

## Senate Bill No. 1194

### CHAPTER 894

An act to amend Section 14087.325 of the Welfare and Institutions Code, relating to public social services.

[Approved by Governor September 27, 1998. Filed  
with Secretary of State September 28, 1998.]

#### LEGISLATIVE COUNSEL'S DIGEST

SB 1194, Rosenthal. Medi-Cal: contracts for services and case management.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law contains various requirements governing reimbursement for Medi-Cal services provided by federally qualified health centers subcontracting with local initiatives or commercial plans.

Existing law requires that the State Department of Health Services require, as a condition of obtaining a contract with the department, that any local initiative offer a subcontract with a federally qualified health center providing defined services in the service area covered by the local initiative's contract with the department.

This bill would apply that requirement to any county organized health plan and any health plan participating in any geographic managed care program.

Existing law requires that any subcontract offered by a local initiative to a federally qualified health center shall be on the same terms and conditions offered to other subcontractors providing a similar scope of service.

This bill would limit that requirement and would apply it to local initiatives, county organized health systems, and geographic managed care program health plans.

Existing law requires the department to provide incentives in the competitive application process to encourage potential commercial plans to offer subcontracts to federally qualified health centers.

This bill would require the department to also provide those incentives to rural health clinics.

Existing law requires that reimbursement for services provided pursuant to a subcontract with a local initiative or commercial plan shall either be paid on the basis of the federally qualified health center's reasonable costs or, at the election of the center or clinic,

reimbursement shall be based on terms negotiated between the center and the individual local initiative or commercial plan.

This bill would require that reimbursement to federally qualified health centers and rural health clinics for those defined services be paid in a manner that is not less than the level and amount of payment that the plan would make for the same scope of services if the services were furnished by a provider that is not a federally qualified health center or rural health clinic, and would apply that requirement to reimbursement for services provided pursuant to a subcontract with a local initiative, a commercial plan, a geographic managed care program health plan, or a county organized health system.

Existing law requires the department to annually perform a reconciliation to determine the federally qualified health center's reasonable cost and pay to or recover from the center the difference between the reimbursement paid by a local initiative or commercial plan pursuant to subcontracts and the entity's reasonable cost in relation to the number of visits to the entity by plan members, and to make another reconciliation and make payments to or obtain a recovery from the federally qualified health center within 6 months of the end of the fiscal year.

This bill would revise those requirements to require the department to administer a program to ensure that total payments to federally qualified health centers and rural health clinics operating as managed care subcontractors comply with applicable federal law regarding reasonable cost reimbursement for services provided by these entities. It would further require federally qualified health centers and rural health clinics subcontracting with local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans to seek supplemental reimbursement from the department through a per visit fee-for-service billing system, and would specify the method of calculating the per visit payment system.

This bill, in addition, would authorize a federally qualified health center or rural health clinic to voluntarily agree to enter into a capitation or at-risk contract, would require a health center or clinic that entered into such a contract to waive its right to supplemental reimbursement and reconciliation to reasonable cost, and would require the department to approve all contracts between health centers or clinics and any local initiative, commercial plan, geographic managed care program health plan, or county organized health system in order to ensure compliance with the above provisions.

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

SECTION 1. The Legislature finds and declares all of the following:



(a) There are over 250 federally qualified health centers, federally qualified health center look-alikes, and rural health clinics in California that are licensed by the state.

(b) These health centers and clinics care for uninsured and underinsured people who would otherwise not have access to care, by providing quality, cost-effective, community-based primary and specialty health care, and dental and vision services, with an emphasis on cultural sensitivity and linguistic appropriateness.

(c) Collectively, federally qualified health centers and rural health clinics serve over 1.3 million patients.

(d) The State Department of Health Services has committed to enrolling children who are Medi-Cal beneficiaries and their families into managed care plans.

(e) In response to the implementation of managed care, federally qualified health centers and rural health clinics have begun developing internal systems and building capacity to manage costs and patient lives in a capitated environment.

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

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

(b) Except as otherwise provided in this section, managed care subcontracts offered to a federally qualified health center or a rural health clinic, as defined in Section 1396d (l)(1) of Title 42 of the United States Code, by a local initiative, county organized health system, as defined in Section 12693.05 of the Insurance Code, commercial plan, as defined in subdivision (h) of Section 53810 of Title 22 of the California Code of Regulations, or a health plan contracting with a geographic managed care program, as defined in subdivision (g) of Section 53902 of Title 22 of the California Code of Regulations, shall be on the same terms and conditions offered to other subcontractors providing a similar scope of service.

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

(d) Reimbursement to federally qualified health centers and rural health centers for services provided pursuant to a subcontract with



a local initiative, a commercial plan, geographic managed care program health plan, or a county organized health system, shall be paid in a manner that is not less than the level and amount of payment that the plan would make for the same scope of services if the services were furnished by a provider that is not a federally qualified health center or rural health clinic.

(e) (1) The department shall administer a program to ensure that total payments to federally qualified health centers and rural health clinics operating as managed care subcontractors pursuant to subdivision (d) comply with applicable federal law regarding reasonable cost reimbursement for services provided by these entities pursuant to Sections 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act (42 U.S.C.A. Secs. 1396a(a)(13)(C) and 1396b(m)(2)(A)(ix)). Under the department's program, federally qualified health centers and rural health clinics subcontracting with local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans shall seek supplemental reimbursement from the department through a per visit fee-for-service billing system utilizing the state's Medi-Cal fee-for-service claims processing system contractor. To carry out this per visit payment process, each federally qualified health system and rural health clinic shall submit to the department for approval a rate differential calculated to reflect the amount necessary to reimburse the federally qualified health center or rural health clinic the difference between the payment the center or clinic received from the managed care health plan and the interim rate established by the department based on the center's or clinic's reasonable cost. The department shall adjust the computed rate differential as it deems necessary to minimize the difference between the center's or clinic's revenue from the plan and the center's or clinic's cost-based reimbursement.

(2) In addition, to the extent feasible, within six months of the end of the center's or clinic's fiscal year, the department shall perform an annual reconciliation to reasonable cost, and make payments to, or obtain a recovery from, the center or clinic.

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

(g) (1) A federally qualified health center or rural health clinic may voluntarily agree to enter into a capitated or other at-risk contract with a managed care program health plan if the clinic agrees to all of the following:



(A) Reimbursement by the health plan under the contract is payment in full for the services provided under the contract and the costs and revenues experienced by the clinic under the contract shall not be subjected to reconciliation to reasonable cost.

(B) The clinic shall not seek supplemental reimbursement from the department, as provided in paragraph (1) of subdivision (e), or seek reconciliation to reasonable cost with the department, as provided in paragraph (2) of subdivision (e).

(2) The existence of a contract specified in paragraph (1) shall not void the center's or clinic's right to reconciliation to reasonable cost for those services that are not part of the center's or clinic's capitated or other at-risk contract with a health plan.

(3) A federally qualified health center or rural health clinic that agrees to enter into a capitated or at-risk contract shall, in writing to the department, affirmatively waive its right to supplemental reimbursement as provided in paragraph (1) of subdivision (e), and reconciliation to reasonable cost as provided in paragraph (2) of subdivision (e) for services provided pursuant to the subcontract with the health plan. Nothing in this paragraph shall restrict a center or clinic that waives its right to cost-based reimbursement from reinstating that right, in writing to the department, if the capitation or at-risk contract between the center or clinic and the health plan that prompted the waiver terminates.

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

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

