

AMENDED IN ASSEMBLY APRIL 5, 2010

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1966

Introduced by Assembly Member Fletcher

February 17, 2010

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1966, as amended, Fletcher. Medi-Cal: federally qualified health center and rural health center services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. 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 permits an FQHC or RHC 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 provides that the costs shall be adjusted out of the FQHC's and RHC's clinic base rate as scope-of-service changes, as prescribed.

This bill would also permit an FQHC or RHC to have inpatient obstetrical *and gynecological* services reimbursed on a fee-for-service basis as described above.

This bill would require the department to seek all necessary federal approvals no later than March 30, 2011.

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
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).

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

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

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

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

38 (D) The net change in the FQHC's or RHC's rate equals or
39 exceeds 1.75 percent for the affected FQHC or RHC site. For
40 FQHCs and RHCs that filed consolidated cost reports for multiple

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the difference between the fee-for-service payments and the
2 FQHC's or RHC's prospective payment rate at that time.

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

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

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

29 (m) The department shall, by no later than March 30, 2011,
30 promptly seek all necessary federal approvals in order to implement
31 this section, including any amendments to the state plan. To the
32 extent that any element or requirement of this section is not
33 approved, the department shall submit a request to the federal
34 Centers for Medicare and Medicaid Services for any waivers that
35 would be necessary to implement this section.

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

O