

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 15, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 1445

Introduced by Assembly Member Chesbro
(Coauthor: Assembly Member V. Manuel Perez)
(Coauthor: Senator Wiggins)

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 amended, Chesbro. Medi-Cal: federally qualified health centers and rural health clinics.

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 (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. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic *an FQHC or RHC* and specified health care professionals. Existing law allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services it provides.

This bill would provide that a maximum of 2 visits, as defined, taking place on the same day at a single location shall be reimbursed when either after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment or the patient has a medical visit, as defined, and another health visit, as defined, or both. ~~The bill would provide that these provisions shall constitute a change in the scope of services and would require an FQHC or RHC to file a scope of service change to the extent required by applicable law.~~ *The bill would require an FQHC or RHC that currently includes the cost of encounters with more than one health professional that take place on the same day at a single location as constituting a single visit for purposes of establishing its FQHC or RHC rate to, by January 1, 2011, apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, require the FQHC or RHC to bill a medical visit and another health visit that take place on the same day at a single location as separate visits. The bill would make other conforming changes.*

This bill would require the department, by January 15, 2010, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described above.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (5) An FQHC or RHC shall submit a scope-of-service rate
34 change request within 90 days of the beginning of any FQHC or
35 RHC fiscal year occurring after the effective date of this section,
36 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
37 RHC experienced a decrease in the scope of services provided that
38 the FQHC or RHC either knew or should have known would have
39 resulted in a significantly lower per-visit rate. If an FQHC or RHC
40 discontinues providing onsite pharmacy or dental services, it shall

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

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

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

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

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

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

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

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

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

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

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

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, 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 services 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 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~~ 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

1 financial incentive payments that are required by federal law to
2 be excluded from the calculation.

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

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

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

20 (C) At a new entity's one-time election, the department shall
21 establish a reimbursement rate, calculated on a per-visit basis, that
22 is equal to 100 percent of the projected allowable costs to the
23 FQHC or RHC of furnishing FQHC or RHC services during the
24 first 12 months of operation as an FQHC or RHC. After the first
25 12-month period, the projected per-visit rate shall be increased by
26 the Medicare Economic Index then in effect. The projected
27 allowable costs for the first 12 months shall be cost settled and the
28 prospective payment reimbursement rate shall be adjusted based
29 on actual and allowable cost per visit.

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

34 (2) In order for an FQHC or RHC to establish the comparability
35 of its caseload for purposes of subparagraph (A) or (B) of paragraph
36 (1), the department shall require that the FQHC or RHC submit
37 its most recent annual utilization report as submitted to the Office
38 of Statewide Health Planning and Development, unless the FQHC
39 or RHC was not required to file an annual utilization report. FQHCs
40 or RHCs that have experienced changes in their services or

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

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number, 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) *For purposes of this subdivision, the following definitions shall apply:*

(A) *"Another health visit" means a face-to-face encounter between an FQHC or RHC patient and a clinical psychologist, licensed clinical social worker, dentist, dental hygienist, or registered dental hygienist in alternative practice.*

(B) *"Medical visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, or a comprehensive perinatal services practitioner, as defined in Section*

1 51179.7 of Title 22 of the California Code of Regulations,
2 providing comprehensive perinatal services.

3 (2) A maximum of two visits, as defined in subdivision (g),
4 taking place on the same day at a single location shall be
5 reimbursed when one or more of the following conditions exist:

6 (A) After the first visit the patient suffers illness or injury
7 requiring additional diagnosis or treatment.

8 (B) (i) The patient has a medical visit and another health visit.

9 (ii) ~~(I) For purposes of this subdivision, “medical visit” means~~
10 ~~a face-to-face encounter between an FQHC or RHC patient and a~~
11 ~~physician, physician assistant, nurse practitioner, certified nurse~~
12 ~~midwife, visiting nurse, or a comprehensive perinatal services~~
13 ~~practitioner, as defined in Section 51179.7 of Title 22 of the~~
14 ~~California Code of Regulations, providing comprehensive perinatal~~
15 ~~services.~~

16 ~~(II) For purposes of this subdivision, “another health visit”~~
17 ~~means a face-to-face encounter between an FQHC or RHC patient~~
18 ~~and a clinical psychologist, licensed clinical social worker, dentist,~~
19 ~~dental hygienist, or registered dental hygienist in alternative~~
20 ~~practice.~~

21 ~~(2) This subdivision shall constitute a change in the scope of~~
22 ~~services for purposes of paragraph (2) of subdivision (e). In order~~
23 ~~to comply with this subdivision, an FQHC or RHC shall file a~~
24 ~~scope of service change to the extent required by applicable law.~~

25 (3) (A) *Notwithstanding subdivision (e), an FQHC or RHC that*
26 *currently includes the cost of encounters with more than one health*
27 *professional that take place on the same day at a single location*
28 *as constituting a single visit for purposes of establishing its FQHC*
29 *or RHC rate shall, by January 1, 2011, apply for an adjustment*
30 *to its per-visit rate, and, after the rate adjustment has been*
31 *approved by the department, the FQHC or RHC shall bill a medical*
32 *visit and another health visit that take place on the same day at a*
33 *single location as separate visits.*

34 (B) *The department shall, by July 1, 2010, develop and adjust*
35 *all appropriate forms to determine which FQHC’s or RHC’s rates*
36 *shall be adjusted and to facilitate the calculation of the adjusted*
37 *rates.*

38 (C) *An FQHC’s or RHC’s application for, or the department’s*
39 *approval of, a rate adjustment pursuant to this paragraph shall*

1 *not constitute a change in scope of service within the meaning of*
2 *subdivision (e).*

3 *(D) An FQHC or RHC that applies for an adjustment to its rate*
4 *pursuant to this paragraph may continue to bill for all other FQHC*
5 *or RHC visits at its existing per-visit rate, subject to reconciliation,*
6 *until the rate adjustment has been approved.*

7 *(4) The department shall, by January 15, 2010, submit a state*
8 *plan amendment to the federal Centers for Medicare and Medicaid*
9 *Services reflecting the changes described in this subdivision.*

10 *(l) An FQHC or RHC may elect to have pharmacy or dental*
11 *services reimbursed on a fee-for-service basis, utilizing the current*
12 *fee schedules established for those services. These costs shall be*
13 *adjusted out of the FQHC's or RHC's clinic base rate as*
14 *scope-of-service changes. An FQHC or RHC that reverses its*
15 *election under this subdivision shall revert to its prior rate, subject*
16 *to an increase to account for all MEI increases occurring during*
17 *the intervening time period, and subject to any increase or decrease*
18 *associated with applicable scope-of-services adjustments as*
19 *provided in subdivision (e).*

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

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

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

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

- 1 (o) The department shall implement this section only to the
- 2 extent that federal financial participation is obtained.

O