Supreme Court of California
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Supreme Court of California
Jorge E. Navarrete, Clerk and Executive Officer of the Court
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S270326

The Supreme Court
State of California

Family Health Center of San Diego

Plaintiff and Appellant,

v.

State Department of Health Care Services

Defendant and Respondent.

On Review From The Court Of Appeal For the Third Appellate District,
Division One, 3rd Civil No. C089555

After An Appeal From the Superior Court For The State of California,
County of Sacramento, Case Number 34201880002953CUWMGDS, Hon. Steven M. Gevercer

MOTION FOR JUDICIAL NOTICE IN SUPPORT OF *AMICUS CURIAE* BRIEF FILED BY AMICI HEALTH CENTERS

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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, Applicants Amici Health Centers[1] hereby move this Court to take judicial notice of the following documents in support of Amici Health Centers' Amicus Brief in support of Plaintiff and Appellant Family Health Centers of San Diego, filed concurrently herewith:

A. The Centers for Medicare and Medicaid Services ("CMS Pub.") Publication 45, The State Medicaid Manual, Section 4231, relating to "Federally Qualified Health Center (FQHC" and Other Ambulatory Services";

B. The CMS Medicare Learning Network "FQHC Fact Sheet"; and

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

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[1] The Amici Health Centers are Avenal Community Health Center, Eisner Health, Golden Valley Health Centers, Innercare, La Maestra Community Health Centers, Neighborhood Healthcare, Open Door Community Clinic, Ravenswood Family Health Network, Shasta Community Health, TrueCare, and WellSpace Health, all California federally-qualified health centers.

These materials are relevant to an overall understanding of the Medicaid requirement that an FQHC must provide "required primary health services" to retain its Medicaid FQHC designation, and the Medicare reasonable cost principles that are applicable to FQHC rate setting.

This motion is based on the attached Memorandum of Points and Authorities and Declaration of Regina M. Boyle, the records and files of this Court, and the accompanying proposed order granting this motion.

DATED: May 12, 2022 HANSON BRIDGETT LLP

By: /s/ Kathryn E. Doi
KATHRYN E. DOI
Attorneys for Amici Health Centers

DATED: May 12, 2022 LAW OFFICE OF REGINA M. BOYLE

By: /s/ Regina M. Boyle
REGINA M. BOYLE
Attorneys for Family Health Centers of San Diego

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Applicants Amici Health Centers seek judicial notice of documents to assist the Court in understanding Medicaid requirements for federally-qualified health centers ("FQHCs") and the California State Plan provisions pertaining to the Medicare reasonable cost principles that are applicable to FQHC rate-setting, which are at the heart of this appeal. Specifically, CMS Pub. 45, the State Medicaid Manual, Section 4231, and the CMS FQHC Fact Sheet demonstrate CMS' requirement that an FQHC provide all "required primary health services" as a condition to participation in Medicaid, and Attachment 4.19 of the California Medicaid State Plan sets forth the Medicare reasonable cost principles that apply to FQHC prospective payment system ("PPS") 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, subd. (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 "[o]fficial acts of the legislative, executive, and judicial departments of the United States and of any state of the United States" 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, subds. (c) & (h).)

California Rules of Court, rule 8.252 provides the means for judicial notice on appeal. The rule provides in subdivision (a)(2) that the motion must state:

> (A) Why the matter to be noticed is relevant to the appeal;
>
> (B) Whether the matter to be noticed was presented to the trial court and, if so, whether judicial notice was taken by that court;
>
> (C) If judicial notice of the matter was not taken by the trial court, why the matter is subject to judicial notice under Evidence Code section 451, 452, or 453; and
>
> (D) Whether the matter to be noticed relates to proceedings occurring after the order or judgment that is the subject of the appeal.

(Cal. Rules of Court, rule 8.252(a)(2).)

B. The Three Exhibits Are Noticeable And Relevant

The Amici Health Centers respectfully submit this Court should notice the documents attached as Exhibits A, B, and C to the Boyle Declaration.

Exhibit A is a provision of the Centers for Medicare and Medicaid Services ("CMS") Pub. 45, the State Medicaid Manual, Section 4231, relating to the requirements that an FQHC must meet to participate in Medicaid. The requirements that an FQHC must meet to participate in Medicaid are integral to the position of the Amici Health Centers as to why outreach costs are allowed under Medicare reasonable cost principles, which is at the heart of

this matter. The accuracy of this publication may be immediately determined by reviewing CMS' online resources. Pursuant to Evidence Code section 452, judicial notice may be taken of this provision as an official act of the executive department of the United States (CMS).

Exhibit B is a Fact Sheet published by CMS to provide guidance to the general public, likewise relates to the requirements that an FQHC must meet to participate in Medicaid. The accuracy of this publication may also be immediately determined by reviewing CMS' online resources. Pursuant to Evidence Code section 452, judicial notice may be taken of this provision as an official act of the executive department of the United States (CMS).

Exhibit C is Attachment 4.19 of the California Medicaid State Plan, the portion of the comprehensive written document created by the State of California and approved by CMS that describes the nature and scope of its Medicaid program which governs FQHC prospective payment reimbursement. Attachment 4.19 identifies the Medicare reasonable cost principles that apply in FQHC rate-setting, which is at the heart of this

matter. The accuracy of this publication may be immediately determined by accessing the State Medicaid Plan on the California Department of Health Care Services' website. Pursuant to Evidence Code section 452, judicial notice may be taken of this provision as an official act of the executive departments of the United States (CMS) and of the State of California (DHCS).

C. Presentation To The Tribunals Below

To the best of the Amici Health Centers' knowledge, none of these materials was presented in full to the administrative law judge, trial court, or the Court of Appeal, and therefore judicial notice was not taken by those courts.

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, none of the Amici Health Centers submitted an amicus brief to the trial court or the Court of Appeal, and thus, the Amici Health Centers have not previously had the opportunity to

request judicial notice of the documents presented as Exhibits A, B, and C to the Boyle Declaration.

CONCLUSION

For the reasons set forth above, the Amici Health Centers respectfully request this Court take judicial notice of the documents attached as Exhibits A, B, and C to the Boyle Declaration.

Respectfully submitted,

DATED: May 12, 2022 HANSON BRIDGETT LLP

By: /s/ Kathryn E. Doi
KATHRYN E. DOI
Attorneys for Family Health Centers of San Diego

DATED: May 12, 2022 LAW OFFICE OF REGINA M. BOYLE

By: /s/ Regina M. Boyle
REGINA M. BOYLE
Attorneys for Family Health Centers of San Diego

DECLARATION OF REGINA M. BOYLE

[Cal. Rules of Court, rule 8.54(a)(2)]

I, Regina M. Boyle, declare:

1. I am an attorney in good standing, licensed to practice before the courts of this state. I am the former legal counsel for the California Primary Care Association, the trade association for FQHCs in California, and have represented FQHCs in connection with rate-setting and other matters since 2003. Based on this work, I am intimately familiar with the federal and state statutory and regulatory scheme applicable to FQHCs, including the evolution of the California State Plan. I am co-counsel of record for the Amici Health Centers in this matter.

2. Attached hereto as Exhibit A is a true and correct copy of the Centers for Medicare and Medicaid Services ("CMS") Publication 45, The State Medicaid Manual, Section 4231, relating to "Federally Qualified Health Center (FQHC" and Other Ambulatory Services", which I obtained from the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 on May 10, 2022.

3. Attached hereto as Exhibit B is a true and correct copy of the CMS Medicare Learning Network "FQHC Fact Sheet," which I obtained from the CMS website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf on May 10, 2022.

4. Attached hereto as Exhibit C is a true and correct copy of the current version of Section 4.19, relating to "Payment for Services," Attachment 4.19, 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/Attachment-4-19B-6-6Y.pdf.on May 10, 2022. The Medicaid State Plan evolves by way of State Plan Amendments ("SPAs") that are submitted under 42 C.F.R. § 430.12(c) by the State whenever necessary to reflect changes in Federal law, regulations, policy interpretations, or court decisions, or material changes in State law, organization, or policy, or in the State's operation of the Medicaid program to be approved by CMS pursuant to 42 C.F.R.

§§ 430.10 – 430.24. When a SPA is approved, the amendment is implemented by swapping out a page from the existing State Plan document and replacing it with a new page showing the effective date of the change, as well as the date CMS approved the SPA. The effective date may pre-date the approval date by months or years, depending on the length of time a SPA was under consideration. Accordingly, the current version of the State Plan shows a variety of effective dates at the bottom of each page, showing when the last amendment was made to the provisions on that page.

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

/s/ Regina M. Boyle
REGINA M. BOYLE

EXHIBIT A

4231. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND OTHER AMBULATORY SERVICES

A. Background.--Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) amended §§1905(a) and (l) of the Social Security Act to provide for coverage and definition of Federally Qualified Health Center (FQHC) services and other ambulatory services offered by an FQHC under Medicaid. Payment for services added by §6404 is effective for services provided on or after April 1, 1990. Payment for FQHC services is discussed in §6303.

B. FQHC Services and Other Ambulatory Services.--FQHC services are defined the same as the services provided by rural health clinics (RHCs) and generally described as RHC services. These services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. For a discussion of RHC services, see the Medicare Rural Health Clinic Manual, Chapter IV. Any other ambulatory service included in a State's Medicaid plan is considered a covered FQHC service, if the FQHC offers such a service.

C. Qualified FQHCs.--FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. For purposes of providing covered services under Medicaid, FQHCs may qualify as follows:

o The facility receives a grant under §§329, 330, or 340 of the Public Health Service (PHS) Act;

o The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Secretary determines that, the facility meets the requirements for receiving such a grant; or

o The Secretary determines that a facility may, for good cause, qualify through waivers of the requirements described above. Such a waiver cannot exceed a period of 2 years.

A list of facilities receiving grants under §§329, 330, and 340, and thereby automatically qualified for provision of and payment for services provided under this section, is found in Exhibit I immediately following this section. The PHS advises HCFA timely of changes in status of grantees and other qualified FQHCs.

Any entity seeking to qualify under this section which does not qualify as a grant receiving facility should contact the PHS for consideration. The PHS is responsible for determining whether an applicant meets eligibility requirements. Applicants for consideration generally must be free-standing entities providing ambulatory care which otherwise qualify under §§329, 330 or 340 of the PHS Act. PHS forwards to HCFA, as determinations are made, a list of qualified entities. HCFA is responsible for the final determination that a facility (other than a grant recipient) can receive payment for services under Medicaid, and will notify states accordingly. Applicants apply to:

Director, Division of Primary Care Services
Bureau of Health Care Delivery and Assistance
U. S. Public Health Service
Room 7A55
5600 Fishers Lane
Rockville, MD 20857

Additionally, an FQHC which is not physician-directed may make certain arrangements similar to those entered into by RHCs, as provided for in § 1861(aa)(2)(B) of the Act. These arrangements concern reviews, supervision and guidance of non-physician staff, preparation of treatment orders, consultation, medical emergencies, and certain other certifying requirements for such facilities. The PHS assures the non-physician directed FQHCs comply with the requirements of §1861 (aa)(2)(B) of the Act.

D. Effective Date.--April 1, 1990 is the effective date for services provided under §6404 of OBRA-89. Submit State plan amendments to the HCFA regional offices no later than June 30, 1990, in order to obtain approval for services provided on or after the effective date. However, when the Secretary determines that State legislation (other than for funding) is necessary in order for the plan to meet the additional requirements of §6404, the State plan is out of compliance only if it fails to comply with such additional requirements after the first day of the first calendar quarter beginning after the close of the first regular session of a State legislature that begins after the date of the enactment of OBRA-89 (December 19, 1989). In a State that has a 2 year legislative session each year of the session is deemed to be a separate regular session of the State legislature.

Exhibit I

FY 1990 CH/MHC Grantee List

REG	90 BDT ST MO	BCRR	PROG	NAME	CITY	ST
01	08	010810	U	SW Community	Bridgeport	CT
01	03	011270	U	Bridgeport Comm	Bridgeport	CT
01	03	011260	U	Community Health	Hartford	CT
01	01	011830	U	Charter Oak Terrace	Hartford	CT
01	06	010070	U	Hill Health Corp	New Haven	CT
01	04	010060	U	Fairhaven Comm Health	New Haven	CT
01	08	010290	U	Roxbury Comp Comm.	Boston	MA
01	07	010160	U	North End Comm Hlth	Boston	MA
01	02	011890	U	Joseph Smith CHC	Boston	MA
01	07	010170	U	Harbor Health Svcs	Boston	MA
01	04	012010	U	Mattapan Comm Hlth	Boston	MA
01	07	010710	U	South Cove Comm.	Boston	MA
01	02	010030	U	Holyoke Health Ctr,	Holyoke	MA
01	07	012160	U	Greater Lawrence	Lawrence	MA
01	08	011460	U	Lowell Community	Lowell	MA
01	03	011430	U	Lynn Community	Lynn	MA
01	07	011930	U	Greater New Bedford	New Bedford	MA
01	08	010860	U	North Shore Comm Hlth	Peabody	MA
01	03	011190	R	Outer Cape Health	Provincetown	MA
01	06	011640	U	Manet Comm Hlth Ctr	Quincy	MA
01	08	010800	U	Family Health &	Worcester	MA
01	06	010830	U	Great Brook Valley	Worcester	MA
01	06	010330	R	Worthington Health	Worthington	MA
01	07	010040	R	Rural Health Centers	Augusta	ME
01	02	012030	R	Bethel Area HC	Bethel	ME
01	07	010340	R	Bucksport Reg Hlth	Bucksport	ME
01	06	011230	R	Sacopee Valley	Kezar Falls	ME
01	12	010380	R	Reg. Medical Center	Lubec	ME
01	12	010420	R	Northern ME Rural	Presque Isle	ME
01	07	010460	R	Kennebec Valley	Waterville	ME
01	05	011580	R	Lamprey Health Care	New Market	NH
01	12	012230	R	Wood River Hlth	Hope Valley	RI
01	01	012240	U	Blackstone Valley	Pawtucket	RI
01	12	010580	U	Providence Ambul.	Providence	RI
01	03	011820	R	Thundermist Hlth Assoc,	Woonsocket	RI
01	07	010640	R	Northern Co. Health	St. Johnsbury	VT
02	01	021270	R/MH	Bridgeton Area	Bridgeton	NJ
02	01	021280	U	Camcare Health	Camden	NJ
02	03	020930	R/MH	Sa-Lantic Health	Hammonton	NJ

Exhibit I(Cont.)

02	04	022290	U	Jersey City Medical	Jersey City	NJ
02	12	020500	U	Newark Comm Hlth Ctr	Newark	NJ
02	01	021300	U	Paterson CHC Network	Paterson	NJ
02	07	021230	U	Plainfield Health	Plainfield	NJ
02	04	020070	U	Henry J. Austin	Trenton	NJ
02	04	020110	U	Whitney M. Young	Albany	NY
02	01	020180	R/MH	Oak Orchard Comm.	Brockport	NY
02	08	021950	U	Soundview Health	Bronx	NY
02	06	021610	U	Morris Heights	Bronx	NY
02	02	020760	U	Bronx Ambulatory	Bronx	NY
02	01	020270	U	Sunset Park	Brooklyn	NY
02	12	021210	U	ODA Primary Care	Brooklyn	NY
02	01	020610	U	CHC East New York	Brooklyn	NY
02	12	022050	U	L B Johnson Health	Brooklyn	NY
02	04	021980	U	Brooklyn Plaza	Brooklyn	NY
02	01	020010	U	North West Buffalo	Buffalo	NY
02	08	021310	R	North Jefferson	Clayton	NY
02	12	021240	R	Cortland Co. Rural	Cortland	NY
02	08	021530	U	Greenburgh Neigh§bd HC	Greenburg	NY
02	08	021500	U	Mt. Vernon N.H.C	Mt. Vernon	NY
02	08	021080	U	Settlement Hlth and	New York	NY
02	12	020390	U	East Harlem Cl. for	New York	NY
02	12	020490	U	William F. Ryan	New York	NY
02	05	021390	U	Chinatown CHC	New York	NY
02	06	020620	U/MH	Fam HC of Orange &	Newburgh	NY
02	08	021520	U	Ossining Open Door HC	Ossington	NY
02	08	021510	U	Peekskill Hlth Ctr	Peekskill	NY
02	01	020870	R	Northern Oswego	Pulaski	NY
02	04	022110	U	Joseph P. Addabbo	Queens	NY
02	01	022070	U	Anthony L. Jordan	Rochester	NY
02	01	020560	U	Rochester Primary	Rochester	NY
02	06	021830	U	Carver Community	Schenectady	NY
02	01	020570	MH	Rochester Gen. Hosp	Sodus	NY
02	04	020160	U	Syracuse Community	Syracuse	NY
02	01	021790	R	Hudson Headwaters	Warrensburg	NY
02	07	021870	R	Barceloneta RH	Barceloneta	PR
02	02	020910	R	Camuy RHI	Camuy	PR
02	05	020660	R/MH	Hosp General de	Castaner	PR
02	03	021250	R	Ciales Health Ctr	Ciales	PR
02	03	020730	MH	Cidra Migrant	Cidra	PR
02	01	021400	R	Florida RHI Hlth Ctr	Florida	PR
02	03	021260	R	Hatillo RHI	Hatillo	PR
02	05	022090	R	Lares Health Center	Lares	PR

Exhibit I(Cont.)

02	07	020670	R/MH	Loiza Comprehensive	Loiza	PR
02	03	021040	MH	Mayaguez Migrant Hlth	Mayaguez	PR
02	06	020650	R/MH	Central Areawide	Naranjito	PR
02	04	020890	R/MH	Patillos RHI	Patillas	PR
02	12	020680	U/MH	Ponce Diagnostic	Playa Ponce	PR
02	05	021030	R	Rincon RH Project	Rincon	PR
02	05	020700	U	Dr. J. S. Belaval	Rio Piedras	PR
02	06	021350	R	Fredericksted Hlth	St. Croix	VI
03	02	031860	U	Community Health Care	Washington	DC
03	04	030070	MH	Delmarva Rural	Dover	DE
03	03	031260	U	Southbridge Medical	Wilmington	DE
03	02	033180	U	Baltimore Medical	Baltimore	MD
03	04	031270	U	South Baltimore	Baltimore	MD
03	07	032810	U	Assoc. Program for	Baltimore	MD
03	12	030150	U	West Baltimore	Baltimore	MD
03	12	030130	U	Parkwest Health	Baltimore	MD
03	07	032750	R	Caroline Hlth	Goldsboro	MD
03	12	031600	R	Tri-State CHC	Hancock	MD
03	06	030170	R	Somerset Co for	Princess Anne	MD
03	06	031220	R	North Penn Comp	Blossburg	PA
03	03	030220	R	Broadtop Area	Broad Top City	PA
03	03	030230	R	Comm. Medical Ctr	Burgettstown	PA
03	02	033930	U	Ches Penn Health	Chester	PA
03	08	032430	R	Glendale Area Med.	Coalport	PA
03	04	032300	R	Keystone Rural	Emporium	PA
03	07	034230	U	Primary Hlth Svcs of	Erie	PA
03	03	034060	R	Shenango Valley Pri.	Farrell	PA
03	02	031700	R	Centerville Clinics	Fredericktown	PA
03	04	033090	R	SE Greene Community	Greensboro	PA
03	04	030290	U	Hamilton Health Ctr	Harrisburg	PA
03	05	031880	MH	Rural Opport.,Inc	Harrisburg	PA
03	03	032440	R	Hyndman Area Medical	Hyndman	PA
03	04	033620	U	SE Lancaster Primary	Lancaster	PA
03	12	032230	U	F.O.R. Sto-Rox NHC	McKees Rocks	PA
03	03	034140	U	Spectrum Health	Philadelphia	PA
03	06	032900	U	Philadelphia Health	Philadelphia	PA
03	06	033780	U	Quality Health	Philadelphia	PA
03	06	033200	U	Greater Philadelphia	Philadelphia	PA
03	12	032220	U	Covenant House Hlth	Philadelphia	PA
03	02	030440	U	Primary Care Health	Pittsburgh	PA
03	12	032560	U	Scranton Primary	Scranton	PA
03	05	030480	R	Barnes Kasson Health	Susquehanna	PA
03	07	030560	R	Rural Hlth Corp of NE	Wilkes Barre	PA

Exhibit I(Cont.)

03	04	031160	U	York Health Corp.	York	PA
03	06	030720	R	Eastern Shore Rural	Accomac	VA
03	03	031970	R	Brunswick Health	Alberta	VA
03	03	032380	R	Tri County Medical	Aylett	VA
03	03	032650	R	Bland County Medical	Bastian	VA
03	08	034170	R	Boydton Comm Hlth	Boydton	VA
03	06	031230	R	Clinch River Health	Dungannon	VA
03	05	033030	R	Western Lee County	Ewing	VA
03	05	032840	R	Ivor Community	Ivor	VA
03	08	034180	R	Lunenburg Co. Health	Kenbridge	VA
03	08	033230	R	Tri - Area Laurel	Laurel Fork	VA
03	08	034050	R	Blue Ridge Health	Lovington	VA
03	08	030700	R	Central Virginia	New Canton	VA
03	05	032240	U	Peninsula Institute	Newport News	VA
03	03	031810	R	Saltville Medical	Saltville	VA
03	06	030740	R	St Charles Council	St Charles	VA
03	03	031760	R	Stony Creek CHC	Stony Creek	VA
03	06	033130	R	E.A. Hawse Retirement	Baker	WV
03	06	030880	R	Valley Hlth Systems,	Barboursville	WV
03	06	030800	R	Clay-Battelle Hlth	Blacksville	WV
03	12	033100	R	Camden-on-Gauley	Camden-on-Gauley	WV
03	12	034090	R	Clay Co Primary Hlth	Clay	WV
03	12	031820	R	Cabin Creek Health	Dawes	WV
03	02	030820	R	Monongahela Valley	Fairmont	WV
03	03	031000	R	Tug River Health	Gary	WV
03	07	034190	R	Minnie Hamilton Hlth	Grantsville	WV
03	06	032580	R	No. Greenbrier/South	Hillsboro	WV
03	06	030890	R	Preston-Taylor CHCs	Kingwood	WV
03	07	030900	R/MH	Intercounty Hlth,	Martinsburg	WV
03	06	031250	R	Bluestone Health	Princeton	WV
03	12	033080	R	Rainelle Medical Center	Rainelle	WV
03	12	034210	R	Tri-County Health	Rock Cave	WV
03	12	032600	R	New River Health	Scarbro	WV
03	02	034120	R	Roane County Family	Spencer	WV
03	04	030790	R	Community Hlth System	Spraque	WV
03	08	030990	R	Monroe Co. Hlth Bd	Union	WV
04	04	042210	R	Autaugaville Medical	Autaugaville	AL
04	02	040070	R	West Alabama Neigh-	Eutaw	AL
04	02	042830	R	Conecuh Medical	Evergreen	AL
04	04	044120	U	Etowah Quality of	Gadsden	AL
04	03	044700	U	Area Health Dev. Bd	Irvington	AL
04	03	048190	U	Central North Ala.	Madison	AL
04	08	044710	U	Franklin Memorial	Mobile	AL
04	06	047080	U	Mobile Co Hlth Dept	Mobile	AL
04	02	040130	U	Montgomery Hlth Svcs	Montgomery	AL
04	12	042180	R	Southern Rural Hlth	Russellville	AL
04	06	045710	R	Jackson Co Primary	Scottsboro	AL

Exhibit I(Cont.)

04	07	042850	R	Rural Hlth Medical	Selma	AL
04	05	048950	R	SE Alabama RHA	Troy	AL
04	12	042450	R	Maude L. Whately	Tuscaloosa	AL
04	08	040040	R	Health Development	Tuscaloosa	AL
04	04	040160	R	Central Alabama	Tuskegee	AL
04	02	041660	R/MH	West Orange Farm	Apopka	FL
04	07	040200	R	Family Medical	Cross City	FL
04	03	045500	R/MH	East Pasco Hlth Ctr,	Dade City	FL
04	02	040210	R/MH	Florida Rural Hlth	Frostproof	FL
04	03	041680	R/MH	Southwest FL Hlth Ctr	Ft Myers	FL
04	02	048960	R	Tri County Health	Greenville	FL
04	04	041700	R/MH	Collier Health	Immokalee	FL
04	08	048970	U	Columbia Co. Health	Lake City	FL
04	05	040290	R	Lafayette Co.	Mayo	FL
04	08	041630	U	Coconut Grove Family	Miami	FL
04	02	040330	U	Economic Opport.	Miami	FL
04	02	040320	U/MH	Community Hlth	Miami	FL
04	02	040310	U	Borinquen Hlth Care	Miami	FL
04	04	044130	U	Stanley C. Myers	Miami Beach	FL
04	12	040340	R/MH	Rural Health Care,	Palatka	FL
04	12	044310	R/MH	Manatee Co. Rural	Parrish	FL
04	01	041670	U	Sunshine Health	Pompano Beach	FL
04	12	044780	R/MH	Gadsden Primary Care	Quincy	FL
04	04	041750	R/MH	Ruskin Migrant & CHC	Ruskin	FL
04	01	041720	R	Central Florida	Sanford	FL
04	06	049070	R	Johnnie Ruth Clark	St. Petersburg	FL
04	04	040250	R	Project Health, Inc.	Sumterville	FL
04	04	0412810	R	Tampa Community Hlth	Tampa	FL
04	07	042710	R	Trenton Medical	Trenton	FL
04	04	040370	R/MH	Florida Comm Hlth	West Palm Beach	FL
04	01	041740	R/MH	Bd of Co Commiss.	West Palm Beach	FL
04	08	040380	R	Wewahitchka Medical	Wewahitchka	FL
04	06	044150	U	Albany Area Primary	Albany	GA
04	06	040400	U	Health South, Inc.	Atlanta	GA
04	07	040410	U	West End Medical Ctr	Atlanta	GA
04	04	040390	R	Northeast Georgia	Crawford	GA
04	08	047430	R	Georgia Highlands	Cumming	GA
04	01	046900	U	Oakhurst Community	Decatur	GA
04	08	049170	MH	Candler County Hlth	Metter	GA
04	06	045260	U	Palmetto Health	Palmetto	GA
04	03	043340	R	Stewart-Webster	Richland	GA
04	08	040490	U	Westside-Urban Hlth	Savannah	GA
04	03	048160	R	Hancock Co Primary	Sparta	GA
04	12	042110	R	Georgia Mountains	Suches	GA
04	02	044790	R	Primary Hlth Care	Trenton	GA
04	05	042390	R	Tri-County Health	Warrenton	GA

Exhibit I(Cont.)

04	08	046980	R	Pike Co. Primary	Zebulon	GA
04	03	044090	U	Northern Kentucky	Covington	KY
04	08	048140	U	Lexington-Fayette Co	Lexington	KY
04	12	046840	U	Louisville Mem Prim	Louisville	KY
04	12	040650	U	Park Duvalle Hlth	Louisville	KY
04	06	044820	R	Health Help, Inc.	McKee	KY
04	02	040670	R	Big Sandy Health	Prestonsburg	KY
04	12	048980	R	Lewis County Primary	Vanceburg	KY
04	05	040600	R	Mountain Comp	Whitesburg	KY
04	05	049100	R	North Benton Co.	Ashland	MS
04	01	042430	R	Coastal Fam Hlth	Biloxi	MS
04	03	042440	U	Rankin Urban Hlth	Brandon	MS
04	05	043060	R	NE Mississippi	Byhalia	MS
04	06	040760	R	Madison Yazoo Leake	Canton	MS
04	06	046150	R	Aaron E. Henry	Clarksdale	MS
04	06	048800	R	Jefferson Compre.	Fayette	MS
04	08	040750	U	Jackson-Hinds Comp Hlth	Jackson	MS
04	05	040570	R	South Mississippi CHC	Laurel	MS
04	08	044470	R	Greene Area Medical	Leaksville	MS
04	03	045780	R	Amite County Med.	Liberty	MS
04	04	042070	R	Greater Meridian	Meridian	MS
04	03	040780	R	Delta Health Center	Mound Bayou	MS
04	07	040770	R	South Central MS	New Hebron	MS
04	07	048420	R	Claiborne Co. Comm.	Port Gibson	MS
04	04	042720	R	East Central MS Hlth	Sebastopol	MS
04	03	045770	R	SE Mississippi RHI,	Seminary	MS
04	06	048870	R	Outreach Health	Shubuta	MS
04	03	046860	R	Three Rivers Area	Smithville	MS
04	12	047330	R	S. W. Hlth Agency	Tylertown	MS
04	04	040840	R	Vicksburg-Warren CHC,	Vicksburg	MS
04	12	041940	R	Tri-County Hlth	Aurora	NC
04	12	040890	R	Orange Chatham Comp	Carrboro	NC
04	05	047770	U	Metrolina Comp	Charlotte	NC
04	07	040910	U	Lincoln CHC/Durham	Durham	NC
04	01	045800	R/MH	Goshen Medical	Faison	NC
04	04	040940	R/MH	Migrant Family Hlth	Hendersonville	NC
04	07	046610	R	Twin Co Rural Health	Hollister	NC
04	12	045200	R	Western Med Group/Boone	Mamers	NC
04	06	045810	R	Morven Area Medical	Morven	NC
04	04	040900	R/MH	Tri-County Comm.	Newton Grove	NC
04	08	049000	R	Robeson Health	Pembroke	NC
04	03	040860	MH	Migrant Hlth Program	Raleigh	NC
04	12	041000	U	Wake Hlth Svcs, Inc.	Raleigh	NC

Exhibit I(Cont.)

04	06	046800	R	Person Fam Med Ctr	Roxboro	NC
04	12	041020	R	Greene Co. Hlth Care,	Snow Hill	NC
04	03	041060	R	Vance Warren Comp.	Soul City	NC
04	03	046910	R	Stedman Wade Hlth	Wade	NC
04	05	049190	R	Bertie County Rural	Windsor	NC
04	08	044920	R	Caswell Family	Yanceyville	NC
04	02	042310	R	Calhoun Falls Area	Calhoun Falls	SC
04	05	041110	U	Franklin C. Fetter	Charleston	SC
04	08	045220	R	Rural Health Svcs,	Clearwater	SC
04	05	041090	MH	SC Mig. Hlth Proj.	Columbia	SC
04	05	047000	R	Britton§s Neck Hlth	Conway	SC
04	02	040110	R	Midlands Primary	Eastover	SC
04	05	043770	R	Allendale Co.- Rural	Fairfax	SC
04	06	047060	R	Little River Medical	Little River	SC
04	07	045050	R	Sandhills Medical	McBee	SC
04	05	048430	R	St James - Santee	McClellanville	SC
04	03	046930	R	Black River	Olanta	SC
04	12	041180	R	Orangeburg Co.	Orangeburg	SC
04	06	041190	R	Beaufort Jasper	Ridgeland	SC
04	06	045230	R	Society Hill Family	Society Hill	SC
04	06	042780	R/MH	Megals Rural Hlth	Trenton	SC
04	02	041230	R/MH	Benton Medical	Benton	TN
04	12	041260	U	Chattanooga Hamilton	Chattanooga	TN
04	02	042160	R	Laurel Fork - Clear	Clairfield	TN
04	04	041780	R	Upper Cumberland	Cookville	TN
04	07	041440	R	Mountain Peoples	Huntsville	TN
04	05	041370	R	Perry County	Linden	TN
04	04	047820	R	Union Grainger	Maynardville	TN
04	01	041410	U	Memphis Health	Memphis	TN
04	05	049040	R	Stewart Co./Tenn Dpt	Nashville	TN
04	02	041420	U	Matthew Walker	Nashville	TN
04	02	044110	U	United Neighborhood	Nashville	TN
04	04	046810	R	Rural Community	Parrotsville	TN
04	05	0412790	R	Rural Hlth Svcs Cons.	Rogersville	TN
04	03	045420	R	Citizens of Lake Co.	Tiptonville	TN
04	01	041290	R	Morgan Co. Hlth	Wartburg	TN
05	03	052180	R	Rural Health Inc.	Anna	IL
05	07	050030	R	Community Health	Cairo	IL
05	01	053320	R	Southern Illinois	Centerville	IL
05	12	051870	U	Frances Nelson	Champaign	IL
05	02	051720	U	New City Health Ctr,	Chicago	IL
05	02	050080	U	KOMED Health Center	Chicago	IL
05	03	050060	MH	Illnois Migrant	Chicago	IL

Exhibit I(Cont.)

05	06	051050	U	Claretian	Chicago	IL
05	01	053280	U	Near North Health	Chicago	IL
05	07	053210	U	Erie Family Hlth Ctr	Chicago	IL
05	04	052130	R	Christopher Greater	Christopher	IL
05	05	053150	U	Community Health	Decatur	IL
05	04	05004D	R/MH	Shawnee Hlth Svcs	Murphysboro	IL
05	01	052140	R	Henderson Co Rural	Oquawka	IL
05	12	052760	U	Crusaders Central	Rockford	IL
05	06	051020	U	People§s Hlth Ctr	Indianapolis	IN
05	12	053200	U	Community Health	Indianapolis	IN
05	05	053110	R/MH	Indiana Health	Indianapolis	IN
05	06	052200	R	Downriver Community	Algonac	MI
05	12	050210	R	Regional Health	Baldwin	MI
05	04	050220	R/MH	MARCHA	Bangor	MI
05	12	052820	R	Monway Citizens	Carleton	MI
05	02	052070	U	Cass CHC	Detroit	MI
05	01	051990	U	Detroit Health Dept	Detroit	MI
05	04	051680	R	East Jordon Family	East Jordon	MI
05	04	053300	U	Hamilton Area	Flint	MI
05	04	052030		Cherry Street Services	Grand Rapids	MI
05	03	053160	R	Thunder Bay, CHC	Hillman	MI
05	01	050290	R	Northern Michigan	Houghton Lake	MI
05	03	056230	U	Family Health Center	Kalamazoo	MI
05	05	051980	R	Alcona Medical	Lincoln	MI
05	03	051440	R	Upper Pennisula	Newberry	MI
05	04	052510	R/MH	Pullman Health	Pullman	MI
05	04	050360	R/MH	Health Delivery Inc.	Saginaw	MI
05	03	050380	MH	Sparta Health Ctr	Sparta	MI
05	04	052250	R	Sterling Area Health	Sterling	MI
05	04	052910	R	Citizens Health	Temperance	MI
05	03	050390	MH	Northwest Michigan	Traverse City	MI
05	06	052710	R	Cook Area Hlth	Cook	MN
05	06	052700	R	Cook Co Clinic	Grand Marais	MN
05	04	051770	U	Indian Hlth Board	Minneapolis	MN
05	03	050320	MH	Migrant Health	Moorehead	MN
05	03	053020	U	Westside Community	St. Paul	MN
05	12	052730	U	Model Cities Health	St. Paul	MN
05	03	050560	R	Barnesville Hlth	Barnesville	OH
05	03	052270	R	P.R.A.V. Health Svcs,	Chillcothe	OH
05	01	051570	U	Cincinnati Health	Cincinnati	OH
05	01	050990	R	South. Ohio Hlth Svcs	Cincinnati	OH
05	01	050580	U	Hough Norwood Fam	Cleveland	OH
05	04	050960	R/MH	Community Hlth Svcs	Freemont	OH

Exhibit I(Cont.)

05	04	050640	R/MH	Family Hlth Service	Greenville	OH
05	05	051660	R	Ironton-Lawrence Co	Ironton	OH
05	02	052900	R	Community Action	Piketon	OH
05	05	053010	U	Toledo Family	Toledo	OH
05	12	051780	U	Cordelia Martin HC/	Toledo	OH
05	08	051490	R	Northern Health Ctrs,	Lakewood	WI
05	06	050840	R	Marshfield Medical	Marshfield	WI
05	04	053060	U	16th Street Clin/HOPE	Milwaukee	WI
05	03	056220	U	Milwaukee Comprehens.	Milwaukee	WI
05	01	052670	U	Indian Hlth Bd of	Milwaukee	WI
05	06	052810	R	North Woods Medical	Minong	WI
05	04	050900	MH	La Clinica De Los	Wildrose	WI
06	01	060940	R	White River Rural	Augusta	AR
06	06	062090	R	Mid-Delta Rural Hlth	Clarendon	AR
06	05	062140	R	CABUN Rural Hlth	Hampton	AR
06	12	060060	R	Lee Co Cooperative	Marianna	AR
06	08	060080	R	Rural Health Inc.	Paragold	AR
06	06	060110	U	Jefferson Comp Care	Pine Bluff	AR
06	02	062730	R	Mainline Health	Portland	AR
06	12	060140	U	East Arkansas Family	West Memphis	AR
06	06	060180	R	Teche Action Board	Franklin	LA
06	08	063380	U	Bayou Comprehensive	Lake Charles	LA
06	08	060190	R	Natchitoches Area	Natchitoches	LA
06	01	062480	R	Catahoula Parish	Sicily Island	LA
06	01	060240	U	Albuquerque Family	Albuquerque	NM
06	07	060330	R	Health Centers of	Espanola	NM
06	08	060360	R	Gallup/Thoreau/Grants	Gallup	NM
06	05	060370	R	Ben Archer Health	Hatch	NM
06	02	062160	R	Centro Rural de	Loving	NM
06	08	061290	R/MH	La Casa de Bueno	Portales	NM
06	07	063010	R/MH	La Clinica de	San Miguel	NM
06	01	063450	R	Presbyterian Med	Santa Fe	NM
06	07	063920	U	La Familia Medical	Santa Fe	NM
06	07	060490	MH	Oklahoma State	Altus	OK
06	08	063930	R	Konawa Community	Konawa	OK
06	02	060530	U	Community Hlth Ctrs	Oklahoma City	OK
06	05	063890	U	Morton Health Center	Tulsa	OK
06	02	062650	R	Panhandle Rural	Amarillo	TX
06	08	061000	R	Chapparral Hlth Clinic	Benavides	TX
06	08	061510	U/MH	Brownsville Comm.	Brownsville	TX
06	04	062120	R/MH	South Texas Rural	Cotulla	TX
06	05	060670	R/MH	Vida y Salud	Crystal City	TX
06	12	061010	U	Martin L. King, Jr.,	Dallas	TX
06	07	060680	U	Los Barrios Unidos	Dallas	TX

Exhibit I(Cont.)

06	12	060710	R/MH	Cross Timbers	De Leon	TX
06	07	060740	R/MH	United Medical Svc	Eagle Pass	TX
06	02	063520	R	Centro Medico Del	El Paso	TX
06	12	061230	U	Centro de Salud	El Paso	TX
06	12	060810	R	Gonzales County	Gonzales	TX
06	08	060820	R	Comm Hlth Svc Agency	Greenville	TX
06	05	060840	R/MH	Su Clinica Familiar/	Harlingen	TX
06	05	061610	U	Galveston Co. Coord.	La Marque	TX
06	04	060900	U/MH	Laredo-Webb Co Hlth	Laredo	TX
06	06	061220	R/MH	South Plains Rural	Levelland	TX
06	08	061260	R	East Texas Community	Nacogdoches	TX
06	08	061190	R	Jasper-Newton Comm	Newton	TX
06	01	060750	R/MH	Hidalgo Co. Health	Pharr	TX
06	06	060950	R/MH	South Plains Health	Plainview	TX
06	08	062390	R	Atascoso RHI Health	Pleasanton	TX
06	04	063190	U	City of Port Arthur	Port Arthur	TX
06	02	060970	R/MH	Comm Action Council	Rio Grande City	TX
06	04	063940	U	Ella Austin Comm.	San Antonio	TX
06	03	062360	U/MH	Barrio Comp Family	San Antonio	TX
06	05	063250	U	Centro Del Barrio	San Antonio	TX
06	08	063910	R/MH	Uvalde Co.-Clinic,	Uvalde	TX
07	03	071170	U	Community Hlth Care	Davenport	IA
07	08	071790	U	Broadlawns Medical	Des Moines	IA
07	02	070050	MH	Muscatine Migrant	Muscatine	IA
07	02	071410	U	Peoples Comm Hlth	Waterloo	IA
07	05	071800	MH	Kansas City Wyandott	Kansas City	KS
07	07	070090	MH	Kansas State Dept	Topeka	KS
07	08	070150	U	Hunter Health Clinic	Wichita	KS
07	12	071660	R	Caldwell Co Medical	Hamilton	MO
07	08	070290	U	Samuel U. Rodgers	Kansas City	MO
07	05	070270	U	Swope Pkwy Comp	Kansas City	MO
07	05	070300	R	NE Missouri Hlth &	Kirksville	MO
07	03	072130	R	Northwest Missouri	Mound City	MO
07	08	071370	R	New Madrid Group	New Madrid	MO
07	12	071670	R	Central Ozark	Richland	MO
07	02	071700	U	Family Care Center	St. Louis	MO
07	06	072100	U	Peoples Clinic	St. Louis	MO
07	02	070370	U	St. Louis Compre	St. Louis	MO
07	03	071190	U	Neighborhood HC, Inc	St. Louis	MO
07	06	070430	R	Big Springs Medical	Van Buren	MO
07	04	070450	MH	Nebraska State Dept	Lincoln	NE
07	03	072110	U	Charles Drew Medical	Omaha	NE
08	12	080030	R/MH	Valley Wide Health	Alamosa	CO

Exhibit I(Cont.)

08	07	081260	R	Gilpin/Columbine	Black Hawk	CO
08	01	081460	U	Comm Hlth of	Colorado Springs	CO
08	01	080010	MH	Colorado Dept. of	Denver	CO
08	01	080060	U	Denver Dept of Hlth	Denver	CO
08	07	080100	R	Dolores Co. Hlth	Dove Creek	CO
08	06	080130	R/MH	Plan de Salud del	Fort Lupton	CO
08	04	080140	R/MH	Sunrise Community	Greeley	CO
08	02	081650	R	La Clinica Campesina	Lafayette	CO
08	08	081740	R	Uncomphadre Combined	Norwood	CO
08	06	080170	U	Pueblo Comm Hlth	Pueblo	CO
08	05	082500	U	Yellowstone City/	Billings	MT
08	02	082160	MH	Montana Migrant	Billings	MT
08	08	083270	R	Butte CHC-Silver Bow	Butte	MT
08	01	082110	R	Mercer-Oliver	Center	ND
08	05	080890	R	Union County Health	Elk Point	SD
08	02	080500	R	NW South Dakota	Faith	SD
08	12	081030	R	East River Health	Howard	SD
08	04	082100	R	Isabel Comm RHI	Isabel	SD
08	08	080590	R	South Dakota Rural	Pierre	SD
08	01	081450	U	Sioux River Valley	Sioux Falls	SD
08	08	081690	R	Tri-County Hlth Care,	Wessington Spring	SD
08	07	082240	R	Wayne Co. Medical	Bicknell	UT
08	08	082480	R	Enterprise Valley	Enterprise	UT
08	08	082490	R	Green River CHC	Green River	UT
08	05	080510	MH	Utah Rural Dev. Corp.	Midvale	UT
08	05	082050	U	Weber County Comm.	Ogden	UT
08	01	080220	U	Salt Lake City Comm	Salt Lake City	UT
08	03	080830	MH	Tri-County Dev. Corp.	Guernsey	WY
08	03	080710	MH	Northwestern Comm.	Worland	WY
09	06	090030	R	West Pinal Family	Casa Grande	AZ
09	12	093030	R/MH	Clinica Adelante,	El Mirage	AZ
09	06	090090	R	Mariposa Community	Marana	AZ
09	07	091300	R	Lake Powell Family	Page	AZ
09	12	093070	U	Memorial Family	Phoenix	AZ
09	08	090130	R/MH	Valley Health Ctr,	Somerton	AZ
09	01	090160	U	El Rio Santa Cruz NHC	Tucson	AZ
09	03	093590	R	United Community	Tuscon	AZ
09	05	090210	R	Family Health Fnd. of	Alviso	CA
09	01	093660	U	Inland Empire CHC	Bloomington	CA
09	06	090250	R/MH	Clinicas de Salud	Brawley	CA
09	12	090260	R	Intermountain Comm.	Brownsville	CA
09	04	091600	R/MH	Buttonwillow Health	Buttonwillow	CA
09	12	093150	R/MH	El Progresso del	Coachella	CA

Exhibit I(Cont.)

09	04	090290	U	Drew Hlth Foundation	East Palo Alto	CA
09	02	093320	U/MH	Sequoia Comm Health	Fresno	CA
09	01	091050	R/MH	La Clinica Popular	King City	CA
09	04	090390	R/MH	Clinica Sierra Vista	Lamont	CA
09	07	091650	R	Long Valley Hlth Ctr,	Laytonville	CA
09	04	093160	U	Arroyo Vista Family	Los Angeles	CA
09	02	091040	U	Asian Pacific Venture	Los Angeles	CA
09	12	093110	U	Altamed	Los Angeles	CA
09	01	090490	U	Community Hlth Fdn	Los Angeles	CA
09	12	090440	U	Watts Health	Los Angeles	CA
09	12	093210	R/MH	El Concilio de Madera	Madera	CA
09	04	090470	R/MH	Merced Family	Merced	CA
09	07	090710	R/MH	Nipomo Comm Med Ctr,	Nipomo	CA
09	04	090540	U	West Oakland Health	Oakland	CA
09	04	091030	U	Asian Health Svcs	Oakland	CA
09	05	091230	U	La Clinica de la	Oakland	CA
09	07	090850	MH	North Sacramento	Olivehurst	CA
09	12	091000	U	Northeast Valley	Pacoima	CA
09	06	090560	R/MH	United Health Ctrs of	Parlier	CA
09	03	093640	MH	Porterville Family	Porterville	CA
09	04	091240	U	West Contra Costa	Richmond	CA
09	01	093120	U	Logan Heights Family	San Diego	CA
09	04	090530	U	San Francisco Med.	San Francisco	CA
09	03	090660	U	Mission Neighborhood	San Francisco	CA
09	01	090670	U	North East Medical	San Francisco	CA
09	01	090720	R/MH	North County Hlth	San Marcos	CA
09	01	091080	U	San Ysidro Health Ctr	San Ysidro	CA
09	07	093080	U	UC Irvine (CCOC)	Santa Ana	CA
09	05	093650	MH	Clinicas del Camino	Saticoy	CA
09	12	090780	R/MH	Agricult§l. Workers	Stockton	CA
09	07	091960	R	Northeast Rural	Susanville	CA
09	01	093190	U	Tiburcio Vasquez	Union City	CA
09	02	091760	R	Commonwealth of Saipan	Saipan	CM
09	05	093530	R	Guam Health Dept.	Agana	GU
09	04	093410	R	K K V Comprehensive	Honolulu	HI
09	03	090990	R	Waianae Coast	Waianae	HI
09	08	091570	R	Central Nevada Rural	Babbitt	NV
09	04	090820	U	CHC of S. Nevada	Las Vegas	NV
09	01	093680	R	Republic of Palaui	Koror	PW
09	02	093570	R	Ministry of Health	Marshall Islands	TT
09	01	091920	R	Ponape State Hosp.	Ponape	TT
10	07	100020	U	Anchorage Neighborhd	Anchorage	AK
10	07	101610	R	Glenns Ferry Area	Glenns Ferry	ID
10	04	100160	R	Terry Reilly Health	Nampa	ID

Exhibit I(Cont.)

10	04	100280	R	Mountain Health	Nampa	ID
10	03	101630	R/MH	Valley Family Health	Payette	ID
10	07	100180	R	Health West Inc.	Pocatello	ID
10	03	101650	R/MH	Family Health Svcs,	Twin Falls	ID
10	08	100790	MH	Clinica Del Valle		OR
10	07	100010	R	Southeast Oregon	Chiloquin	OR
10	04	101230	MH	Virginia Garcia Mem	Cornelius	OR
10	03	102080	R/MH	La Clinica del Carino	Hood River	OR
10	07	101120	U	Multnomah Co Dept.	Portland	OR
10	12	100760	U	NW Human Svcs, Inc.	Salem	OR
10	04	100340	R/MH	Salud Medical Center	Woodburn	OR
10	03	100360	R	N E W Health Programs	Chewelah	WA
10	08	100270	R	West Coast Health	Copalis Beach	WA
10	04	101770	MH	Okanogan Farmworkers	Okanogan	WA
10	12	100460	R	Columbia Basin Hlth	Othello	WA
10	08	101520	R/MH	La Clinica/South	Pasco	WA
10	03	100640	U	Puget Sound Neighbor	Seattle	WA
10	04	101020	U/MH	Sea-Mar Community	Seattle	WA
10	03	100630	U	Central Seattle	Seattle	WA
10	06	100450	U	Community Health Care	Tacoma	WA
10	04	101030	R/MH	Yakima Valley Farm	Topennish	WA
10	04	100570	R/MH	N C WASH Mig Health	Wenatchee	WA

Exhibit I(Cont.)

1990 HOMELESS GRANTEES

SECTION 340 HEALTH CARE FOR THE HOMELESS

Project Name:	City:	State:
Charter Oak Terrace/Rice Heights Health Center	Hartford	CT
Hill Health Center	New Haven	CT
Southwest Bridgeport Comm. Hlth Ctr.	Bridgeport	CT
Windham Area Comm. Action Prog., Inc.	Danielson	CT
Boston Health Care for Homeless Project	Boston	MA
Springfield Hlth Svs. for the Homeless	Springfield	MA
Worcester Area Community Mental Health Center, Inc.	Worcester	MA
City of Manchester Public Health Dept.	Manchester	NH
Providence Ambulatory Hlth Care Found	Providence	RI
Community Hlth Ctr. for Burlington, Inc.	Burlington	VT
William F. Ryan CHC	New York	NY
United Hospital Fund	New York	NY
Bowery Residents Committee Human Services, Corp.	New York	NY
Westchester Health Network Neighborhood Health Association of Mt. Vernon	White Plains	NY
Newark Homeless Health Care Project	Newark	NJ
Under 21 - Covenant House	New York	NY
St Vincent§s Hospital	New York	NY
NY Childrens Health Project	New York	NY
Jersey City Family Hlth Ctr	Jersey City	NJ
San Juan Department of Health	San Juan	PR
Henry J. Austin Hlth Ctr. HCH	Trenton	NJ
Health Care for the Homeless Proj., Inc.	Washington	DC
Health Care for the Homeless	Baltimore	MD
Primary Health Care Services	Erie	PA
Philadelphia Health Mgmt. Corporation	Philadelphia	PA
Primary Care Health Services	Pittsburgh	PA
Rural Health Corporation of NE PA	Wilkes-Barre	PA
The Daily Planet	Richmond	VA
Peninsula Institute for Comm. Hlth	Hampton	VA
Valley Health Systems, Inc.	Huntington	WV
Georgia Hill Street Neighborhood Fac.	Atlanta	GA
Birmingham Hlth Care for the Homeless	Birmingham	AL
Charleston Interfaith Crisis Ministry	Charleston	SC
Chattanooga Hamilton County Hlth Dept.	Chattanooga	TN

Exhibit I(Cont.)

Lincoln Community Health Center, Inc.	Durham	NC
Midlands Center for the Homeless	Eastover	SC
Broward County HCH	Ft. Lauderdale	FL
Jackson-Hinds Comprehensive HC	Jackson	MS
Lexington-Fayette County Hlth Dpt	Lexington	KY
Seven Counties Services, Inc.	Louisville	KY
Memphis Health Center, Inc.	Memphis	TN
Camillus Health Concern	Miami	FL
Pinellas County Department St.	Petersburg	FL
Metropolitan Health Dept.	Nashville	TN
Wake Health Services, Inc.	Raleigh	NC
Tampa Community Health	Tampa	FL
Travelers and Immigrants Aid	Chicago	IL
Crusaders Central Clinic	Rockford	IL
Indiana Health Centers, Inc.	Indianapolis	IN
East Side Promise, Inc.	Indianapolis	IN
Visiting Nurse Services of So. Mich.	Battle Creek	MI
Ingham County Health Dept.	Lansing	MI
St. Mary§s Health Services	Grand Rapids	MI
Family Health Center, Inc.	Kalamazoo	MI
Detroit Health Care for the Homeless	Detroit	MI
Downriver Community Services	Algonat	MI
Hamilton Family Health Ctr.	Flint	MI
Hennepin Cty Homeless Assistance Proj.	Minneapolis	MN
West Side Health Center, Inc.	St. Paul	MN
ECCO Family Health Center	Columbus	OH
Cordelia Martin Health Center	Toledo	OH
Cincinnati Health Network	Cincinnati	OH
Federation for Community Planning	Cleveland	OH
Coalition for Comm. Hlth Care	Milwaukee	WI
New Orleans Health Department	New Orleans	LA
Albuquerque Hlth Care for the Homeless	Albuquerque	NM
Community Health Center, Inc.	Oklahoma City	OK
Morton Comprehensive Health Serv. Inc.	Tulsa	OK
Amarillo Hospital District	Amarillo	TX
Dept of Hlth & Human Serv. - Dallas	Dallas	TX
City of Forth Worth Health Department	Fort Worth	TX
Harris County Hospital Dist.	Houston	TX
Guadalupe Economic Services Group	Lubbock	TX
The United Way of San Antonio & Bexar Cty	San Antonio	TX
Community Health Care, Inc.	Davenport	IA
Polk County Health Services	Des Moines	IA

Exhibit I(Cont.)

People's Community Health Clinic, Inc.	Waterloo	IA
Hunter Health Clinic, Inc.	Wichita	KS
Charles Drew Health Center	Omaha	NE
Swope Parkway Health Center	Kansas City	MO
Grace Hill Neighborhood Health Center	St. Louis	MO
Colorado Coalition for the Homeless	Denver	CO
Community Hlth Ctr of Colorado Springs	Colorado Spgs	CO
Health Care for the Homeless	Rapid City	SD
Salt Lake Community Health Ctrs, Inc.	Salt Lake City	UT
El Rio Santa Cruz Neighborhood Hlth Ctr	Tucson	AZ
Maricopa County Dept. of Hlth Services	Phoenix	AZ
The Family Health Foundation	Alviso	CA
Drew Health Foundation	E. Palo Alto	CA
Clinica Sierra Vista, Inc.	Lamont	CA
Logan Heights Family Health Center	San Diego	CA
Merced Family Health Centers, Inc.	Merced	CA
San Francisco Community Clinic	San Francisco	CA
Northeast Valley Health Corp.	Pacoima	CA
Nipomo Community Medical	Nipomo	CA
Sequoia Community Health	Fresno	CA
West Contra Cost HC Corp.	Richmond	CA
WCDCH Hosp. Board, Inc.	Waianae	HI
Sacramento County Health Dept.	Sacramento	CA
Santa Cruz Co. Hlth Svcs Agency	Santa Cruz	CA
Alameda Co. Health Care Svcs Agency	Oakland	CA
Santa Barbara County Hlth Care Svcs	Santa Barbara	CA
Terry Reilly Health Services	Nampa	ID
White Bird Clinic	Eugene	OR
Sea Mar Community Health Ctr.	Seattle	WA
Multnomah County Health	Portland	OR
Metropolitan Development	Tacoma	WA
Central Seattle Community Hlth Ctrs	Seattle	WA
Northwest Human Services	Salem	OR

EXHIBIT B

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

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FEDERALLY QUALIFIED HEALTH CENTER

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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UPDATES

Note: We revised this product with the following content updates:

- For calendar year 2021, the market basket update under the FQHC PPS is 1.7% and the FQHC PPS base payment rate is $176.45
- Beginning January 1, 2021, CMS added PCM HCPCS codes G2064 and G2065 to the calculation of HCPCS code G0511 payment rate, and CMS will update them annually
- CMS added new and expanded FQHC flexibilities during the COVID-19 public health emergency

Learn about Federally Qualified Health Center (FQHC) topics:

- Background
- FQHC Patient Services
- FQHC Certification
- FQHC Visits
- FQHC Payments
- Cost Reports
- Key Takeaways
- Resources
- Helpful Websites and Regional Office Rural Health Coordinators

Note: The information in this publication may not apply to Grandfathered Tribal FQHCs.

BACKGROUND

FQHCs are safety net providers for services typically from an outpatient clinic. SSA Section 1861(aa) allows additional FQHC Medicare payments.

FQHCs include:

- Community health centers
- Migrant health centers
- Health care for the homeless health centers
- Public housing primary care centers
- Health center program "look-alikes"
- Outpatient health programs or facilities a tribe or tribal organization or an urban Indian organization operates

FQHC PATIENT SERVICES

FQHCs provide:

- Physician services
- Services and supplies "incident to" physician services
- Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services
- Services and supplies provided "incident to" NP, PA, CNM, CP, or CSW services

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- Medicare Part B-covered drugs supplied “incident to” FQHC practitioner services
- Patient homebound visiting nurse services in an area where CMS certified a shortage of home health agencies
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for patients with diabetes or renal disease from qualified DSMT and MNT practitioners when provided in a 1-on-1, face-to-face visit
- Certain care management services, such as transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), principal care management (PCM), and psychiatric collaborative care model (CoCM) services
- Certain virtual communication services such as communications-based technology and remote evaluation services

FQHC CERTIFICATION

To qualify as an FQHC, an entity must meet **1** of these requirements:

- Get a grant under Section 330 of the Public Health Service (PHS) Act (42 USC Section 254a) or funded by the same grant contracted to the recipient
- **Not** getting a grant under Section 330 of the PHS Act but the HHS Secretary allows such a grant, which qualifies the entity as an “FQHC look-alike” based on a Health Resources and Services Administration (HRSA) recommendation
- Treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, for Medicare Part B purposes
- Operating as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act

FQHC certification requires the entity meet **all** these requirements:

- Provide comprehensive services including an ongoing quality assurance program and annual review
- Meet all health and safety requirements
- Not approved as a Rural Health Clinic
- Meet **all** Section 330 of the PHS requirements, including:
    - Serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP)
    - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
    - Governed by a board of directors, where most members get care at the FQHC

FQHC VISITS

FQHC visits **must**:

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC practitioner (physician, NP, PA, CNM, CP, or CSW), and the practitioner provides one or more qualified FQHC services
- In certain limited situations, include a registered nurse (RN) or a licensed practical nurse (LPN) homebound patient visit
- Under certain conditions, a qualified practitioner offers outpatient DSMT or MNT services when the FQHC meets the relevant program requirements to provide these services

FQHC visits **may** take place:

- In the FQHC
- At the patient's home, including an assisted living facility
- In a Medicare-covered Part A skilled nursing facility (SNF)
- At the scene of an accident

FQHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a critical access hospital (CAH)
- A facility with specific requirements excluding FQHC visits

FQHC PAYMENTS

Medicare FQHC PPS

Medicare pays FQHCs based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services from an FQHC practitioner.

- FQHCs must include an FQHC payment code on their claim.
- Medicare pays claims at 80% of the lesser of the FQHC charges based on their payment codes or the FQHC PPS rate (a national encounter-based rate with geographic and other adjustments).
- CMS annually updates the FQHC PPS base payment rate using the FQHC market basket. For calendar year 2021, the market basket update under the FQHC PPS is 1.7% and the FQHC PPS base payment rate is $176.45.
- Coinsurance is 20% of the lesser of the FQHC's charge for the specific payment code or the PPS rate, except for certain preventive services.

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- Medicare waives Part B coinsurance and deductible for preventive services, including specific Medicare Wellness Visits such as the Initial Preventive Physical Examination (IPPE), and Annual Wellness Visit (AWV). For more information, refer to the FQHC Preventive Services Chart and coinsurance and deductible requirements webpage.
- Except for telehealth services, there's no FQHC benefit services Part B deductible.

Per-Diem Payment & Exceptions

More than one visit with an FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, counts as a single visit, except when:

- The patient suffers an illness or injury requiring additional diagnosis or treatment on the same day. For example, a patient sees their practitioner in the morning for a medical condition and later in the day falls and returns to the FQHC.
- A patient has a qualified medical visit and a qualified mental health visit on the same day.

Payment Adjustments

These adjustments apply to the FQHC PPS payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- An IPPE or AWV adjustment

Charges & Payment

FQHCs set their own charges for their services and determine which services to include with each FQHC G code. Patient charges must be uniform.

For more information about FQHC PPS payment codes when submitting claims and a list of billable visits, refer to the FQHC webpage.

Payment is for professional services only. Medicare pays laboratory tests (excluding venipuncture) and the technical component of billable visits separately. Medicare includes procedures in the payment of an otherwise qualified visit not separately billable. If a procedure is associated with a qualified visit, include the procedure charges on the claim with the visit.

Chronic Care Management (CCM) Services or General Behavioral Health Integration (BHI)

Medicare pays CCM or general BHI services at the **average of the national non-facility physician fee schedule (PFS) payment rate** for CPT codes 99490, 99487, 99484, and 99491 (30 minutes or more of CCM provided by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an FQHC claim alone or with other payable services. Beginning January 1, 2021, CMS added PCM HCPCS codes G2064 and G2065 to HCPCS code's G0511 payment rate calculation. CMS will update this payment rate annually based on the PFS amounts.

Coinsurance for care management services is 20% of the lesser of submitted charges or the payment rate for G0511. Report care management costs in the non-reimbursable section of the cost report and don't determine the FQHC PPS rate.

You can bill G0511 once per month per patient when you deliver at least 20 minutes of CCM services, at least 20 minutes of general BHI services, or at least 30 minutes of PCM services, and your services meet all other requirements. The FQHC can count only services from an FQHC practitioner or auxiliary personnel within the scope of service elements toward the 20-minute minimum for billing general care management services or the 30-minute minimum for PCM services and **doesn't** include administrative activities such as transcription or translation services.

Psychiatric Collaborative Care Model (CoCM)

Medicare pays at the national non-facility PFS payment rate for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services), when HCPCS code G0512 is on an FQHC claim either alone or with other payable services.

Coinsurance for care management services is 20% of the lesser of submitted charges or the payment rate for G0512. Report care management costs in the non-reimbursable section of the cost report and don't determine the FQHC PPS rate.

You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services, and your services meet all other requirements. The FQHC can count only services from an FQHC practitioner or auxiliary personnel within the scope of service elements toward the 60-minute minimum for billing psychiatric CoCM and **doesn't** include administrative activities such as transcription or translation services.

Flu, Pneumococcal, & COVID-19 Shot

Medicare pays flu, pneumococcal, and COVID-19 shots and their administration at 100% of reasonable cost. The cost is included in the cost report so you bill no visit. FQHCs must include these charges on the claim if they're part of a visit. If the shot administration is the only service provided on that day, do not file a claim and waive the patient coinsurance.

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Hepatitis B Shot Administration & Payment

Medicare includes the hepatitis B shot and its administration in the FQHC visit. They aren't separately billable. If you provide a qualifying FQHC visit on the same day as the hepatitis B shot, report the charges for the shot and related administration on a separate line item to ensure no coinsurance is applied. You can't bill a visit if shot administration is the only service provided.

Telehealth Services Payment

FQHCs can serve as telehealth services originating sites if they're in a qualifying area. An originating site is where an eligible Medicare patient is during the telehealth service. FQHCs serving as telehealth originating sites get an originating site facility fee. Although FQHC services aren't subject to a deductible, you must apply the deductible when an FQHC bills the telehealth originating site facility fee. This fee isn't considered an FQHC service.

FQHCs aren't authorized to serve as a distant site for telehealth consultations, except during the COVID-19 public health emergency (PHE) (see COVID-19 Flexibilities below). A distant site is where the practitioner is during the time of the telehealth service. You can't bill the cost of the visit or include it on the cost report.

Virtual Communication Services

Medicare pays FQHCs for virtual communication services when an FQHC practitioner provides a patient at least 5 minutes of a billable FQHC communication technology-based or remote evaluation service. The patient must have had a billable visit within the previous year, and the services must meet **both** requirements below:

- The patient didn't get FQHC-related services within the last 7 days of the virtual medical discussion or remote evaluation
- The patient needs no FQHC service within the next 24 hours or at the next available appointment

Medicare requires FQHCs submit HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services) virtual communication services claims, when the virtual communication HCPCS code, G0071, is on an FQHC claim alone or with other payable services.

When an FQHC practitioner provides a patient Virtual Communication Services, Medicare waives the FQHC face-to-face requirements and applies the coinsurance. For more information, refer to the Virtual Communication Services FAQs.

COVID-19 Flexibilities

For information on new and expanded FQHC flexibilities during the COVID-19 PHE, refer to MLN Matters® Article SE20016.

COST REPORTS

FQHCs must file an annual cost report using FQHC Cost Report, Form CMS-224-14, to determine their payment rate and reconcile interim payments, including graduate medical education adjustments, bad debt, and flu and pneumococcal shots and their administration payments.

Provider-based FQHCs must complete the appropriate worksheet for FQHC services within the parent provider's cost report. To find more cost reports and forms, refer to the Provider Reimbursement Manual – Part 2.

KEY TAKEAWAYS

- FQHCs are safety net providers for services typically from an outpatient clinic.
- Medicare pays FQHCs based on the FQHC PPS for medically necessary primary health services and qualified preventive health services from an FQHC practitioner.
- CMS added new and expanded FQHC flexibilities during the COVID-19 PHE.

RESOURCES

- Care Management Services in Rural Health Clinics (RHCs) and FQHCs FAQs
- Chronic Care Management Services
- FQHC Center
- FQHC PPS
- Medicare Benefit Policy Manual, Chapter 13 — RHC and FQHC Services
- Medicare Claims Processing Manual, Chapter 9 — RHCs/FQHCs
- New and Expanded Flexibilities for RHCs and FQHCs During the COVID-19 Public Health Emergency (PHE)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Rural Providers Helpful Websites

- American Hospital Association Rural Health Care
- CMS Rural Health
- Critical Access Hospitals Center
- Disproportionate Share Hospitals
- Federal Office of Rural Health Policy
- Federally Qualified Health Centers Center
- Health Resources and Services Administration
- Hospital Center
- Medicare Learning Network®
- National Association of Community Health Centers
- National Association of Rural Health Clinics
- National Rural Health Association
- Rural Health Clinics Center
- Rural Health Information Hub
- Swing Bed Providers
- Telehealth
- Telehealth Resource Centers
- U.S. Census Bureau

Regional Office Rural Health Coordinators

Find contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.

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EXHIBIT C

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 l902(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. FOHCs 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 l 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 l 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 FOHCs 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.l.

(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.l due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.l 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. l 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.l, 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. l, 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 l 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. <u>Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage</u>

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 Applicants Amici Health Centers' Motion for Judicial Notice is granted. IT IS FURTHER ORDERED that this Court shall take judicial notice of the following:

A. The Centers for Medicare and Medicaid Services ("CMS Pub.") Publication 45, The State Medicaid Manual, Section 4231, relating to "Federally Qualified Health Center (FQHC" and Other Ambulatory Services";

B. The CMS Medicare Learning Network "FQHC Fact Sheet"; and

C. The California Medicaid State Plan, as approved by CMS, Section 4.19, relating to "Payment for Services," Attachment 4.19, 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

STATE OF CALIFORNIA, COUNTY OF SACRAMENTO

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Sacramento, State of California. My business address is 500 Capitol Mall, Suite 1500, Sacramento, CA 95814.

On May 12, 2022, I served true copies of the following document(s) described as

MOTION FOR JUDICIAL NOTICE IN SUPPORT OF AMICUS CURIAE BRIEF FILED BY AMICI HEALTH CENTERS

on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: (Superior Court and Court of Appeal) I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Hanson Bridgett LLP's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

BY TRUE FILING ELECTRONIC TRANSMISSION: Using the True Filing Service option on all counsel

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

Executed on May 12, 2022, at Sacramento, California.

/s/ Jessica L. Walker

Jessica L. Walker

SERVICE LIST

<u>Family Health Centers of San Diego v. Department of Health Care Services</u>
Supreme Court Case No. S270326
Court of Appeal No. C089555
Sacramento County Superior Court
No. 34201880002953CUWMGDS

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Supreme Court of California
Jorge E. Navarrete, Clerk and Executive Officer of the Court
Electronically FILED on 5/18/2022 by Celia Wong, Deputy Clerk

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: **kdoi@hansonbridgett.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
BRIEF	Shasta - Amicus Brief [Final]
REQUEST FOR JUDICIAL NOTICE	Shasta - RJN ISO Amicus Brief [Final]

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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/Kathryn Doi

Signature

Doi, Kathryn (121979)

Last Name, First Name (PNum)

Hanson Bridgett LLP

Law Firm