

ASSEMBLY BILL

No. 1445

Introduced by Assembly Member Chesbro

February 27, 2009

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1445, as introduced, Chesbro. Medi-Cal.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. Existing law provides that federally qualified health center services and rural health clinic 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. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals.

This bill would provide that more than one encounter between a patient and the same health care professional on the same day and at a single location may each be separately reimbursed in specified circumstances. The bill would also provide that, under specified circumstances, visits with different health care professionals on the same day of service may be billed as separate visits. The bill would require the department, by March 30, 2010, to seek all necessary federal approvals in order to implement the bill, including any necessary amendments to the state Medi-Cal plan.

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

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

1 SECTION 1. Section 14132.100 of the Welfare and Institutions
2 Code is amended to read:
3 14132.100. (a) The federally qualified health center services
4 described in Section 1396d(a)(2)(C) of Title 42 of the United States
5 Code are covered benefits.
6 (b) The rural health clinic services described in Section ~~1396d~~
7 ~~(a)(2)(B)~~ 1396d(a)(2)(B) of Title 42 of the United States Code are
8 covered benefits.
9 (c) Federally qualified health center services and rural health
10 clinic services shall be reimbursed on a per-visit basis in
11 accordance with the definition of “visit” set forth in subdivision
12 (g).
13 (d) Effective October 1, 2004, and on each October 1, thereafter,
14 until no longer required by federal law, federally qualified health
15 center (FQHC) and rural health clinic (RHC) per-visit rates shall
16 be increased by the Medicare Economic Index applicable to
17 primary care services in the manner provided for in Section
18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
20 by the Medicare Economic Index in accordance with the
21 methodology set forth in the state plan in effect on October 1,
22 2001.
23 (e) (1) An FQHC or RHC may apply for an adjustment to its
24 per-visit rate based on a change in the scope of services provided
25 by the FQHC or RHC. Rate changes based on a change in the
26 scope of services provided by an FQHC or RHC shall be evaluated
27 in accordance with Medicare reasonable cost principles, as set
28 forth in Part 413 (commencing with Section 413.1) of Title 42 of
29 the Code of Federal Regulations, or its successor.
30 (2) Subject to the conditions set forth in subparagraphs (A) to
31 (D), inclusive, of paragraph (3), a change in scope of service means
32 any of the following:
33 (A) The addition of a new FQHC or RHC service that is not
34 incorporated in the baseline prospective payment system (PPS)

1 rate, or a deletion of an FQHC or RHC service that is incorporated
2 in the baseline PPS rate.

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

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

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

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

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

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

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

24 (I) Any changes in the scope of a project approved by the federal
25 ~~Health Resources and Service Administration (HRSA) Centers~~
26 ~~for Medicare and Medicaid Services (CMS).~~

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

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

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

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

39 (D) The net change in the FQHC's or RHC's rate equals or
40 exceeds 1.75 percent for the affected FQHC or RHC site. For

1 FQHCs and RHCs that filed consolidated cost reports for multiple
2 sites to establish the initial prospective payment reimbursement
3 rate, the 1.75-percent threshold shall be applied to the average
4 per-visit rate of all sites for the purposes of calculating the cost
5 associated with a scope-of-service change. “Net change” means
6 the per-visit rate change attributable to the cumulative effect of all
7 increases and decreases for a particular fiscal year.

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

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

27 (6) Notwithstanding paragraph (4), if the approved
28 scope-of-service change or changes were initially implemented
29 on or after the first day of an FQHC’s or RHC’s fiscal year ending
30 in calendar year 2001, but before the adoption and issuance of
31 written instructions for applying for a scope-of-service change,
32 the adjusted reimbursement rate for that scope-of-service change
33 shall be made retroactive to the date the scope-of-service change
34 was initially implemented. Scope-of-service changes under this
35 paragraph shall be required to be submitted within the later of 150
36 days after the adoption and issuance of the written instructions by
37 the department, or 150 days after the end of the FQHC’s or RHC’s
38 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 ~~(t)~~ (m). 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 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

1 PPS rates, and shall be repaid by the FQHC or RHC to the extent
2 that it is not expended for the specified purposes.

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

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

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

27 (B) Notwithstanding subdivision (e), an FQHC or RHC that
28 currently includes the cost of the services of a dental hygienist in
29 alternative practice for the purposes of establishing its FQHC or
30 RHC rate shall apply for an adjustment to its per-visit rate, and,
31 after the rate adjustment has been approved by the department,
32 shall bill these services as a separate visit. However, multiple
33 encounters with dental professionals that take place on the same
34 day shall constitute a single visit. The department shall develop
35 the appropriate forms to determine which FQHC's or RHC rates
36 shall be adjusted and to facilitate the calculation of the adjusted
37 rates. An FQHC's or RHC's application for, or the department's
38 approval of, a rate adjustment pursuant to this subparagraph shall
39 not constitute a change in scope of service within the meaning of
40 subdivision (e). An FQHC or RHC that applies for an adjustment

1 to its rate pursuant to this subparagraph may continue to bill for
2 all other FQHC or RHC visits at its existing per-visit rate, subject
3 to reconciliation, until the rate adjustment for visits between an
4 FQHC or RHC patient and a dental hygienist or a dental hygienist
5 in alternative practice has been approved. Any approved increase
6 or decrease in the provider's rate shall be made within six months
7 after the date of receipt of the department's rate adjustment forms
8 pursuant to this subparagraph and shall be retroactive to the
9 beginning of the fiscal year in which the FQHC or RHC submits
10 the request, but in no case shall the effective date be earlier than
11 January 1, 2008.

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

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

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

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

36 (B) In the absence of three comparable FQHCs or RHCs with
37 a similar caseload, the rate may be calculated on a per-visit basis
38 in an amount that is equal to the average of the per-visit rates of
39 three comparable FQHCs or RHCs located in the same or an
40 adjacent service area, or in a reasonably similar geographic area

1 with respect to relevant social, health care, and economic
2 characteristics.

3 (C) At a new entity's one-time election, the department shall
4 establish a reimbursement rate, calculated on a per-visit basis, that
5 is equal to 100 percent of the projected allowable costs to the
6 FQHC or RHC of furnishing FQHC or RHC services during the
7 first 12 months of operation as an FQHC or RHC. After the first
8 12-month period, the projected per-visit rate shall be increased by
9 the Medicare Economic Index then in effect. The projected
10 allowable costs for the first 12 months shall be cost settled and the
11 prospective payment reimbursement rate shall be adjusted based
12 on actual and allowable cost per visit.

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

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

33 (3) The rate for any newly qualified entity set forth under this
34 subdivision shall be effective retroactively to the later of the date
35 that the entity was first qualified by the applicable federal agency
36 as an FQHC or RHC, the date a new facility at a new location was
37 added to an existing FQHC or RHC, or the date on which an
38 existing FQHC or RHC was relocated to a new site. The FQHC
39 or RHC shall be permitted to continue billing for Medi-Cal covered
40 benefits on a fee-for-service basis *under its existing provider*

1 *number* until it is informed of its ~~enrollment as an~~ new FQHC or
2 RHC *provider number*, and the department shall reconcile the
3 difference between the fee-for-service payments and the FQHC's
4 or RHC's prospective payment rate at that time.

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

13 *(k) More than one encounter with the same health care*
14 *professional, of the type described in subdivision (g), that takes*
15 *place on the same day and at a single location may be separately*
16 *reimbursed as a visit if after the first encounter, the health center*
17 *or clinic patient suffers illness or injury requiring additional*
18 *diagnosis or treatment. Multiple visits on the same day of services*
19 *may be billed and separately reimbursed if the health center or*
20 *clinic patient receives services from more than one health care*
21 *professional, of the type described in subdivision (g), and the*
22 *nature of the services or the patient diagnoses are unrelated. A*
23 *medical visit and a mental health services visit with a licensed*
24 *professional that takes place on the same day may be billed as two*
25 *separate visits. A medical visit and a visit with a dental*
26 *professional, as authorized by subdivision (g), on the same day*
27 *may be billed as two separate visits.*

28 ~~(k)~~

29 (l) An FQHC or RHC may elect to have pharmacy or dental
30 services reimbursed on a fee-for-service basis, utilizing the current
31 fee schedules established for those services. These costs shall be
32 adjusted out of the FQHC's or RHC's clinic base rate as
33 scope-of-service changes. An FQHC or RHC that reverses its
34 election under this subdivision shall revert to its prior rate, subject
35 to an increase to account for all MEI increases occurring during
36 the intervening time period, and subject to any increase or decrease
37 associated with applicable scope-of-services adjustments as
38 provided in subdivision (e).

39 ~~(l)~~

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

7 ~~(m) The department shall, by no later than March 30, 2008,~~
8 ~~promptly seek all necessary federal approvals in order to implement~~
9 ~~this section, including any amendments to the state plan. To~~

10 (n) (1) *Except as provided in paragraph (2), the department*
11 *shall, by no later than March 30, 2008, promptly seek all necessary*
12 *federal approvals in order to implement this section, including*
13 *any amendments to the state plan.*

14 (2) *The department, no later than March 30, 2010, shall*
15 *promptly seek all necessary federal approvals in order to*
16 *implement subdivision (k), including any necessary amendments*
17 *to the state plan.*

18 (3) *To the extent that any element or requirement of this section*
19 *is not approved, the department shall submit a request to the federal*
20 *Centers for Medicare and Medicaid Services for any waivers that*
21 *would be necessary to implement this section.*

22 ~~(n)~~

23 (o) *The department shall implement this section only to the*
24 *extent that federal financial participation is obtained.*