

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 966 VERSION: INTRODUCED FEBRUARY 9, 2022

AUTHOR: LIMON SPONSOR:

- CALIFORNIAHEALTH+ ADVOCATES
- CALIFORNIA ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS (CAMFT)

RECOMMENDED POSITION: SUPPORT

SUBJECT: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS: VISITS

Summary:

This bill would allow Medi-Cal reimbursement for covered mental health services provided by an associate clinical social worker or an associate marriage and family therapist employed by a federally qualified health center or a rural health clinic.

Existing Law:

- 1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [WIC §14000, et seq.]
- 2) Establishes that federally qualified health center (FQHCs) services and rural health clinic (RHC) services are covered Medi-Cal benefits that are reimbursed on a per-visit basis. (Welfare and Institutions Code (WIC) §14132.100(c))
- 3) Allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of service that it provides. (WIC §14132.100(e))
- 4) Defines a FQHC or RHC “visit” as a face-to-face encounter between an FQHC or RHC patient and one of the following (WIC §14132.100(g)):
 - A physician;
 - A physician assistant;
 - A nurse practitioner;
 - A certified nurse-midwife;
 - A clinical psychologist;
 - A licensed clinical social worker;
 - A visiting nurse;
 - A dental hygienist; or
 - A marriage and family therapist.

This Bill:

- 1) Provides that an FQHC or RHC “visit” also includes a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker (ASW) or associate marriage and family therapist (AMFT), when they are supervised by a licensee as required by the Board. (WIC §14132.100(g)(1)(B))
- 2) Provides that an FQHC or RHC that elects to add the services of an ASW or AMFT does not constitute a change in scope of service where the FQHC or RHC must apply for an adjustment to its per-visit rate. (WIC §14132.100(g)(1)(B))
- 3) Provides that the above two provisions become effective 60 days after the national COVID State-of-Emergency ends. (WIC §14132.100(g)(1)(B))
- 4) Removes the requirement that an FQHC or RHC that elects to add the services of an LMFT and bill these services as a separate visit constitutes a change in scope of services where it must apply for an adjustment in its per-visit rate. (WIC §14132.100(g)(2)(C))

Comments:

- 1) **Background.** The author’s office states that there are over 1,300 community health centers in California that provide comprehensive care to 7.2 million people each year. In May 2020, DHCS temporarily allowed ASWs and AMFTs to serve as billable provider types for FQHCs and RHCs due to the COVID-19 State of Emergency.
- 2) **Author’s Intent.** In their fact sheet for the bill, the author’s office notes the following:

“Senate Bill 966 would extend flexibilities allowed during the declared public health emergency to hire and bill for ASWs and AMFTs, therefore sustaining continuity of care for patients and increasing access to a diverse behavioral health workforce. This bill will also remove the current administrative barrier to utilizing LMFTs by aligning FQHC/RHC Medi-Cal Change in Scope-Of-Service Request (CSOSR) requirements for both medical and behavioral health services, ensuring that health centers are not disadvantaged when trying to bring in critical behavioral health workforce.”
- 3) **LPCCs and APCCs Not Included.** One additional way to increase the pool of mental health professionals eligible to provide services to FQHCs and RHCs would be to add the Board’s professional clinical counselor license type (LPCCs) as well as its corresponding associates (APCCs).

4) Related Legislation

AB 2666 (Salas) proposes establishing a stipend program for students in behavioral health fields of study and practice, who are participating in internships or completing licensure hours, through unpaid positions, at FQHCs, with priority to mental health professional shortage areas and underrepresented groups in the behavioral health workforce.

5) Previous Legislation

Previous Legislation Related to LPCCs

- AB 769 (Smith, 2019) proposed allowing Medi-Cal reimbursement for covered mental health services provided by an LPCC employed by an FQHC or RHC. However, AB 769 died in 2020.
- AB 1591 (Berman, 2017) also proposed allowing Medi-Cal reimbursement for covered mental health services provided by an LPCC employed by an FQHC or RHC. The bill was vetoed by the Governor.

Previous Legislation Related to LMFTs

- AB 1863 (Chapter 610, Statutes of 2016) allowed Medi-Cal reimbursement for covered mental health services provided by an LMFT employed by an FQHC or RHC.
- AB 690 (Wood, 2015) proposed adding marriage and family therapists to the list of health care professionals that are able to provide Medi-Cal reimbursable services for an FQHC or RHC visit. The bill was vetoed by the Governor.
- AB 1785 (B. Lowenthal, 2012) proposed adding marriage and family therapists to the list of health care professionals that are able to provide Medi-Cal reimbursable services for an FQHC or RHC visit. However, the bill died in the Assembly Appropriations Committee.

6) Recommended Position. At its April 20, 2022 meeting, the Policy and Advocacy Committee recommended that the Board consider taking a “support” position on this bill.

7) Support and Opposition

Support

- CaliforniaHealth+ Advocates (Co-Sponsor)
- CAMFT (Co-Sponsor)
- Alameda Health Consortium
- AltaMed
- APLA Health

- Asian Health Services
- California Alliance of Child and Family Services
- California School Based Health Alliance
- Community Clinic Association of Los Angeles
- Community Medical Centers, Inc.
- DAP Health
- Depression and Bipolar Support Alliance
- Golden Valley Health Center
- Health Alliance of Northern California
- Health Center Partners of Southern California
- Herald Christian Health Center
- Hill Country Health and Wellness Center
- Innercare
- La Clinica de la Raza
- LifeLong Medical Care
- Marin Community Clinic
- National Association of Social Workers, California Chapter
- North Coast Clinics Network
- North East Medical Services
- Northeast Valley Health Corporation
- Peach Tree Health
- Redwood Community Health Coalition
- Ritter Center
- Saban Community Clinic
- San Francisco Community Clinic Consortium
- San Ysidro Health
- Sierra Family Health Center
- South Central Family Health Center
- St. Johns Well Child & Family Health Center
- St. Jude Neighborhood Health Center
- Steinberg Institute
- The Achievable Foundation
- Tiburcio Vasquez Health Center INC
- Venice Family Clinic
- Vista Community Clinic
- West Oakland Health
- Westside Family Health Center

Oppose

- One individual

8) History

2022

04/18/22	April 18 hearing: Placed on APPR suspense file.
04/05/22	Set for hearing April 18.
03/24/22	From committee: Do pass and re-refer to Com. on APPR with recommendation: To consent calendar. (Ayes 11. Noes 0.) (March 23). Re-referred to Com. on APPR.
03/11/22	Set for hearing March 23.
02/16/22	Referred to Com. on HEALTH.
02/10/22	From printer.

02/09/22 Article IV Section 8(a) of the Constitution and Joint Rule 55 dispensed
with February 7, 2022, suspending the 30 calendar day requirement.
02/09/22 Introduced. Read first time. To Com. on RLS. for assignment. To print.

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Introduced by Senator Limón
(Principal coauthor: Assembly Member Salas)

February 9, 2022

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

legislative counsel's digest

SB 966, as introduced, Limón. Federally qualified health centers and rural health clinics: visits.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist.

This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13, 2020.

If an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, existing law requires the FQHC or RHC to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, to bill these services as a separate visit. Under existing law, multiple encounters with dental professionals or marriage and family therapists that take place on the same day constitute a single visit. Existing law requires the department to develop the appropriate forms to determine which FQHC's or RHC's rates are to be adjusted and to facilitate the calculation of the adjusted rates.

This bill would require that the forms for calculation of the adjusted rates be the same or substantially similar for each provider described above.

Existing law requires an FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, to process the addition of these services as a change in scope of service, as specified.

This bill would remove marriage and family therapist services from that requirement.

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).

(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.

(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

1 or expanded service facilities, regulatory compliance, or changes
2 in technology or medical practices at the center or clinic.

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

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

8 (3) A change in costs is not, in and of itself, a scope-of-service
9 change, unless all of the following apply:

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

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

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

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

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

35 (5) An FQHC or RHC shall submit a scope-of-service rate
36 change request within 90 days of the beginning of any FQHC or
37 RHC fiscal year occurring after the effective date of this section,
38 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
39 RHC experienced a decrease in the scope of services provided that
40 the FQHC or RHC either knew or should have known would have

1 resulted in a significantly lower per-visit rate. If an FQHC or RHC
2 discontinues providing onsite pharmacy or dental services, it shall
3 submit a scope-of-service rate change request within 90 days of
4 the beginning of the following fiscal year. The rate change shall
5 be effective as provided for in paragraph (4). As used in this
6 paragraph, “significantly lower” means an average per-visit rate
7 decrease in excess of 2.5 percent.

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

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

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

1 at an adult day health care center, and any other provider identified
2 in the state plan's definition of an FQHC or RHC visit.

3 *(B) A visit shall also include a face-to-face encounter between*
4 *an FQHC or RHC patient and an associate clinical social worker*
5 *or associate marriage and family therapist when supervised by a*
6 *licensed behavioral health practitioner as required by the Board*
7 *of Behavioral Sciences. The election to add an associate clinical*
8 *social worker or associate marriage and family therapist under*
9 *supervision of a licensed behavioral health practitioner shall not*
10 *constitute a change in scope of service within the meaning of*
11 *subdivision (e). This subparagraph shall become operative 60 days*
12 *after the termination of the national emergency declared on the*
13 *federal level on March 13, 2020.*

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

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

1 in the provider's rate shall be made within six months after the
2 date of receipt of the department's rate adjustment forms pursuant
3 to this subparagraph and shall be retroactive to the beginning of
4 the fiscal year in which the FQHC or RHC submits the request,
5 but in no case shall the effective date be earlier than January 1,
6 2008.

7 (C) An FQHC or RHC that does not provide dental-hygienist,
8 *hygienist services or dental hygienist in alternative practice, or*
9 ~~marriage and family therapist practice~~ services, and later elects to
10 add these services and bill these services as a separate visit, shall
11 process the addition of these services as a change in scope of
12 service pursuant to subdivision (e).

13 (3) Notwithstanding any other provision of this section, no later
14 than July 1, 2018, a visit shall include a marriage and family
15 therapist.

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) Provided that the following entities are not operating as
27 intermittent clinics, as defined in subdivision (h) of Section 1206
28 of the Health and Safety Code, each entity shall have its
29 reimbursement rate established in accordance with one of the
30 methods outlined in paragraph (2) or (3), as selected by the FQHC
31 or RHC:

32 (A) An entity that first qualifies as an FQHC or RHC in 2001
33 or later.

34 (B) A newly licensed facility at a new location added to an
35 existing FQHC or RHC.

36 (C) An entity that is an existing FQHC or RHC that is relocated
37 to a new site.

38 (2) (A) An FQHC or RHC that adds a new licensed location to
39 its existing primary care license under paragraph (1) of subdivision
40 (b) of Section 1212 of the Health and Safety Code may elect to

1 have the reimbursement rate for the new location established in
2 accordance with paragraph (3), or notwithstanding subdivision
3 (e), an FQHC or RHC may choose to have one PPS rate for all
4 locations that appear on its primary care license determined by
5 submitting a change in scope of service request if both of the
6 following requirements are met:

7 (i) The change in scope of service request includes the costs
8 and visits for those locations for the first full fiscal year
9 immediately following the date the new location is added to the
10 FQHC's or RHC's existing licensee.

11 (ii) The FQHC or RHC submits the change in scope of service
12 request within 90 days after the FQHC's or RHC's first full fiscal
13 year.

14 (B) The FQHC's or RHC's single PPS rate for those locations
15 shall be calculated based on the total costs and total visits of those
16 locations and shall be determined based on the following:

17 (i) An audit in accordance with Section 14170.

18 (ii) Rate changes based on a change in scope of service request
19 shall be evaluated in accordance with Medicare reasonable cost
20 principles, as set forth in Part 413 (commencing with Section
21 413.1) of Title 42 of the Code of Federal Regulations, or its
22 successors.

23 (iii) Any approved increase or decrease in the provider's rate
24 shall be retroactive to the beginning of the FQHC's or RHC's fiscal
25 year in which the request is submitted.

26 (C) Except as specified in subdivision (j), this paragraph does
27 not apply to a location that was added to an existing primary care
28 clinic license by the State Department of Public Health, whether
29 by a regional district office or the centralized application unit, prior
30 to January 1, 2017.

31 (3) If an FQHC or RHC does not elect to have the PPS rate
32 determined by a change in scope of service request, the FQHC or
33 RHC shall have the reimbursement rate established for any of the
34 entities identified in paragraph (1) or (2) in accordance with one
35 of the following methods at the election of the FQHC or RHC:

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

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

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

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

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

38 (5) The rate for any newly qualified entity set forth under this
39 subdivision shall be effective retroactively to the later of the date
40 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 FQHC or RHC enrollment approval, 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) (1) 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, in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision 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

1 to any increase or decrease associated with applicable
2 scope-of-service adjustments as provided in subdivision (e).

3 (I) Reimbursement for Drug Medi-Cal services shall be provided
4 pursuant to this subdivision.

5 (1) An FQHC or RHC may elect to have Drug Medi-Cal services
6 reimbursed directly from a county or the department under contract
7 with the FQHC or RHC pursuant to paragraph (4).

8 (2) (A) For an FQHC or RHC to receive reimbursement for
9 Drug Medi-Cal services directly from the county or the department
10 under contract with the FQHC or RHC pursuant to paragraph (4),
11 costs associated with providing Drug Medi-Cal services shall not
12 be included in the FQHC's or RHC's per-visit PPS rate. For
13 purposes of this subdivision, the costs associated with providing
14 Drug Medi-Cal services shall not be considered to be within the
15 FQHC's or RHC's clinic base PPS rate if in delivering Drug
16 Medi-Cal services the clinic uses different clinical staff at a
17 different location.

18 (B) If the FQHC or RHC does not use different clinical staff at
19 a different location to deliver Drug Medi-Cal services, the FQHC
20 or RHC shall submit documentation, in a manner determined by
21 the department, that the current per-visit PPS rate does not include
22 any costs related to rendering Drug Medi-Cal services, including
23 costs related to utilizing space in part of the FQHC's or RHC's
24 building, that are or were previously calculated as part of the
25 clinic's base PPS rate.

26 (3) If the costs associated with providing Drug Medi-Cal
27 services are within the FQHC's or RHC's clinic base PPS rate, as
28 determined by the department, the Drug Medi-Cal services costs
29 shall be adjusted out of the FQHC's or RHC's per-visit PPS rate
30 as a change in scope of service.

31 (A) An FQHC or RHC shall submit to the department a
32 scope-of-service change request to adjust the FQHC's or RHC's
33 clinic base PPS rate after the first full fiscal year of rendering Drug
34 Medi-Cal services outside of the PPS rate. Notwithstanding
35 subdivision (e), the scope-of-service change request shall include
36 a full fiscal year of activity that does not include Drug Medi-Cal
37 services costs.

38 (B) An FQHC or RHC may submit requests for scope-of-service
39 change under this subdivision only within 90 days following the
40 beginning of the FQHC's or RHC's fiscal year. Any

scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, 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. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on

1 whether the services are provided in a county that participates in
2 the Drug Medi-Cal organized delivery system (DMC-ODS).

3 (A) In a county that participates in the DMC-ODS, the FQHC
4 or RHC shall receive reimbursement pursuant to a mutually agreed
5 upon contract entered into between the county or county designee
6 and the FQHC or RHC. If the county or county designee refuses
7 to contract with the FQHC or RHC, the FQHC or RHC may follow
8 the contract denial process set forth in the Special Terms and
9 Conditions.

10 (B) In a county that does not participate in the DMC-ODS, the
11 FQHC or RHC shall receive reimbursement pursuant to a mutually
12 agreed upon contract entered into between the county and the
13 FQHC or RHC. If the county refuses to contract with the FQHC
14 or RHC, the FQHC or RHC may request to contract directly with
15 the department and shall be reimbursed for those services at the
16 Drug Medi-Cal fee-for-service rate.

17 (5) The department shall not reimburse an FQHC or RHC
18 pursuant to subdivision (h) for the difference between its per-visit
19 PPS rate and any payments for Drug Medi-Cal services made
20 pursuant to this subdivision.

21 (6) For purposes of this subdivision, the following definitions
22 apply:

23 (A) “Drug Medi-Cal organized delivery system” or
24 “DMC-ODS” means the Drug Medi-Cal organized delivery system
25 authorized under the California Medi-Cal 2020 Demonstration,
26 Number 11-W-00193/9, as approved by the federal Centers for
27 Medicare and Medicaid Services and described in the Special
28 Terms and Conditions.

29 (B) “Special Terms and Conditions” has the same meaning as
30 set forth in subdivision (o) of Section 14184.10.

31 (m) Reimbursement for specialty mental health services shall
32 be provided pursuant to this subdivision.

33 (1) An FQHC or RHC and one or more mental health plans that
34 contract with the department pursuant to Section 14712 may
35 mutually elect to enter into a contract to have the FQHC or RHC
36 provide specialty mental health services to Medi-Cal beneficiaries
37 as part of the mental health plan’s network.

38 (2) (A) For an FQHC or RHC to receive reimbursement for
39 specialty mental health services pursuant to a contract entered into
40 with the mental health plan under paragraph (1), the costs

1 associated with providing specialty mental health services shall
2 not be included in the FQHC's or RHC's per-visit PPS rate. For
3 purposes of this subdivision, the costs associated with providing
4 specialty mental health services shall not be considered to be within
5 the FQHC's or RHC's clinic base PPS rate if in delivering specialty
6 mental health services the clinic uses different clinical staff at a
7 different location.

8 (B) If the FQHC or RHC does not use different clinical staff at
9 a different location to deliver specialty mental health services, the
10 FQHC or RHC shall submit documentation, in a manner
11 determined by the department, that the current per-visit PPS rate
12 does not include any costs related to rendering specialty mental
13 health services, including costs related to utilizing space in part of
14 the FQHC's or RHC's building, that are or were previously
15 calculated as part of the clinic's base PPS rate.

16 (3) If the costs associated with providing specialty mental health
17 services are within the FQHC's or RHC's clinic base PPS rate, as
18 determined by the department, the specialty mental health services
19 costs shall be adjusted out of the FQHC's or RHC's per-visit PPS
20 rate as a change in scope of service.

21 (A) An FQHC or RHC shall submit to the department a
22 scope-of-service change request to adjust the FQHC's or RHC's
23 clinic base PPS rate after the first full fiscal year of rendering
24 specialty mental health services outside of the PPS rate.
25 Notwithstanding subdivision (e), the scope-of-service change
26 request shall include a full fiscal year of activity that does not
27 include specialty mental health costs.

28 (B) An FQHC or RHC may submit requests for a
29 scope-of-service change under this subdivision only within 90
30 days following the beginning of the FQHC's or RHC's fiscal year.
31 Any scope-of-service change request under this subdivision
32 approved by the department is retroactive to the first day that
33 specialty mental health services were rendered and reimbursement
34 for specialty mental health services was received outside of the
35 PPS rate, but the effective date shall not be earlier than January 1,
36 2018.

37 (C) The FQHC or RHC may bill for specialty mental health
38 services outside of the PPS rate when the FQHC or RHC contracts
39 with a mental health plan to provide these services pursuant to
40 paragraph (1).

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

7 (E) Rate changes based on a request for scope-of-service change
8 under this subdivision shall be evaluated in accordance with
9 Medicare reasonable cost principles, as set forth in Part 413
10 (commencing with Section 413.1) of Title 42 of the Code of
11 Federal Regulations, or its successor.

12 (F) For the purpose of recalculating the PPS rate, the FQHC or
13 RHC shall provide upon request to the department verifiable
14 documentation as to which employees spent time, and the actual
15 time spent, providing federally qualified health center services or
16 rural health center services and specialty mental health services.

17 (G) After the department approves the adjustment to the FQHC's
18 or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the
19 PPS rate for any specialty mental health services that are provided
20 pursuant to a contract entered into with a mental health plan
21 pursuant to paragraph (1).

22 (H) An FQHC or RHC that reverses its election under this
23 subdivision shall revert to its prior PPS rate, subject to an increase
24 to account for all Medicare Economic Index increases occurring
25 during the intervening time period, and subject to any increase or
26 decrease associated with the applicable scope-of-service
27 adjustments as provided for in subdivision (e).

28 (4) The department shall not reimburse an FQHC or RHC
29 pursuant to subdivision (h) for the difference between its per-visit
30 PPS rate and any payments made for specialty mental health
31 services under this subdivision.

32 (n) FQHCs and RHCs may appeal a grievance or complaint
33 concerning ratesetting, scope-of-service changes, and settlement
34 of cost report audits, in the manner prescribed by Section 14171.
35 The rights and remedies provided under this subdivision are
36 cumulative to the rights and remedies available under all other
37 provisions of law of this state.

38 (o) The department shall promptly seek all necessary federal
39 approvals in order to implement this section, including any
40 amendments to the state plan. To the extent that any element or

1 requirement of this section is not approved, the department shall
2 submit a request to the federal Centers for Medicare and Medicaid
3 Services for any waivers that would be necessary to implement
4 this section.

5 (p) The department shall implement this section only to the
6 extent that federal financial participation is available.

7 (q) Notwithstanding any other law, the director may, without
8 taking regulatory action pursuant to Chapter 3.5 (commencing
9 with Section 11340) of Part 1 of Division 3 of Title 2 of the
10 Government Code, implement, interpret, or make specific
11 subdivisions (l) and (m) by means of a provider bulletin or similar
12 instruction. The department shall notify and consult with interested
13 parties and appropriate stakeholders in implementing, interpreting,
14 or making specific the provisions of subdivisions (l) and (m),
15 including all of the following:

16 (1) Notifying provider representatives in writing of the proposed
17 action or change. The notice shall occur, and the applicable draft
18 provider bulletin or similar instruction, shall be made available at
19 least 10 business days prior to the meeting described in paragraph
20 (2).

21 (2) Scheduling at least one meeting with interested parties and
22 appropriate stakeholders to discuss the proposed action or change.

23 (3) Allowing for written input regarding the proposed action or
24 change, to which the department shall provide summary written
25 responses in conjunction with the issuance of the applicable final
26 written provider bulletin or similar instruction.

27 (4) Providing at least 60 days advance notice of the effective
28 date of the proposed action or change.

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