiropractor. A visit shall also include a
21 face-to-face encounter between an FQHC or RHC patient and a
22 comprehensive perinatal practitioner, as defined in Section 51179.7
23 of Title 22 of the California Code of Regulations, providing
24 comprehensive perinatal services, a four-hour day of attendance
25 at an adult day health care center, and any other provider identified
26 in the state plan's definition of an FQHC or RHC visit.

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

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

1 RHC's rates shall be adjusted and to facilitate the calculation of
2 the adjusted rates. An FQHC's or RHC's application for, or the
3 department's approval of, a rate adjustment pursuant to this
4 subparagraph shall not constitute a change in scope of service
5 within the meaning of subdivision (e). An FQHC or RHC that
6 applies for an adjustment to its rate pursuant to this subparagraph
7 may continue to bill for all other FQHC or RHC visits at its existing
8 per-visit rate, subject to reconciliation, until the rate adjustment
9 for visits between an FQHC or RHC patient and a dental hygienist,
10 a dental hygienist in alternative practice, or a marriage and family
11 therapist has been approved. Any approved increase or decrease
12 in the provider's rate shall be made within six months after the
13 date of receipt of the department's rate adjustment forms pursuant
14 to this subparagraph and shall be retroactive to the beginning of
15 the fiscal year in which the FQHC or RHC submits the request,
16 but in no case shall the effective date be earlier than January 1,
17 2008.

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

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

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

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

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

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

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

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

1 or RHCs to the department, but shall be required to identify the
2 comparable FQHCs or RHCs.

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

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

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

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

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

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

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

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

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

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

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

29 ~~(5)~~

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

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

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

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

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

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

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

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

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

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

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

34 14124.28. Notwithstanding any other provision of this article
35 or regulation adopted thereunder, a county may contract with a
36 federally qualified health center (FQHC) or rural health center
37 (RHC), in accordance with subdivision (k) of Section 14132.100,
38 for the provision of alcohol and drug use services within the county
39 service area.

1 SEC. 3. The amendments made by this act to subdivision (k)
2 of Section 14132.100 of, and the changes made by this act by the
3 addition of Section 14124.28 to, the Welfare and Institutions Code
4 shall be implemented only to the extent that federal financial
5 participation is available and any necessary federal approvals have
6 been obtained.

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