County of Santa Cruz

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HEALTH SERVICES AGENCY

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HEALTH SERVICES AGENCY
ADMINISTRATION

April 17, 2002 AGENDA: May 7,2002

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

SUBJECT: Resolution in Support of Senate Bill 1413 to Provide Primary and Preventive Care to Indigent and Uninsured Members of our Community

Dear Members of the Board:

The ability of our county clinics to continue to provide both compensated and uncompensated care to the high number of high-risk individuals and families in our community depends on the stability of Medi-Cal reimbursements. Under the old Federally Qualified Health Center (FQHC) Medi-Cal cost-based reimbursement system, the Health Services Agency (HSA) had been able to keep our doors open to a steadily increasing number of uninsured individuals and families, as well as effectively serving our Medi-Cal population.

However, under the new FQHC Prospective Payment System, which took effect January 1, 2001, HSA clinic's financial stability is at increased risk, particularly as costs rise in pharmacy, specialty procedures, and other medical costs. As described to your Board in reports on November 20, 2001, and April 16, 2002, the newly imposed system will reimburse clinic services at a rate less than the cost to provide these services to our clients.

SB 1413, authored by Senator Chesbro, would revise the formula used to calculate capitation rates paid to local initiatives, commercial plans, and county organized health systems by tying the annual cost of living increase to the medical care component of the California consumer price index, instead of the Medicare Economic Index, which has been much lower historically. This bill would also provide that FQHC services and Rural Health Clinic services are covered benefits under the Medi-Cal program, to be reimbursed to providers on a per-visit basis.

It is, therefore, RECOMMENDED that your Board:

Adopt the attached resolution supporting SB 1413 (Chesbro).

Sincerely,

Rama Khalsa, Ph.D.
Health Agency Administrator

RECOMMENDED

Susan A. Mauriello
County Administrative Officer

attachment

RK/jde

cc. County Administrative Office
County Counsel
Auditor-Controller
HSA Administration

BEFORE THE BOARD OF SUPERVISORS
OF THE COUNTY OF SANTA CRUZ, STATE OF CALIFORNIA

RESOLUTION NO.

On the motion of Supervisor
Duly seconded of Supervisor
The following resolution is adopted

RESOLUTION SUPPORTING THE PASSAGE OF SENATE BILL 1413

WHEREAS, the ability of our County clinics to provide effective services to the community is dependent on our ability to receive adequate cost reimbursement for services to our Medi-Cal clients; and

WHEREAS, our ability to serve the uninsured population is determined by our ability to receive maximum reimbursement for services to the insured population; and

WHEREAS, existing law requires the implementation of a new prospective payment reimbursement system that will pay our clinics less than cost for services rendered; and

WHEREAS, SB 1413, authored by Senator Chesbro would revise the formula used to calculate capitation rates paid to local initiatives, commercial plans, and county organized health systems; and

WHEREAS, SB 1413 would provide that federally qualified health center services and rural health clinic services are covered benefits under the Medi-Cal program, to be reimbursed to providers on a per-visit basis

NOW, THEREFORE, BE IT RESOLVED that the Santa Cruz County Board of Supervisors support Senate Bill 1413 to ensure maximum reimbursement for clinic services to the Medi-Cal population.

PASSED AND ADOPTED, by the Board of Supervisors of the County of Santa Cmz, State of California, this seventh day of May, 2002 by the following vote:

AYES: SUPERVISORS
NOES: SUPERVISORS
ABSTAIN: SUPERVISORS

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Chair of the Board

APPROVED AS TO FORM:

Assistant County Counsel

Distribution: CAO, Auditor-Controller, County Counsel, HSA Administration

AMENDED IN SENATE MARCH 21,2002

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SENATE BILL No. 1413

Introduced by Senator Chesbro

February 14,2002

An act to amend Section 14087.325 of, *and to add Section 14132.100 to,* the Welfare and Institutions Code, relating to Medi-Cal, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1413, as amended, Chesbro. Medi-Cal.

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

Existing law authorizes the department to enter into contracts to provide health care benefits in a designated area under a 2-plan model managed care plan through no more than 2 prepaid health care plans, a local initiative, ~~that~~ *which* is defined as a prepaid health care plan ~~which~~ *that* is organized by a county government or by county governments of a region designated by the director, or organized by stakeholders of the designated region, and awarded a contract by the department, and a commercial plan, which is defined as a prepaid health plan awarded a contract pursuant to a competitive bidding process.

Existing law establishes requirements as a condition of obtaining a contract with the department to provide Medi-Cal services and provides that a federally qualified health center or rural health clinic may voluntarily agree to enter into a ~~capitation~~ *capitated* or other at-risk contract ~~with a managed care program contract~~ with a managed care program health plan if the clinic agrees to specified conditions.

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This bill would ~~eliminate that requirement and would instead authorize a federally qualified health center or rural health clinic to enter into a capitated or other at-risk contract with a managed care program health plan local initiative, commercial plan, geographic managed care program, county organized health system, medical group, or independent practice association.~~ *revise the formula used by the department to calculate capitation rates to be paid to local initiatives, commercial plans, geographic managed care program health plans, and county organized health systems.*

~~Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Managed Health Care. Willful violation of the law regulating health care service plans is a crime.~~

~~This bill would exempt a federally qualified health center or rural health clinic that enters into the agreement described above from the requirement that it secure a license to operate as a health care service plan.~~

This bill would provide that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed to providers on a per-visit basis.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

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

(a) It is the policy of the State of California to ensure that its residents have access to health care that is both cost-effective and of high quality.

(b) It is the intent of the Legislature to ~~enact legislation that will~~ ensure that the health care safety net in California remains strong and a viable provider of health care for the uninsured and the underinsured.

(c) Federally qualified health centers and rural health clinics play an essential role in the health care safety net for low-income and uninsured or underinsured residents of California.

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

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

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

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

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

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

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

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

(g) *(1)* A federally qualified health center or rural health clinic may voluntarily agree to enter into a capitated or other at-risk

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contract with a managed care program health plan ~~local initiative, commercial plan, geographic managed care program, county organized health system, medical group, or independent practice association. If the federally qualified health center or rural health clinic voluntarily agrees to enter into the at-risk contract under this subdivision, it shall be exempt from the requirements of Section 1349 of the Health and Safety Code.~~ *if the clinic agrees to all of the following:*

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

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

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

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

(h) On or before September 30, 2002, the director shall conduct a study of the actual and projected impact of the transition from a cost-based reimbursement system to a prospective payment system for federally qualified health centers and rural health clinics. In conducting the study, the director shall evaluate the extent to which the prospective payment system stimulates expansion of services, including new facilities to expand capacity of the centers, and the extent to which actual and estimated prospective payment rates of federally qualified health centers and

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rural health clinics for the first five years of the prospective payment system are reflective of the cost of providing services to Medi-Cal beneficiaries. Clinics may submit cost reporting information to the department to provide data for the study.

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

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

SEC. 3. Section 14132.100 is added to the Welfare and Institutions Code, to read:

14132.100. (a) Thefederally qualified health center services described in Section 1396d (a) (2) (C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a) (2) (B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of "visit" setforth in subdivision (h).

(d) Effective October 1, 2002, and on each October 1, thereafter, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the average of the prior 12 months' percentage increases in the medical care component of the Consumer Price Index for all Urban Customers (CPI-U) of the United States Department of Labor; for California, as reported by Rand California.

(e) (1) A 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 center or clinic. Rate changes based on a change in the scope of servicesprovided by a center or clinic shall be evaluated in accordance with Medicare reasonable cost principles, as set out forth in Part 413 (commencing with Sec. 413.1) of Title 42 of the Code of Federal Regulations, or its successor

(2) A change in scope of service means any of thefollowing:

(A) The addition of a new FQHC or RHC sewice that is not incorporated in the baseline prospective payment system (PPS)

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

(Bj A change in service due to amended regulatory requirements or rules.

(C) A change in service resultingfrom relocation, remodeling, opening a clinic, or closing an existing clinic site.

(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 services or provider mix provided by a FQHC or RHC or one of its sites.

(Gj Changes in operations costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new servicefacilities or regulatory compliance.

(Hj Changes in operating costs attributable to changes in technology or medical practices at the center or clinic.

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

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

(3) Providers may submit requestsfor scope of service changes once at any time during the clinic's fiscal year, and once additionally during that fiscal year, if the reasonable cost of the scope of service changes exceeds 2.4 percent of the allowable per-visit rate, as determined for the fiscal period.

(f) (1) Providers shall have the right to request a rate reconsideration if extraordinary circumstances beyond the control of theprovider occur after December 31,2001, and PPS payments are insufficient due to these extraordinary circumstances. These rate reconsiderations shall be determined separately from the scope of service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of God, 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

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for rate reconsideration. If a provider's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a rate reconsideration is not warranted.

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

(3) Requests for rate reconsiderations 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 reconsideration is requested meet the requirements set forth in this section. Documentation shall included all of the following:

(A) A presentation of data to demonstrate reasons for the provider's request for a rate reconsideration.

(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 rate reconsideration requests shall be paid as lump-sum amounts for those years and not as revised PPS rates.

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

(7) A provider may appeal the department's decision on the rate reconsideration if the impact is in the amount of ten thousand dollars ($10,000) or more.

(g) Once the department has adopted regulations setting forth the form of application and criteria for evaluating scope of service applications, rate changes as described in subdivision (e) shall be retroactive to the date on which the application was submitted to the department. Prior to the adoption of these regulations, rate increases based on scope of service changes shall be retroactive to the date on which the services were first added or expanded. Rate decreases shall not be retroactive unless they would result in a change of greater than 30 percent of the per-visit rate. Rate changes based on extraordinary circumstances, as described in

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subdivision (f), shall be effective on the first day of the clinic's fiscal year during which the reconsideration request is received.

(h) An FQHC or RHC "visit" means a face-to-face encounter between a center or clinic patient and a physician, physician assistant, nurse practitionel; certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, and any other health professional whose services would be reimbursed under the Medi-Cal program were the services not provided by an FQHC or RHC. 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: and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor: For adult day health care purposes, a visit equals one four-hour day of attendance. This subdivision is intended to clarify existing law.

(i) Multiple visits on the same day are independently reimbursable f a clinic or center patient sees more than one health care professional of a different discipline or specialty. For example, a medical visit and a dental visit on the same day would be reimbursed as two visits, as would visits with both a medical provider and a comprehensive perinatal practitionel; as defined in Section 51179.7 of Title 22 of the California Code of Regulations.

(j) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a local initiative, commercial plan, the Medicare program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse a 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 shall only include receipts for recognized visits that are within the definition of a FQHC or RHC visit in the applicable state plan.

(k) (1) An entity that j r s t qualifies as a FQHC or RHC in a center or clinic fiscal year ending in the year 2001 or later shall have its rate set in accordance with the following:

(A) The rate shall be calculated on a per-visit basis in an amount that is equal to 100 percent of its costs of furnishing the services described in subdivision (a) or (b) during the initial fiscal year based on the rates established under this section for the fiscal

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year for other centers or clinics located in the same or adjacent area with a similar case load.

(B) In the absence of any adjacent qualified center or clinic with a similar case load, the rate may be based on:

(i) The method described in Section 1396a(aa)(2) of Title 42 of the United States Code.

(ii) Any other test of reasonableness as set forth in regulations setting forth an alternative test of reasonableness and promulgated under Section 1396a(aa)(4) of Title 42 of the United States Code.

(iii) The rates established for the fiscal year for other centers or clinics located in a reasonably similar geographic area within the state with a similar case load.

(2) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the date that the entity first qualified as a FQHC or RHC. The center or clinic 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 center's or clinic's prospective payment rate at that time.

(3) *The department shall inform the newly qualified entity of its new rate no later than 90 days following the date on which the center or clinic informs the department of its qualification as an FQHC or RHC.*

(l) 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 shall be billed by and reimbursed at the same rate as the center or clinic establishing the intermittent clinic site, subject to the right of the center or clinic to request a scope of service adjustment to the rate.

(m) 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 center or the clinic base rate as scope of service changes.

(n) Notwithstanding any other provision of law, FQHCs and RHCs may appeal a grievance or complaint concerning rate setting, scope of sewice changes, settlement of cost report audits, payment of amounts due under this section, or the processing or

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payment of money alleged by a provider of services to be payable by reason of any of the provisions of this section, in the manner prescribed by Section 14171.

(o) By November 1,2002, the department shall submit a state plan amendment to thefederal Centersfor Medicare and Medicaid Services to implement this section. To the extent that any element or requirement of this section is not approved, the department shall submit a request to thefederal Centersfor Medicare and Medicaid Servicesfor any waivers that would be necessary to implement this section.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. Thefacts constituting the necessity are:

In order to ensure the availability of essential health care servicesfor low-income and uninsured or underinsured persons, it is necessary that this act take effect immediately.

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SENATE HEALTH AND HUMAN SERVICES
COMMITTEE ANALYSIS
Senator Deborah V. Ortiz, Chair

BILL NO: SB 1413
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AUTHOR: Chesbro
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AMENDED: March 21, 2002
HEARING DATE: April 24, 2002
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FISCAL: Appropriations/URGENCY
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CONSULTANT:
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Matosantos / ak

SUBJECT

Medi-Cal

SUMMARY

Replaces the Medicare Economic Index with the medical care component of the California consumer price index for the purposes of adjusting FQHC/RHC rates. Implements a mechanism to incorporate a scope-of-service change within the FQHC/RHC reimbursement rate. Clarifies procedures for reimbursing new clinics and intermittent sites. Clarifies visits to be reimbursed at the prospective payment rate. Provides an elective carve out of pharmacy or dental services as an alternative to discontinuation.

ABSTRACT

Existing law:
1. Requires that the phase-out of cost based reimbursement methodology for federal qualified health centers (FQHCs) and rural health centers (RHCs) be replaced by a minimum per visit payment rate in the form of a prospective payment system (PPS) effective on January 1, 2001. Requires that this minimum per visit payment rate be
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adjusted annually for changes in the scope of services provided by the federally qualified health center or rural health clinic, and be increased by the Medicare Economic Index. Provides states the option to choose to use an "Alternative Payment Methodology" in lieu of the PPS, if certain conditions are met.

2. Requires states to submit a state plan amendment to implement the new reimbursement methodology for FQHCs/RHCs by March 31, 2001. Requires that center/clinic rates be modified on October 1, 2001, for changes in the scope of FQHC/RHC services provided.

3. Establishes a new reimbursement methodology for FQHCs/RHCs.

DHS proposes reimbursing existing clinics under a prospective payment system or an alternative payment methodology. Services reimbursed under the proposed reimbursement methodologies include most services provided by clinics, but exclude several services generally reimbursed by Medi-Cal including speech pathology, audiology, physical therapy, and acupuncture.

This bill:

1. Requires DHS to adjust the reimbursement rate for clinics based on the medical care component of the California consumer price index, instead of the Medicare Economic Index.

2. Requires implementation of a mechanism to revise reimbursement rates to reflect scope of service changes. The proposed methodology includes consideration of changes due to:

Amended regulatory requirements,

Relocation, remodeling or opening a clinic,

Changes in the types of services to incorporate new technology,

An increase in service intensity attributable to changes in the types of patients served, and

Changes in services or provider mix provided by an

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FQHC/RHC.

1. Provides for discretionary rate changes where

extraordinary circumstances beyond the control of the clinic threaten the continued existence of the clinic.

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2. Changes the definition of a reimbursable visit to include reimbursement for all services that are currently reimbursed as visits under Medi-Cal. Proposes reimbursing providers for multiple visits on the same day that involve more than one health care professional of a different discipline or specialty.

3. Clarifies the effective date of the clinic's new rate and permits clinics to continue to be compensated for Medi-Cal services on a fee-for-service basis in the period prior to the setting of the clinic's rate, with subsequent reconciliation to the PPS rate.

4. Permits FQHCs/RHCs to be reimbursed on a fee-for-service basis for pharmacy and dental services in the event that the significantly increased costs associated with these services require closure of on-site pharmacies or dental facilities.

FISCAL IMPACT

Unknown.

BACKGROUND AND DISCUSSION

Currently, there are a total of 345 federally qualified health centers (FQHCs) and 225 rural health clinics (RHCs) in California. All of the FQHCs, and a majority of the RHCs, are non-profit community clinics or government entities. They are open-door providers treating patients on a sliding fee scale basis, and making their services available regardless of patients' ability to pay.

FQHCs and RHCs serve significant uninsured and underinsured

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populations, and their continued survival depends heavily on the stability and adequacy of receipts from the Medi-Cal program. California has historically provided reimbursement of 100% of the reasonable, allowable (under Medicare reasonable cost principles) costs for FQHCs and RHCs. Reimbursement to centers/clinics is provided through the Medi-Cal Program for this purpose. Under the cost based reimbursement process, the DHS used state audit staff to

review clinic costs to discern that a clinic's costs are "allowable" and to determine the eventual cost-based reimbursement amount. 0280

Federal law enacted in 2001 amended the Social Security Act by phasing out reasonable cost-based reimbursement requirements for FQHC/RHC services. This phase-out of the requirement was replaced by a new prospective payment system (PPS) which went into effect on January 1, 2001. States were given the option to choose to use an "Alternative Payment Methodology" in lieu of the PPS, if certain conditions are met.

States were required to submit a Medicaid State Plan Amendment (SPA) to the Health Care Financing Authority (HCFA) by no later than March 31, 2001 to transition to the new PPS requirement or to use an Alternative Payment Methodology.

California submitted its SPA on March 29, 2001. DHS proposed reimbursing existing clinics under a prospective payment system or an alternative payment methodology. Facilities that qualified as an FQHC or an RHC prior to the close of the 2000 fiscal years were authorized to choose either of the proposed reimbursement methodologies. FQHCs reimbursed under the Los Angeles Medicaid 1115 waiver are required by the Special Terms and Conditions of that waiver to be reimbursed, for the term of the waiver, for 100% of their reasonable and allowable costs, but are permitted to elect the prospective payment rate if they choose. Services reimbursed under the proposed reimbursement methodologies include most services provided by clinics, but exclude several services generally reimbursed by Medi-Cal including speech pathology, audiology, physical therapy, occupational therapy, and acupuncture.

Under the prospective payment methodology, each FQHC or RHC
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receives payment in an amount that is equal to 100 percent of the average cost based reimbursement rate per visit for fiscal years 1999 and 2000. In subsequent years, DHS will adjust FQHC/RHC reimbursement rates by the Medicare Economic Index.

Under the Alternative Payment Methodology, the reimbursement rate for an FQHC or RHC would be based on the reported cost based rate for the 2000 fiscal year for the particular clinic. This rate would be adjusted on a yearly basis by the Medicare Economic Index.

The Centers for Medicare and Medicaid Services, in their

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letter of approval of the proposed methodologies, clarified that the same definition of a clinic visit must be used in the 1999/2000 base years as in the SPA, requested that the Department clarify the process for revising rates to incorporate changes in the scope of services, and requested clarification regarding an FQHC/RHC's ability to participate in risk arrangements with managed care organizations to ensure that it was in compliance with federal law and policy. 0281

The Department **of** Health Services submitted a new state plan amendment to CMS on March 29, 2002. The new state plan amendments adds four or more hours of Adult Day Health Care services per day as a billable visit and adds a new section regarding reimbursement to FQHCs/RHCs for additional costs incurred as a result **of** "extraordinary events". The SPA also clarifies rate-setting procedures for new facilities and defines a process for scope of services rate adjustments.

SB 1413 seeks to ensure the continued financial stability of FQHCs and RHCs in California. Specifically, it replaces the MEI with the medical care component of the consumer price index for California for the purposes of adjusting FQHC/RHC rates, it implements a mechanism to incorporate a scope-of-service changes within the FQHC/RHC reimbursement rate, it clarifies procedures for reimbursing new clinics and intermittent sites, and it provides an elective carve out of pharmacy or dental services as an alternative to discontinuation.

POSITIONS

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Support: Alameda Health Consortium
Alta Family Health ClinicClinicas De Salud Del Pueblo, Inc.
California Primary Care Association
Community Health Partnership
Copper Towers Family Medical Center
Council of Community Clinics
Darin **M.** Camarena Health Centers, Inc.
Del Norte Clinics, Inc.
Escondido Community Health Center
Family Healthcare Network
Family Health Centers **of** San Diego
Indian Health Council, Inc.

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La Maestra Family Clinic
LifeLong Medical Care
Livingston Medical Group
Long Valley Health Center
Marin Community Clinic
Mendocino Community Health Clinic, Inc.
Mid-City Community Clinic
National Health Services, Inc.
North Coast Clinics Network
North County Health Services
North East Medical Services
Northeastern Rural Health Clinics, Inc.
Open Door Community Health Centers
Salud Para La Gente, Inc.
San Ysidro Health Center
Shasta Community Health Center
Shasta Consortium **of** Community Health Centers
Shingletown Medical Center, Inc.
Siskiyou Family Healthcare, Inc.
Southern Trinity Health Services
Southwest community Health Center
Vista Community Clinic

West Oakland Health Council, Inc.
11 individual letters

0283

Oppose: None received

-- END --

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