S270326
(3d Dist. Ct of Appeal No. C089555)

IN THE SUPREME COURT OF THE STATE OF CALIFONRIA

FAMILY HEALTH CENTERS OF SAN DIEGO,
PLAINTIFF AND APPELLANT
V.
STATE DEPARTMENT OF HEALTH CARE SERVICES,
DEFENDANT AND RESPONDENT

APPEAL FROM THE SUPERIOR COURT OF CALIFORNIA
SACRAMENTO COUNTY
NO. 34201880002953CUWMGDS
THE HON. STEVEN M. GEVERCER

MOTION FOR JUDICIAL NOTICE IN SUPPORT OF *AMICUS CURIAE BRIEF* FILED BY THE CALIFORNIA PRIMARY CARE ASSOCIATION

Deborah J. Rotenberg (SBN: 241613)
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Counsel for Amicus Curiae
California Primary Care Association

To the Honorable Chief Justice and Associate Justices of the California Supreme Court:

Pursuant to California Rules of Court, rule 8.252, and California Evidence Code, sections 451, 452 and 459, Amicus Curiae California Primary Care Association hereby moves this Court to take judicial notice of the following documents in support of its Amicus Brief in support of Plaintiff and Appellant Family Health Centers of San Diego, filed concurrently herewith:

A. The California Primary Care Association ("CPCA") "2021 State Profile;"

B. CPCA "All California District Profiles (2017);"

C. The Department of Health Care Services, Medi-Cal Eligibility Statistics;

D. Medicare Provider Reimbursement Manual, Sections 2102.2 and 2102.3;

E. The California State Medicaid Plan, as approved by CMS, Section 4.19B, pages 6-11, relating to "Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)."

These materials are relevant to the overall understanding of the FQHC provider type generally, as well as the requirements imposed on Medi-Cal with respect to calculating an FQHC's reimbursement rate under both state and federal law.

This motion is based on the attached Memorandum of Points and Authorities and Declaration of Deborah J. Rotenberg, the records and files of this Court, and the accompanying proposed order granting this motion.

DATED: May 12, 2022

Respectfully submitted,
DJR García, APC
By

_____
Deborah J. Rotenberg
Attorneys for *Amicus Curiae*
California Primary Care
Association

Memorandum of Points and Authorities

INTRODUCTION

Applicant Amicus Curiae California Primary Care Association ("CPCA") seeks judicial notice of documents to assist the Court in understanding the unique nature and role played by California's federally-qualified health centers ("FQHCs") and the various complexities associated with FQHC rate-setting under the Medi-Cal program. Amicus Curiae is offering fact sheets, statistics, and other materials that explain the number of FQHCs in California, the number of Medi-Cal patients served by FQHCs, and the costs-savings of utilizing FQHCs in delivering healthcare through the Medi-Cal program. To assist the Court in understanding the State's obligation to pay for FQHCs' costs in delivering healthcare to Medi-Cal beneficiaries, a key policy issue presented in this case, CPCA is offering the relevant portions of California's State Plan Amendment applicable to FQHC rate-setting.

A. General Principals of Judicial Notice

"Judicial notice is the recognition and acceptance by the court, for use ... by the court, of the existence of a matter of law or fact that is relevant to an issue in the action without requiring formal proof of the matter." (*Lockley v. Law Office of Cantrell, et*

al. 91 Cal.App.4th 875, 882 (2001).) "The underlying theory of judicial notice is that the matter being judicially noticed is a law or fact that is not reasonably subject to dispute." (Ibid. [emphasis original]; see Evid. Code,§ 452(h).)

This Court may take judicial notice of any materials that are: (1) specified in Evidence Code, section 452, and (2) relevant to the dispositive questions before the court. (Evid. Code, § 459; *Hughes Electronics Corp. v. Citibank Delaware* 120 Cal.App.4th 251, 266, fn. 13 (2004) [material must be relevant to be subject to judicial notice].) The materials specified in Evidence Code, section 452 include records of "any court of this state" and items "that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (Evid. Code,§ 452(c), (h).)

B. All Exhibits Are Noticeable And Relevant

Amicus Curiae respectfully submits this Court should notice the documents attached as Exhibits A, B, C, D, and E to the Rotenberg Declaration.

Exhibit A is a fact sheet published publicly by CPCA relating to various statistics governing the number of FQHCs in California and the patients and special populations they serve. As CPCA is the federally designated Primary Care Association for FQHCs in California, these statistics and facts are not reasonably subject to dispute, and the Court may take judicial notice of them under Evidence Code Section 452(h). This

information is relevant for understanding the critical role that effective FQHC outreach activities play in the delivery of healthcare to California's most underserved communities.

Exhibit B is similarly a fact sheet of historical data that was published publicly by CPCA in 2017 and compiled by CPCA in its role as the federal PCA; this information is judicially noticeable by the Court as the statistics and facts contained therein are not reasonably subject to dispute. This is information is relevant for understanding the important public health and fiscal policies advanced by utilizing FQHCs to deliver Medi-Cal services in California.

Exhibit C is noticeable as an official act of the executive branch of the State of California, as it is a record compiled by the California Department of Health Care Services ("DHCS") relating to Medi-Cal enrollment statistics. DHCS is the state entity charged with administering the Medi-Cal program, and statistics relating to the number of beneficiaries enrolled in this program are relevant to the matter at hand as they illustrate the number of Medi-Cal patients served by FQHCs statewide.

Exhibit D is noticeable as an official act of the executive branch of the United States, as it contains published provisions from the Medicare Provider Reimbursement Manual governing what constitutes allowable costs for patient care under the Medicare Program. These provisions were relied upon heavily by the Defendant-Respondent and the Court of Appeal and are central to the issue before this Court in this matter.

Exhibit E is Section 4.19B of the California State Medicaid Plan, relating to the requirements that an FQHC must meet to participate in Medicaid. It is noticeable as an official act of the executive branch of both the federal government and the State of California, and is relevant to this matter because it is the legal underpinning governing how the State is required to reimburse FQHCs under the Medi-Cal program.

C. Presentation To The Tribunals Below

To the best of the Amicus Curiae's knowledge, none of these materials were presented in full to the administrative law judge, trial court, or the Court of Appeal, and therefore judicial notice was not taken by those tribunals.

D. Timing Of The Request

The matters to be noticed do not relate to proceedings occurring after the order or judgment that is the subject of the appeal. However, Amicus Curiae did not submit an amicus brief to the trial court or the Court of Appeal, and thus, Amicus Curiae has not previously had the opportunity to request judicial notice of the documents presented as Exhibits A, B, C, D, and E to the Rotenberg Declaration.

CONCLUSION

For the reasons set forth above, Amicus Curiae respectfully requests this Court take judicial notice of the documents attached as Exhibits A, B, C, D, and E to the Rotenberg Declaration.

DATED: May 12, 2022

Respectfully submitted,
DJR García, APC
By

_____
Deborah J. Rotenberg
Attorneys for *Amicus Curiae*
California Primary Care
Association

DECLARATION OF DEBORAH J. ROTENBERG
[Cal. Rules of Court, rule 8.54(a)(2)]

I, Deborah J. Rotenberg, declare:

1. I am an attorney in good standing, licensed to practice before the courts of this state. I am the CEO/Shareholder of DJR García, APC, counsel of record for Amicus Curiae California Primary Care Association in this matter**.**

2. Attached hereto as Exhibit A is a true and correct copy of the California Primary Care Association's ("CPCA") "2021 State Profile," which I obtained from CPCA's website at https://www.dropbox.com/s/fk25l6guc1prqv0/2021_CPCA_CAstateprofile.pdf?dl=0 on May 12, 2022.

3. Attached hereto as Exhibit B is a true and correct copy of CPCA's "All California District Profiles (2017)," page 1, which I obtained via email from the California Primary Care Association on August 10, 2021.

4. Attached hereto as Exhibit C is a true and correct copy of the Department of Health Care Services' ("DHCS") Medi-Cal Eligibility Statistics, which I obtained from DHCS' website at https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx on May 12, 2022.

5. Attached hereto as Exhibit D is a true and correct copy of the Medicare Provider Reimbursement Manual, Sections 2102.2 and 2102.3, which I obtained from the Centers for Medicare & Medicaid Services' website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 on May 12, 2022.

6. Attached hereto as Exhibit E is a true and correct copy of the California State Medicaid Plan, as approved by CMS, Section 4.19B, pages 6-11, relating to "Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)," which I obtained from the Department of Health Care Services' website at https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Attachm ent-4-19B-6-6Y.pdf. on May 12, 2022.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed May 12, 2022, in Sacramento, California

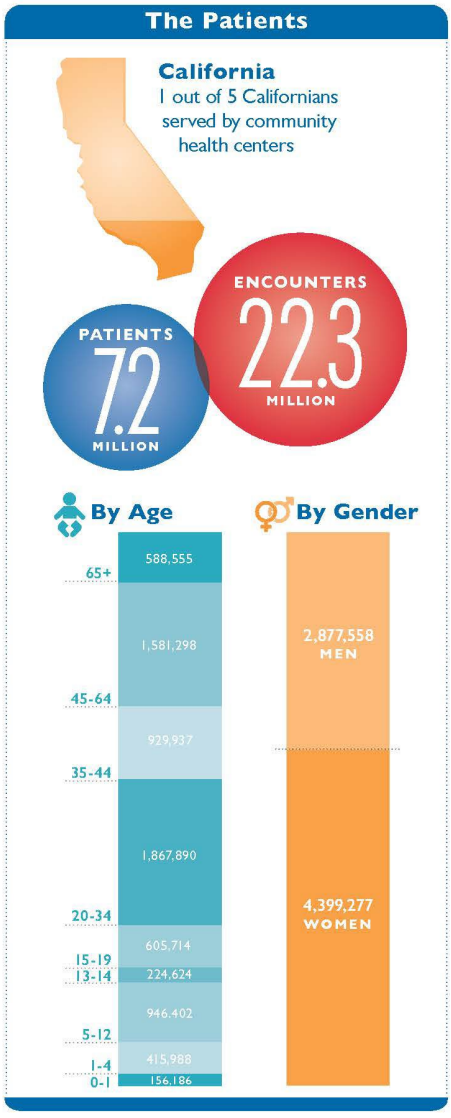
Deborah J. Rotenberg

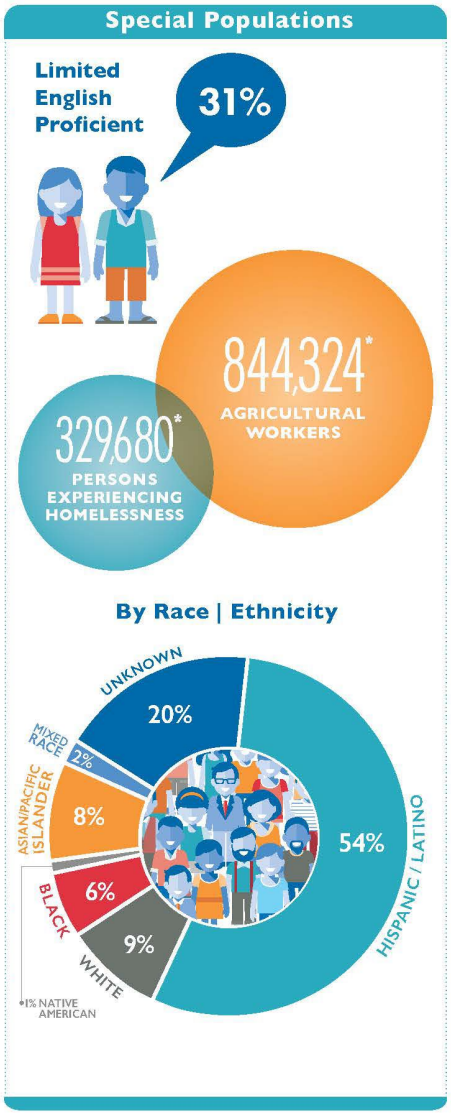
EXHIBIT A

CALIFORNIA PRIMARY CARE ASSOCIATION

COMMUNITY HEALTH CENTERS

2021 STATE PROFILE





Data is based on 2020 OSHPD AUR.

**Special Populations data is specific to Federally Qualified Health Center (FQHC) collected data only.*

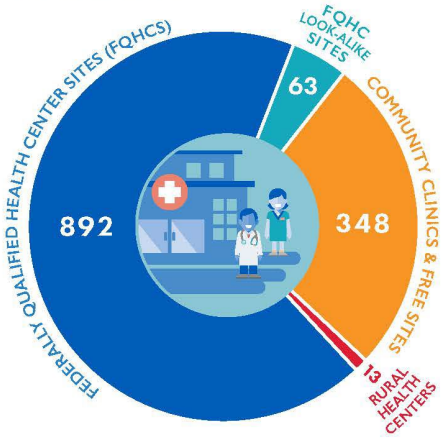
CALIFORNIA PRIMARY CARE ASSOCIATION

COMMUNITY HEALTH CENTERS

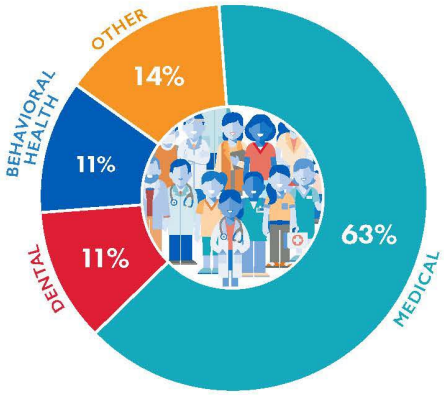
2021 STATE PROFILE

Community Health Centers

1,303 total licensed CCHCs

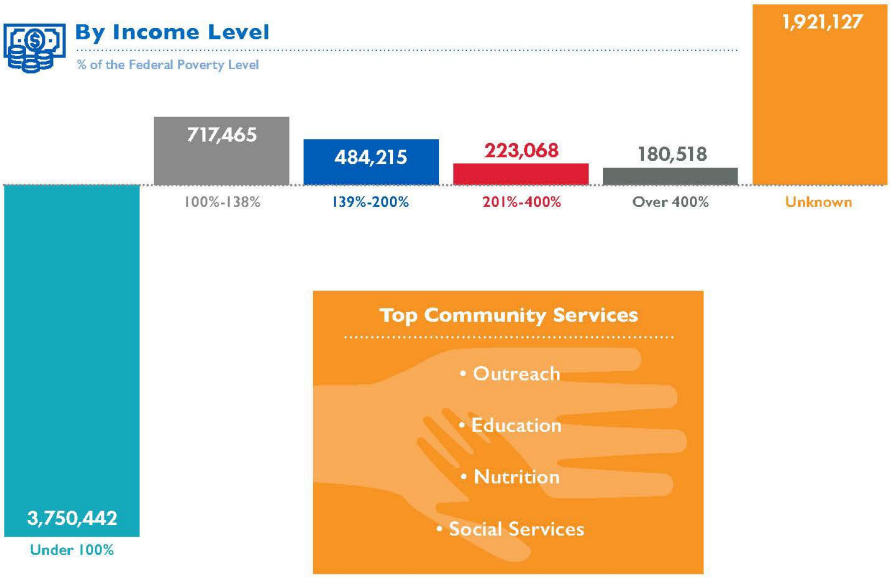


Clinical Services



By Income Level

% of the Federal Poverty Level



Top Community Services

- Outreach
- Education
- Nutrition
- Social Services

Data is based on 2020 OSHPD AUR.

EXHIBIT B

Value of Health Centers TODAY

California's Federal District 1

Prepared by:
CAPITAL LINK
www.caplink.org

Federally Qualified Health Centers (FQHCs) and other safety-net clinics are locally-controlled, non-profit organizations that offer a range of quality services, including primary care, behavioral health, dental and vision. In 2015, California health centers contributed over **$8 billion in total economic impact** and **over 59,000 jobs**. These health centers served **20% of the Medi-Cal population**, but received only **2.8% of total Medi-Cal expenditures**.

District 1 Health Centers Provide...

JOBS
and other positive impacts on the **ECONOMY**

- **1,637** TOTAL JOBS
- **$195,892,017** TOTAL ECONOMIC IMPACT of current operations
- **992** HEALTH CENTER JOBS and **645** OTHER JOBS IN THE COMMUNITY
- **$117,549,970** DIRECT HEALTH CENTER SPENDING
- **$78,342,047** COMMUNITY SPENDING

SAVINGS
to the health system

- **22%** LOWER COSTS FOR HEALTH CENTER MEDI-CAL PATIENTS compared to other providers
- **$117 Million** SAVINGS TO MEDI-CAL
- **$187 Million** SAVINGS TO OVERALL HEALTH SYSTEM

ACCESS
to care for vulnerable populations

- **15%** three-year PATIENT GROWTH
- **91%** of patients are LOW-INCOME (Below 200% of the Federal Poverty Level)
- **109,378** PATIENTS SERVED
- **32,757** patients are CHILDREN AND ADOLESCENTS
- **12%** of patients identify as an ETHNIC OR RACIAL MINORITY

Since 2012:

- **45%** decline in UNINSURED PATIENTS
- **14,177** additional patients covered by MEDI-CAL
- **48%** of total health center patients COVERED BY MEDI-CAL

EXHIBIT C

Medi-Cal Enrollment

Enrollment in Medi-Cal, California's Medicaid program, represents approximately one-third of the state's population. The information that can be accessed from this page represents the most recent data regarding Medi-Cal enrollment. Currently, about 83 percent of enrollees have coverage provided by a Medi-Cal managed care plan, while other enrollees receive their care through the fee-for-service delivery system.

Monthly Statewide Medi-Cal Enrollment

Month	Medi-Cal Enrollment
June 2021	13,981,096
May 2021	13,962,162
April 2021	13,904,378
March 2021	13,814,922
February 2021	13,715,668
January 2021	13,661,259
December 2020	13,525,178
November 2020	13,374,644
October 2020	13,292,449
September 2020	13,200,120
August 2020	13,104,940

EXHIBIT D

2100. PRINCIPLE

All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries or, in the case of acute care hospitals, the prospective payment system (PPS). (See Chapter 28 on PPS.) Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.--These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs Not Related to Patient Care.--Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Such costs are not allowable in computing reimbursable costs and include, for example:

- Cost of meals sold to visitors;
- Cost of drugs sold to other than patients;
- Cost of operation of a gift shop;

- Cost of alcoholic beverages furnished to employees or to others regardless of how or where furnished, such as cost of alcoholic beverages furnished at a provider picnic or furnished as a fringe benefit;

- Cost of gifts or donations;

- Cost of entertainment, including tickets to sporting and other entertainment events;

- Cost of personal use of motor vehicles;

- Cost of fines or penalties resulting from violations of Federal, State, or local laws;

- Cost of educational expenses for spouses or other dependents of providers of services, their employees or contractors, if they are not active employees of the provider or contractor;

- Cost of meals served to executives that exceed the cost of meals served to ordinary employees due to the use of separate executive dining facilities (capital and capital-related costs), duplicative or additional food service staff (chef, waiters/waitresses, etc.), upgraded or gourmet menus, etc.; and

- Cost of travel incurred in connection with non-patient care related purposes.

2102.4 Donations to a Provider of Produce, Supplies, Space, Etc.--If a provider receives a donation of produce, supplies, the use of space owned by another organization, etc., the provider may not properly impute a cost for the value of the donations and include the imputed cost in allowable costs. If an imputed cost has been included in the provider's costs, that amount is deleted in determining allowable costs. If the provider and donor organization are both part of a larger organizational entity, such as units of a state or county government, costs related to the donations are includable in the allowable costs of the provider. For example, if a county home health agency is given space to use in the county office building, costs related to that space may be included in the agency's costs, e.g., depreciation, costs of janitorial services, maintenance and repairs.

EXHIBIT E

STATE PLAN AMENDMENT
PROSPECTIVE PAYMENT REIMBURSEMENT

A. General Applicability

1. Notwithstanding any other provision of this State Plan, reimbursement to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the types of services described in this Amendment will be made as set forth below. *This* Amendment will apply to Medi-Cal Services furnished to Medi-Cal beneficiaries for purposes of implementing Section 1902(bb) of the Social Security Act (the Act).

2. Under the California Section 1115 Medicaid Demonstration Project for Los Angeles No. 11 W-00076/9 (LA Waiver), specified FQHCs (or "FQHC look alike clinics") received 100 percent cost-based reimbursement under the Special Terms and Conditions of that waiver. Beginning July 1, 2005, FQHCs that received cost-based reimbursement under the LA Waiver will be paid under the methodology described under Section I.

3. Any facility that first qualified as an FQHC or RHC (as defined in Section B) prior to the close of its fiscal year ending in calendar year 2000 was reimbursed through the prospective payment methodology described under Section D, unless, within 30 days of written notification from DHS, the facility elected to be reimbursed under the alternative payment methodology described under **Section** E. If the alternative payment methodology described under Section E was selected by the facility, the initial selection of a payment methodology remained in effect through September 30, 2002.

4. Prior to October 1, 2002, each FQHC and RHC was required to choose a reimbursement method and to inform DHS of its election. The choice was whether its reimbursement rate calculation, which was to serve as the basis for all future Medicare Economic Index (MEij increases and scope-of-service changes, would be either of the following:

   (a) The prospective payment reimbursement methodology described under Section D.

   (b) The alternative payment reimbursement methodology described under Section E.

For purposes of this segment of the State Plan, relating to prospective reimbursement for FQHCs and RHCs, the MEI is the annual percentage increase in costs as defined in Section 1842(i)(3) of the Act for primary care services, defined in Section 1842(i)(4) of the Act. The MEI is published each year in the Federal Register. The base rate selected for purposes of reimbursement under the methodology described under Section Dor Section Eis inclusive of the MEI increases that applied prior to October 1, 2002, as described under Section O and Section E. An FQHC or RHC that failed to notify OHS of its election of the alternative payment methodology within 30 days of written notification was assigned a reimbursement rate calculated using the prospective payment methodology described under Section 0.

5. Provider-based entities are defined as the following:

(a) An FQHC that was provider-based as of July 1, 1998, or that had provider-based status pending on April 22, 1999, and has received Medi-Cal payments based on its provider-based status continuously since that date, was paid under either the prospective payment methodology (Section 0) or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its FQHC provider-based status. The term "appropriately adjusted" means that an FQHC's provider-based rate includes the amount of the hospital's total costs allocable to the FQHC. These costs are in addition to those costs directly attributable to the operation of the FQHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If an FQHC receives "FQHC provider-based" designation under Medicare, pursuant to 42 CFR Part 413.65(n), from CMS, the FQHC may apply to OHS for Medi-Cal provider-based FQHC reimbursement status. Upon verification of such status, the FQHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its FQHC provider-based status.

(b) In accordance with 42 CFR Section 491.3, an RHC that received provider-based designation and RRC certification under Medicare from CMS as a "provider-based RHC", will continue to be paid under either the prospective payment methodology (Section 0), or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its RHC provider-based status. The term "appropriately adjusted" in this context means that an RHC's provider-based rate includes the amount of the hospital's shared costs allocable to the RHC. These costs are in addition to those

costs directly attributable to the operation of the RHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If subsequent to the approval of this State Plan Amendment, an RHC receives provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", pursuant to 42 CFR Part 41 3.65, the RHC may apply to DHCS for Medi-Cal provider-based RHC reimbursement status pursuant to 42 CFR Part 491.3. Upon verification of such status, the RHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its RHC provider-based status.

6. An FQHC or RHC may elect to have pharmacy services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. An FQHC or RHC that elects to have pharmacy services reimbursed on a fee-for-service basis will not have its reimbursement rate for those services converted to a fee-for-service basis until the FQHC or RHC completes a scope-of-service rate change request and the adjustment to the prospective payment system reimbursement rate has been completed. An FQHC or RHC that reverses its election under this provision will revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period adjusted for any increase or decrease associated with an applicable scope-of-service change as provided in Section K.

B. FQHCs and RHCs Eligible for Reimbursement Under This Amendment

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Federally Qualified Health Center" or "Rural Health Clinic" in Section 1905(1)(2)(B), and Section 1905(1)(1), respectively, ofthe Act.

C. Services Eligible for Reimbursement Under This Amendment

I. (a) Services eligible for prospective or alternative payment reimbursement are covered benefits described in Section 1905(a)(2)(C) of the Act that are furnished by an FQHC and services described in Section 1905(a)(2)(B) of the Act that are furnished by an RHC. The services furnished will be reported to DHCS annually, in a format prescribed by DHCS.

(b) Optional services that are furnished by an FQHC and RHC within the scope of subparagraph C.l(a), or any other provision of this State Plan, are covered only to the extent that they are identified in the State Plan segments titled, "Limitations on Attachment 3.1-A" and "Limitations on Attachment 3.1-B" on pages 3 through 3e, effective July 1, 2016.

2. A "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:

(a) A face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, acupuncturist, certified nurse

midwife, clinical psychologist, licensed clinical social worker, dental hygienist, a dental hygienist in alternative practice, marriage and family therapist, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.I.(a). For purposes of this subparagraph 2(a), "physician" includes the following:

(i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.

(ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.

(iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.

(iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

(b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner.

3. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

   (a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

   (b) The clinic patient has a face-to-face encounter with a.dentist and then also has a face-to-face encounter with any one of the following providers: physician (as defined in subparagraphs C.2(a)(i)-(iv)), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or a comprehensive perinatal services practitioner.

D. Prospective Payment Reimbursement

An FQHC or RHC that does not elect the alternative payment reimbursement methodology under Section E will receive reimbursement under the following prospective payment reimbursement methodology provisions:

1. On July 1, 2001, DHS implemented a prospective payment reimbursement methodology on a phased-in basis. Each FQHC or RHC receives payment in an amount calculated using the methodology described under paragraphs D.2 and D.4 effective the first day of the fiscal year on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section D became effective for a particular facility, each FQHC or RHC was paid in accordance with Section H.

2. (a) Beginning on January 1, 2001, the prospective payment reimbursement rate for an FQHC or RHC was equal to 100 percent of the average reported cost-based reimbursement rate per visit for fiscal years 1999 and 2000 for the FQHC or the RHC, as determined in accordance with cost reimbursement principles for allowable costs explained in 42 CFR Part 413, as well as, Generally Accepted Accounting Principles. For each FQHC or

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph b.2(a) was calculated using a visit defmition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week, or mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity, as well as, licensed or enrolled as a Medi-Cal provider.

4. Effective October 1 51 of each year, for services furnished on and after that date, DHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section 1 842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

1. Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January l, 2001, until the payment methodology described in this Section E became effective for the

particular facility, the FQHC or RHC was paid in accordance with Section H.

(a) Payments made to each FQHC or RHC in accordance with the alternative payment reimbursement methodology set forth in this Section E will be an amoun(calculated on a per-visit basis) that is, equal to its reported cost-based rate (based on allowable costs) for the particular facility's fiscal year ending in calendar year 2000, increased by the percentage increase in the MEI. OHS determines all rates in accordance with cost reimbursement principles in 42 CFR Part 413, and with Generally Accepted Accounting Principles..

(b) (i) Each participating FQHC's or RHC's reported cost-based reimbursement rate (calculated on a per-visit basis) for the particular facility's fiscal year ending in calendar year 2000 serves as its prospective payment reimbursement rate under the alternative payment reimbursement methodology.

(ii) If the cost per visit for the period used to establish the alternative payment methodology rate in subparagraph E. l(b)(i) was calculated using a visit definition that does not conform with Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certification of accuracy within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC in determining if a rate adjustment was necessary. Subparagraph E.l(b)(ii) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

(c) As described in more detail below, the prospective payment reimbursement rate is increased by the percentage increase in the MEI applicable to primary care services, defined in Section 1842(i)(4) of the Act, for the particular calendar year as published in **the Federal Register.**

(d) Beginning July 1, 2001 and thereafter, the MEI increase is applicable to the period starting with the mid-point of each FQHC's or RHC's fiscal year through the mid-point of the rate periods (January l, 2001 through June 30, 2001 and July 1, 2001 through September 30, 2002).

For example, if a FQHC or RHC had a June 30th fiscal year end, the period determining the first MEI increase was December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) through April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30, 2001). The period determining the second MEI increase was April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If a FQHC or a RHC has a December 31st fiscal year end, the period detennining the first MEI increase was June 30, 2000 through April l, 2001. As in the previous example, the period detemrining the second MEI increase was April I, 2001 through February 15, 2002.

(e) In accordance with Section 1902(bb)(6)(B) of the Act, in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, the rate must be no less than the rate calculated using the methodology described in Section D.

2. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week or in mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when it is owned or operated by the same entity and is licensed or enrolled as a Medi-Cal provider.

3. Beginning October l, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHS will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.l{c), above).

F. Alternative Pay_ment Methodology for an **Existing** FOHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DHS will establish a rate {calculated on a per-visit basis) that is equal to either of the following (as selected by the FQHC or RHC):

(a) The average of the rates established for three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph is subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal

year of the facility's operation at the newly relocated site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

2. A rate established for an existing FQHC or RHC under this Section F is effective for visits occurring at the new facility.

G. Payment Methodology for Extraordinary Circumstances

1. Supplemental payments, in proportion to the Medi-Cal services provided by the facility, may be established in accordance with this Amendment to reflect the net realized additional costs (as approved by OHS), not otherwise reimbursed by other sources, incurred as a result of extraordinary circumstances attributed to any of the following:

   (a) Acts of nature (e.g., flood, earthquake, lightning, or storms).

   (b) Acts of terrorism.

   (c) Acts of war.

   (d) Riots.

   (e) Changes in applicable requirements in the Health and Safety Code.

   (f) Changes in applicable licensing requirements.

   (g) Changes in state or federal laws or regulations applicable to FQHCs or RHCs.

2. The supplemental payment provided for in this Section G will apply only to the extent, and only for the period of time, that the additional costs for the event specified in paragraph G.1 are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation.

3. Where applicable, the supplemental payment provided in this Section G will be governed by cost reimbursement principles identified in 42 CFR

Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

4. A request for supplemental payment will be accepted by DHS at any time in the prospective payment rate year. A request will be submitted for each affected year. A written request under this Section G must be made to DHS for its consideration and must include differences in costs and visits, if applicable, associated with operations before and after the event specified in paragraph G. l. Documentation in a manner and form specified by DHS showing the cost implications must be submitted. A supplemental payment will not be paid unless the cost impact will be material and signifkant (two hundred thousand dollars ($200,000) or 1.0 percent of an FQHC's or RHC's total costs, whichever is less).

5. DHS will decide whether a request for supplemental payment will be granted, and the amount of such payment. Amounts granted for supplemental payment requests will be paid as lump-sum amounts for those years and not as revised PPS rates. The FQHC or RHC must repay the unspent portion of the supplemental payment to OHS if it does not expend the full amount of the supplemental payment to meet costs associated with the catastrophic event.

6. The supplemental payment provided in this Section G is independent of a rate adjustment resulting from a scope-of-service change in accordance with Section K and will only be made for a qualifying event as described in this Section G. Costs eligible for a supplemental payment under this Section will be proportionate to the Medi-Cal services provided by the facility, determined utilizing a cost report format as specified by DHS, and will not include payment for any costs recovered as scope-of-service rate change(s) under Section K.

7. When determining eligibility for a supplemental payment, the FQHC or the RHC must show that its PPS rate is not sufficient to cover the costs associated with the extraordinary circumstance. If the PPS rate is sufficient to cover the costs associated with the events specified in paragraph G. l, or the PPS rate was adjusted to compensate the events specified in paragraph G.1, then no supplemental payment will be made.

H. Alternative Payment Methodology for Retroactive Reimbursement

I. For the period January l, 2001, until the date that a particular FQHC or RHC begins to receive payment pursuant to the methodology set forth in Section D or Section E, such FQHC or RHC may elect to retroactively receive reimbursement under Section Dor Section E, or to decline such reimbursement. An FQHC or RHC that fails to make an election within 30 days of written notification from DHS will receive retroactive payment

to January 1, 2001, under the prospective payment methodology described under Section D.

2. An FQHC or RHC that elected in writing to decline retroactive reimbursement under both Section D and Section E may continue to be paid under the cost-based reimbursement methodology as in effect prior to BIPA 2000 until payments under Section D or Section E take effect, subject to the requirements of Section 1902(bb)(6) of the Act, and to cost reconciliation when appropriate.

I. Alternative Payment Methodology for FQHCs Participating Under the LA Waiver

1. The LA Waiver expired on July l, 2005. FQHCs participating in the LA Waiver that were established as an FQHC (as defined in Section B) prior to 1999 and elected to remain under cost-based reimbursement must convert to a prospective payment system reimbursement rate, effective July 1, 2005. FQHCs as described above must choose one of the following options for calculating their prospective payment system reimbursement rate:

   (a) Utilize the average of their "as reported" FY 1999 and FY 2000 cost reports, plus adjustments for the annual MEI increases described under paragraphs D.2-5.

   (b) Utilize only the "as reported" FY 2000 cost report, plus adjustments for annual MEI increases as described under subparagraph E.l(a)-(e) and paragraph E.3.

2. On October 1, 2005 and each October 1st thereafter, DHS will adjust the rate established under subparagraphs I.l(a) or (b) by the applicable percentage increase in the MEI, as specified in paragraph D.4 or paragraph E.3.

3. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 1999, but prior to the close of their FY 2000 will have their prospective payment system reimbursement rate calculated according to the methodology described in subparagraph I.I(b) above, and will have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

4. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 2000 will have their prospective payment system reimbursement rate calculated based on the first full fiscal year "as audited" cost report adjusted by the applicable MEI increase(s) to bring the prospective payment system reimbursement rate current to July l,

2005, and will also have their prospective payment system reimbursement rate adjusted in accordance with paragraph 1.2 above.

5. FQHCs that failed to elect an option by June 30, 2005, under either subparagraphs I.l(a) or (b) above, will be assigned the prospective payment system reimbursement rate described in Section I.I(a). ·

6. FQHCs participating in the LA Waiver that had applicable scope-of-service change(s) prior to July 1, 2005, must submit a scope-of-service change request describing the qualifying event FQHCs must submit a scope-of-service change request no later than July 1, 2006.

J. Rate Setting for New Facilities

1. For the pwpose of this Section J, a new facility is an FQHC or RHC (as defined in Section B) that meets all applicable licensing or enrollment requirements, and satisfies any of the following characteristics:

   (a) First qualifies as an FQHC or RHC after its fiscal year ending on or after calendar year 2000.

   {b) A new facility at a new location is added to an existing FQHC or RHC and is licensed or enrolled as a Medi-Cal provider.

2. DHS will require that the new facility identify at least three comparable FQHCs or RHCs providing similar services in the same or an adjacent geographic area with similar caseload. If no comparable FQHCs or RHCs are in operation in the same or an adjacent geographic area, the new facility will be required to identify at least three comparable FQHCs or RHCs in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics. If the facility is unable to identify three comparable FQHCs or RHCs, DHS will identify at least three comparable facilities with respect to relevant social, health care, and economic characteristics.

3. At a new facility's one time election, DHS will establish a rate (calculated on a per visit basis) that meets the requirements of Section 1902(bb)(4) of the Act and that is equal to one of the following:

   (a) The average of the rates established for the three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph will be subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent bf the projected allowable costs of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph 0.4.

4. If a new facility does not respond within 30 days of OHS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), OHS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

5. The effective date for the rate of a new facility under Section J is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.

   (a) An FQHC or RHC may 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. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than 20 hours per week or in mobile facilities.

   (b) OHS will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following notification to the provider that its FQHC or RHC number has been activated.

6. In order to establish comparable FQHCs or RHCs providing similar services, OHS will require all FQHCs or RHCs to submit to DHS either of the following:

(a) Its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report.

(b) A similar report utilizing a format as specified by DHS applicable to the prior calendar year.

FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit a completed report in the format used in the prior calendar year. A new FQHC or RHC that has not previously submitted an annual utilization report will submit an annual utilization report or similar report as specified byDHS.

K. Scope-of-Service Rate Adjustments

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, subject to all of the following:

I. A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

(a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.

(b) The cost.is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

(c) The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(d) The net change in the FQHC's or RHC's per-visit rate equals or exceeds I.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the l. 75 percent threshold will be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

2. Rate changes based on a change in the scope-of-services provided by an FQHC or RHC **will be** evaluated in accordance with Medicare reasonable cost principles, as set forth in 42 CFR Part 413, or its successor. Subject

to the conditions set forth in subparagraphs (a) through (d), inclusive, of paragraph (1), a change in scope-of-service means any of the following:

(a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.

(b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C. 1 due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) An increase in the intensity of a service described in paragraph C.1 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) Changes in any of the services described in paragraph C.1, 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 paragraph C. 1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C. l.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C. l.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section Kif, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

5. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by OHS.

6. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and subsequent fiscal years will be calculated as follows:

(a) IfDHS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, OHS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

(b) The difference computed as in 6(a), between the newly calculated cost per-visit rate and the current PPS per-visit rate, is then multiplied by an 80 percent adjustment factor to arrive at an amoW1t that is to be considered applicable to a scope-of-service adjustment for that year.

(c) That 80 percent adjustment amount is then added to the current PPS rate and the newly established rate becomes the newly adjusted PPS reimbursement rate, effective the first day following the fiscal year end that the FQHC or RHC submitted the documentation for the scope-of-service change. For example, a FQHC or RHC has a:

(i) Newly established per-visit rate of $115.00,

(ii) Current PPS per-visit rate of $95.00,

(iii) July l, 2003, to June 30, 2004, fiscal year and a

(iv) Scope-of-service change date of February 15, 2004.

The newly established PPS rate is calculated and effective as follows:

(v) $20.00 is the difference between the newly established per-visit rate ($115.00) and the current PPS rate ($95.00),

(vi) $16.00 is the 80 percent adjustment amount ($20.00 X 80 percent),

(vii) $111.00 is the newly established PPS rate ($95.00 + $16.00),

(viii) July l, 2004, is the date the $111.00 rate becomes effective.

(ix) The MEI will be applied to the PPS rate established in calendar year 2004 and subsequent fiscal years on the first day of October that is not within the particular FQHC's or RHC's fiscal year. For anyFQHC or RHC that has a July l, 2003, to June 30, 2004, fiscal year (as described in the example above), October l , 2004, is the date of the MEI, which will be applied to the July 1, 2004, established PPS rate. For any FQHC or RHC that has a January 1, 2004 to December 31, 2004, fiscal year, October 1, 2005, is the

date the MEI will be applied to the January 1, 2005, established PPS rate.

(d) For scope-of-service changes implemented between the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001 and the last day of the FQHC's or RHC's fiscal year ending in'calendar year 2003, the reimbursement rate will be calculated by taking the difference between the newly established per-visit rate and the initial PPS rate, then multiplying the difference by 80 percent for either two or three periods, depending on when the scope-of-service change occurred and when the cost report is filed. For example, an FQHC or RHC has a:

(i) Newly established per-visit rate of $120.00,

(ii) Initial PPS rate of $95.00,

(iii) July 1, 2002, to June 30, 2003, fiscal year, and

(iv) Scope-of-service change date of February 15, 2001.

Then the retroactive PPS rate for the fiscal years in question is calculated and becomes effective as follows:

(v) $25.00 is the difference between the newly established per-visit rate ($120.00) and the initial PPS rate ($95.00),

(vi) $20.00 is the 80 percent adjustment amount ($25.00 X 800/o) for the July 1, 2002, to June 30, 2003, period, is added to the initial PPS rate for a PPS rate of $115.00 ($95.00 + $20.00), and is effective July 1, 2002, to September 30, 2003,

(vii) $16.00 is the 80 percent adjustment factor ($20.00 X 80%) for the July 1, 2001, to June 30, 2002, period, is added to the initial PPS rate for a PPS rate of $111.00 ($95.00 + $16.00), and is effective July l, 2001, to June 30, 2002,

(viii) $12.80 is the 80 percent adjustment amount ($16.00 X 800/o) for the January 1, 2001, to June 30, 2001, period, is added to the initial PPS rate for a PPS rate of $107.80 ($95.00 + $12.80), and is effective February 15, 2001, to June 30, 2001.

(ix) The MEI will be applied to the PPS rate established in calendar 2003 on the first day of October that is not within

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

7. A written request under Section K must be made to DHS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHS. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

8. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(l)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1. will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the methodology described in Section D, E, or J, and, if applicable, Section F.

(b) At the end of each FQHC's or RHC's fiscal year, the total amowit of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amowit that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D, E, or J, and, if applicable, Section G.

(c) If the amowit calculated wider the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amowit of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D, E, or J, and, if applicable, Section G amowit calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amowit calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amowit of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amowit calculated using the methodology described in Section D, E, or J, and, if applicable, Section G (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs 1 and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to e excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

1. Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DHS will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

N. Alternative Payment Methodology for FQHCs and RHCs that Elect to Provide Dental Hygienist Services or Dental Hygienist in Alternative Practice Services as a Billable Vi

1. An FQHC or RHC may, on or after January 1, 2008, elect to provide the services of a dental hygienist or dental hygienist in alternative practice as a separate and discreet "billable visit" under an alternative payment methodolo gy (APM). Multiple encounters with dental professionals that take place on the same day will constitute a single visit. For purposes of this Section N, the term "dental hygienist in alternative practice" means a person licensed pursuant to Section 1774 of the California Business and Professions Code.

2. An FQHC or RHC has an option to provide dental hygienist services or dental hygienist in alternative practice services as a billable visit, in the following situations:

   (a) For those FQHCs or RHCs that have the cost of dental hygienist services or dental hygienist in alternative practice services included in their PPS reimbursement rate on or before January 1, 2008, and continue to provide those services, the FQHC or RHC may elect to have these services billed as a billable visit under this Section N. However if the APM total reimbursement results in an amount that is less (in the aggregate -- defined in paragraph N.2(c)) than under the methodology described in Section D, E, F, I, J, or K, whichever is applicable, then the FQHC or RHC will be compensated in accordance with the reconciliation proces:f as defined in paragraph N.2.(e) below.

   If an FQHC or RHC requests the APM, including separat billable visits, the FQHC or RHC must submit appropriate form(s) as prescribed by DHCS in order for DHCS to recalculate the PPS reimbursement rate to an APM reimbursement rate described in this Section N. The recalculated reimbursement rate will include the services of a dental hygienist or dental hygienist in alternative practice as a billable visit.

   An FQHC or RHC that elects to have its PPS reimbursement rate recalculated under an APM reimbursement rate pursuant to this paragraph N.2 may continue to bill for all other FQHC or RHC visits at its existing per-visit PPS reimbursement rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or dental hygienist in alternative practice has been approved. Any approved APM reimbursement rate shall be calculated within six months after the date that DHCS receives the FQHC's or RHC's form(s) as prescribed by DHCS.· DHCS will also complete a revenue reconciliation(defined in paragraph N.2(e)) of the approved APM reimbursement rate to ensure that the APM total reimbursement results in an amount that is no less (in the aggregate -- defined in paragraph N.2 (c)) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. An approved APM reimbursement rate will be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case will the effective date be earlier than January 1, 2008.

No scope-of-service change request for dental hygienist services or dental hygienist in alternative practice services will be considered for an FQHC or RHC that elects the APM reimbursement rate pursuant to this paragraph N.2(a).

(b) If an FQHC or RHC did not provide the services of a dental hygienist or dental hygienist in alternative practice before January 1, 2008, and later adds these services, a scope-of-service change may be requested as provided in Section K. After a scope-of-service change to add the additional service has been calculated and the PPS reimbursement rate has been revised to include the new service, an FQHC or RHC may elect the option to have dental hygienist services or dental hygienist in alternative practice services be reimbursed as a billable visit under the APM described in this Section N.

(c) For purposes of this Section N, "in the aggregate" when referenced with respect to the APM, is defined as the total revenue a facility would receive, calculated by multiplying the applicable reimbursement rate by the total number of services provided by dental hygienist or dental hygienist in alternative practice services in a given year and adding that revenue to the PPS reimbursement rate multiplied by the total nwnber of services provided in given year that are compensated using the PPS reimbursement rate.

(d) For purposes of this Section N, "in the aggregate" when referenced with respect to the reimbursement rate under Section D, E, F, I, J, or K is defined as the total reimbursement which an FQHC or RHC would have been received using a PPS reimbursement rate (which does not include the services of a dental hygienist or dental hygienist in alternative practice as separate, billable visits) multiplied by the total number of services provided in a given year that are compensated using the PPS reimbursement rate.

(e) If the estimated total aggregate revenue for an FQHC or RHC under paragraph (d) ab'ove is greater than what the FQHC or RHC received in accordance with paragraph (c) above, DHCS will reimburse an FQHC or RHC for the difference between the amount it received in accordance with paragraph (c) above and the amount it would have received in accordance with paragraph (d) above. This process applies to the circumstance described in the first paragraph of paragraph N.2(a).

3. For FQHCs or RHCs that fall under one of the circumstances described in subparagraph N.2(a) or (b) above, and elect readjustment of their reimbursement rate under this Section N, DHCS shall recalculate the rate and make the appropriate rate adjustment as an APM as long as the FQHC or RHC agrees to the APM reimbursement rate and if the APM results in a total reimbursement that is no less (in the aggregate) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. In circumstances where the APM results in a total reimbursement that is less than what the FQHC or RHC would have received under Section D, E, F, I, J, or K, whichever is applicable, DHCS will complete a revenue reconciliation as described in paragraph N.2.(d).

0. Additional Provisions Regarding Multiple Encounters

In addition to the multiple encounters as provided in paragraph C.3(b), more than one visit may be counted on the same day when the FQHC or RHC patient has a face-to-face encounter with a dental hygienist, or dental hygienist in alternative practice, and then also has a face-to-face encounter with any non-dental health provider, as provided in paragraph C.3(b). Multiple encounters with a dentist and a dental hygienist or dental h ienist in alternative practice that take rlace on the same day will constitute a single visit.

P. Scope of Service Rate Adjustments for Marriage and Family Therapist

1. If an FQHC or RHC does not provide Marriage and Family Therapy Services, but wishes to add the service, the following shall apply:

   Notwithstanding Section K, an FQHC or RHC shall submit a change in scope of services request in order to add and bill for services provided by Marriage and Family Therapists (MFTs). The FQHC or RHC must add the MFT service for a full fiscal year (12 months) before it can submit a change in scope of service request. 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. After the FQHC or RHC adds MFT services for a full fiscal year, the FQHC or RHC may request a change in scope within 150 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

2. Notwithstanding Section K, if an FQHC's or RHC's PPS rate currently includes the cost of MFT services, and the FQHC or RHC elects to bill MFT services as a separately reimbursable PPS visit, it shall apply for an adjustment to its PPS rate by utilizing the change in scope of services request forms to determine the FQHC's of RHC's rate within 150 days following the beginning of the FQHC's or RHC's fiscal year. The rate adjustment request must include one full fiscal year (12 months) of MFT costs and visits. DHCS' approval of a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of services within the meaning of Section K. Rate changes based on an FQHC's or RHC's application for a rate adjustment, and DHCS's reconciliation of costs and visits 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY
State: California

Q. ALTERNATIVE PAYMENT METHODOLOGY (APM) for payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for Developmental Screenings

a. The APM for Developmental Screenings will consist of the Prospective Payment System (PPS) rate or applicable APM for the visit with the associated eligible screening service and a separate supplemental incentive payment for developmental screenings. FQHCs and RHCs must agree to receive the APM, and the APM will not be less than the PPS rate. The supplemental incentive payment will be available at the fee-for-service rate and will not impact the reconciliation of their PPS rate. FQHCs and RHCs will not put their PPS payment at risk by failing to qualify for the supplemental incentive payment.

> Developmental Screening APM = [Applicable Office Visit PPS or Office Visit APM for the visit associated with the eligible screening service] + [Developmental Screening Supplemental Incentive Payment]

b. APM Pilot Term:
   i. Dates of service effective January 1, 2020, through December 31, 2021.

c. Eligible Services:
   i. Developmental Screenings are Early and Periodic Screening, Diagnostic, and Treatment eligible services pursuant to Section 1905(a)(4)(B) and 1905(r) of the Social Security Act; and regulations at 42 CFR 441, Subpart B for individuals under age 21. Screening services for all eligible Medicaid beneficiaries are described in regulations at 42 CFR 440.130(b).

d. Billing Requirements: In order to bill the developmental screening supplemental incentive payment portion of the APM, the following code must be used and the provider will be reimbursed the corresponding supplemental incentive payment amount for that code:

Supplemental/ Incentive CPT Code	CPT Description	Reimbursement Amount
96110	Developmental screening, with scoring and documentation, per standardized instrument	$59.90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY
State: California

R. ALTERNATIVE PAYMENT METHODOLOGY (APM) for payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for Trauma Screenings

a. The APM for Trauma Screenings will consist of the Prospective Payment System (PPS) rate or applicable APM for the visit with the associated eligible screening service and a separate supplemental incentive payment for trauma screenings. The FQHCs and RHCs must agree to receive the APM, and the APM will not be less than the PPS rate. The supplemental incentive payments will be available at the fee-for-service rate and will not impact the reconciliation of their PPS rate. FQHCs and RHCs will not put their PPS payment at risk by failing to qualify for the supplemental incentive payment.

Providers of trauma screenings are only eligible to receive the supplemental incentive payment one time per beneficiary.

Trauma Screening APM = [Applicable Office Visit PPS or Office Visit APM for the visit associated with the eligible screening service] + [Trauma Screening Supplemental Incentive Payment]

b. Eligible Services:
   i. Trauma Screenings per Supplement 32 to Attachment 4.19-B, Page 1.

c. APM Pilot Term:
   i. Dates of service effective January 1, 2020, through December 31, 2021.

d. Billing Requirements: In order to bill the trauma screening supplemental incentive payment portion of the APM, the following codes must be used and the provider will be reimbursed the corresponding supplemental incentive payment amount for that code:

Supplemental/ Incentive CPT Code	CPT Description	Reimbursement Amount
G9919	High-risk, patient score of 4 or greater	$29.00
G9920	Lower-risk, patient score of 0 – 3	$29.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY
State: California

ALTERNATE PAYMENT METHODOLOGY (APM) for payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for select dental preventive services and select annual dental exam services.

Effective January 1, 2022, this APM will pay an additional supplemental incentive payment for select dental preventive and annual dental exam services. FQHCs and RHCs must agree to receive the APM, which will not be less than the Prospective Payment System (PPS) rate. FQHCs and RHCs qualify for the payment by rendering the service, which is paid once monthly as a lump sum. FQHCs and RHCs will not put their PPS rate reimbursement at risk by failing to qualify for the supplemental incentive payment. The supplemental payments are paid monthly in a lump sum separate from the PPS rate and based upon dental claims detail submitted by FQHCs and RHCs within the previous month. The supplemental payment rates are 75 percent of the dental SMA rate (located in Attachment 4.19-B, Page 20b) for each eligible dental preventive service and a flat rate of $55 once a year for each member who received an eligible dental exam and received an eligible dental exam the previous year from the same dental office.

FQHCs and RHCs furnishing of dental services are only eligible to receive the supplemental payments for select preventive dental services one time per date of service. FQHCs and RHCs are eligible to receive the supplemental payments for select annual dental exam codes once annually per beneficiary. The formula will be calculated as follows:

a. For providers who receive the PPS for select dental preventive and select annual dental exam services, this APM will result in a total payment as indicated below:

   Select Preventive and Annual Dental Exam Services APM = [Applicable Office Visit PPS] + [Select Dental Preventive Service or Select Annual Dental Exam Service Supplemental Incentive Payment]

For providers who receive an APM for select dental preventive and select annual dental exam services, this APM will result in a total payment as indicated below:

Select Preventive and Annual Dental Exam Services APM = [Applicable Office Visit APM] + [Select Dental Preventive Service or Select Annual Dental Exam Service Supplemental Incentive Payment]

b. Supplemental incentive payment methodology

   i. For select preventive dental services listed in paragraph c.i, the supplemental incentive payment amount is calculated at 75% of the standard fee-for-service rate. DHCS' dental fee schedule and rates updates are located in Attachment 4.19-B, Page 20b of California's State Plan.

   ii. For select annual dental exam services listed in paragraph c.ii, the supplemental incentive payment amount is $55.

c. Eligible Services:

i. Preventive services Current Dental Terminology (CDT) codes (children under age 21):

- D1120
- D1206
- D1208
- D1351
- D1352
- D1510
- D1516
- D1517
- D1526
- D1527
- D1551
- D1552
- D1553
- D1556
- D1557
- D1558
- D1575

Preventive services CDT codes (adults age 21 and over):

- D1320
- D1999

ii. Dental exam services CDT codes (all ages)

- D0120
- D0145
- D0150

[Proposed]
Order Taking Judicial Notice

Good cause appearing, IT IS HEREBY ORDERED that Applicant Amicus Curiae California Primary Care Association's Motion for Judicial Notice is granted. IT IS FURTHER ORDERED that this Court shall take judicial notice of the following:

A. The California Primary Care Association ("CPCA") "2021 State Profile;"

B. CPCA "All California District Profiles (2017);"

C. The Department of Health Care Services, Medi-Cal Eligibility Statistics;

D. Medicare Provider Reimbursement Manual, Sections 2102.2 and 2102.3;

E. The California State Medicaid Plan, as approved by CMS, Section 4.19B, pages 6-11, relating to "Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)."

DATED: _____ _____

Chief Justice Tani Gorre Cantil-Sakauye

PROOF OF SERVICE:

Family Health Centers of San Diego v. Department of Health Care Services

Supreme Court Case No. S270326
Court of Appeal No. C089555
Sacramento County Superior Court No.
34201880002953CUWMGDS

I declare:

At the time of service I was at least 18 years of age and not a party to this legal action. My business address is 1824 29th Street, Sacramento, CA 95816. I served documents(s) described as Motion for Judicial Notice in Support of Amicus Curiae Brief Filed by the California Primary Care Association as follows:

By True Filing

On May 12, 2022, I served via TrueFiling and no error was reported, a copy of the document(s) identified above on:

Supreme Court of California

Sacramento County Superior Court

Family Health Centers of San Diego

Marianne Pansa
(For Department of Health Care Services)

Joshua Patashnik
(For Department of Health Care Services)

Douglas S. Cummings
(For Gamily Health Centers of San Diego)

George Murphy
(for Family Health Centers of San Diego)

Kevin L. Quade
(for State Department of Health Care Services)

California Court of Appeal, Third District

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: May 12, 2022 By: /s/Mallory Petterelli

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **FAMILY HEALTH CENTERS OF SAN DIEGO v. STATE DEPARTMENT OF HEALTH CARE SERVICES**
Case Number: **S270326**
Lower Court Case Number: **C089555**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **deborah@djrgarcia.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
REQUEST FOR JUDICIAL NOTICE	CPCAAmicusBrief RJN FINAL

Service Recipients:

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Joshua Patashnik Deputy Solicitor General 295120	josh.patashnik@doj.ca.gov	e-Serve	5/12/2022 6:16:03 PM
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This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

5/12/2022

Date

/s/Deborah Rotenberg

Signature

Rotenberg, Deborah (241613)

Last Name, First Name (PNum)

DJR Garcia, APC

Law Firm