



Complying with CHIPRA PPS Requirements for Services Provided by FQHCs/RHCs: Background and Options

INTRODUCTION

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) includes a provision that changes the way in which Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed for services they provide to Children's Health Insurance Program (CHIP) subscribers. While there is no requirement in CHIPRA that states contract with FQHCs/RHCs for services to their CHIP subscribers, CHIPRA Section 503 requires the application of Medicaid's prospective payment system (PPS) for states that choose to do so. CHIPRA also provides \$5 million for state grants for expenditures related to implementing this provision. (Please see Attachment A for the language of Section 503.)

The purpose of this issue brief is to (1) identify for the Managed Risk Medical Insurance Board (Board) options for complying with the CHIPRA requirement to implement PPS for services provided by FQHCs/RHCs; and (2) seek Board guidance as to which option MRMIB staff should pursue in its discussions with the Administration, state Legislature, and stakeholders about implementing this provision.

Impact on HFP

Currently, MRMIB contracts solely with managed care organizations (MCOs), which in turn contract with providers for services to Healthy Families Program (HFP) subscribers. Complying with CHIPRA Section 503 will require a change in how MRMIB reimburses services provided by FQHCs/RHCs. It will also increase state costs and could have implications for HFP rate negotiations.

BACKGROUND

Federally Qualified Health Centers and Rural Health Clinics

Community health centers were first funded by the federal government in the 1960s. According to the National Academy for State Health Policy (NASHP), they share two key characteristics: (1) they maintain an "open door" policy, providing services to patients regardless of their ability to pay; and (2) a significant proportion of their patient mix is uninsured or in the Medicaid

program. There are a diverse array of community health centers, including FQHCs/RHCs; some are nonprofit while others are for-profit, and some are free-standing while others are county or hospital affiliated. There are also "FQHC look-alike" clinics, which resemble FQHCs but do not receive federal funding.

NASHP reports that in 2007, 110 FQHCs/RHCs with a total of 796 delivery sites served more than 2.3 million patients in California. The majority of these patients had incomes below 100% of the federal poverty level (FPL) and well over half were Hispanic/Latino. Medi-Cal, which provided these clinics with over \$597 million (41% of their total revenue) in 2007, is key to the financial operations of these FQHCs/RHCs.

Medi-Cal Implementation of PPS

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2001 (BIPA) required Medi-Cal to implement a PPS reimbursement approach for FQHCs/RHCs. In theory, the PPS approach gave providers a financial incentive to operate efficiently by establishing a per-visit payment rate in advance based on the historical, reasonable costs of each clinic. (Medi-Cal Medical Care Statistics Section, June 2007) Although implementation was delayed for several years, state statute passed in 2003 (SB 36, Chapter 527, Statutes of 2003) requiring Medi-Cal to reimburse FQHCs/RHCs on a PPS basis, consistent with federal law. The Medi-Cal PPS rate, which is clinic-specific, includes fixed overhead and infrastructure costs as well as payment for services such as education, translation and transportation. Chapter 527 requires MCOs contracting with FQHCs/RHCs for services to Medi-Cal patients to contract with these clinics under the same terms and conditions as they do with other providers. The law also authorizes an alternative payment methodology to calculate the PPS rate, and allows for adjustments in the PPS rate for changes in the scope of services provided by a FQHC or RHC. The base PPS rate is also adjusted annually by the Medicare Economic Index. (Please see Attachment C for the Code sections implementing PPS in Medi-Cal.)

Each year, participating managed care plans negotiate a reimbursement rate with each FQHC/RHC. These rates are required by law to be similar to rates paid to similar providers. The Department of Health Care Services (DHCS) then pays each clinic an interim, clinic-specific "wrap-around"¹ payment for each encounter, based on the average of all plan payments the clinic receives. This supplemental payment represents an estimate of how much is required to fully reimburse clinics for their services pursuant to PPS. Once a year DHCS reconciles and adjusts FQHCs/RHCs payments as needed to reimburse them fully for their costs based on information provided by the FQHC or RHC. DHCS also conducts audits on the data provided; however, their primary focus has been with the front-end payments. According to CPCA, the average per encounter PPS rate paid to FQHCs in 2008 was \$130, with county and public hospital FQHCs and Indian clinics receiving significantly higher rates. However, both utilization

¹ Under federal Medicaid statute, when a contract between a managed care organization and a FQHC/RHC results in the clinic receiving less than the amount of reimbursement due under the FQHC/RHC PPS, the state must make a supplemental "wrap-around" payment to the FQHC/RHC, to make up the difference the clinic is owed.

and wrap-around expenditures vary considerably among the twenty-two managed care Medi-Cal counties. (Medi-Cal Medical Care Statistics Section, June 2007)

The change in 2003 to a PPS reimbursement approach for services provided to Medi-Cal patients has provided a significant source of increased revenue for FQHCs/RHCs. The DHCS estimates that the managed care "wrap-around" payment to FQHCs/RHCs comprised just under 26% of total Medi-Cal payments to these clinics, and were 75% greater in 2005-06 than in 2001-02. According to DHCS, "The FQHC wrap-around PMPM (per member per month) expenditures have been rising among beneficiaries enrolled in managed care plans as contracting health plans make greater use of FQHCs as network providers." Generally, counties that contain Health Professional Shortage Areas experience the highest FQHC/RHC utilization rates. (Medi-Cal Medical Care Statistics Section, June 2007)

Current Connections between the HFP and FQHCs/RHCs

In 2008-09, HFP plans contracted with FQHCs/RHCs providing coverage to HFP subscribers in 52 counties. (Six counties do not currently have any FQHCs/RHCs for plans to contract with). (MRMIB data) According to NASHP, only a small percentage of California FQHCs' operating revenue (about 2%) is currently derived from their HFP subscribers. This may be because, despite contracts with MCOs representing HFP subscribers in most parts of the state, the overall size of the HFP subscriber population is dwarfed by the much larger number of Medi-Cal and uninsured patients seen by FQHCs/RHCs. In addition, the current reimbursement rates FQHCs/RHCs receive for services to HFP subscribers may be substantially below the PPS reimbursement rates they receive for Medi-Cal patients.

MRMIB has no information about the proportion of HFP subscribers who currently receive care from FQHCs/RHCs, nor does staff know the rates negotiated between MCOs and these clinics, as this information is not required to implement the HFP under its current managed care configuration. Informal discussions with several MCOs indicate that in some areas of the state, a significant amount of care received by HFP subscribers may be provided by FQHCs/RHCs. For example, the San Francisco Health Plan estimates that almost 50% of its HFP subscribers receive their care from FQHCs.

Impact of ARRA

The American Recovery and Reinvestment Act of 2009 (ARRA) includes provisions that encourage and support the creation of additional FQHCs. Although organizations such as NASHP and the CPCA anticipate this will increase the number of clinics available to provide services to HFP subscribers in California, there is no specific information available at this time. However, according to a study done by the California Health Care Foundation in March 2009, the number of community clinic sites in the state increased from 596 to 762 between 2003 and 2006. The study attributes this growth at least in part to the increase in federal funding (including the change in Medi-Cal reimbursements to PPS for clinic services). If, as expected, the number of FQHCs/RHCs increases as a result of ARRA, their share of services to HFP

subscribers may also be expected to increase, especially once the more favorable PPS reimbursement requirements are fully implemented.

Approaches in Other States

States have the option of implementing their CHIP programs through a Medicaid expansion, a separate CHIP, or a combination of the two (as California has chosen to do). According to information from NASHP, a majority of states have chosen over time to utilize contractor-based delivery systems, in which managed care plans provide some or all of the services for CHIP subscribers. MRMIB staff posted questions on CHIP Chat, the all-state on-line listserv for CHIP administrators, requesting information from other states utilizing managed care arrangements on how they currently comply with PPS requirements in their Medicaid programs and how they intend to comply (or are already complying) with this provision in their CHIP programs. To date, MRMIB has received responses from the following states:

- **Arizona:** Has a separate CHIP program. Arizona calculates one PPS rate for each FQHC/RHC in both the AHCCCS (Arizona Medicaid) and CHIP programs. The state currently provides wrap-around reconciliation payments to these clinics for services provided to Medicaid subscribers but not for CHIP subscribers.
- **Delaware:** Has a combination CHIP program. Delaware requires the MCOs it contracts with to pay FQHCs using the same PPS methodology used under the Medicaid fee-for-service program. The actual rates paid can be greater than the Medicaid fee-for-service rate, but not less. PPS rates are paid whether the services are provided to Medicaid or CHIP subscribers.
- **Florida:** Has a combination CHIP program. Florida has enacted legislation to pass the PPS requirement along to the MCOs it contracts with, and to allow MCOs to take this into consideration in their annual rate adjustment requests.
- **Kentucky:** Has a combination CHIP program. Kentucky requires the MCOs it contracts with to pay FQHCs/RHCs using the same PPS methodology used under the Medicaid fee-for-service program. However, while the state does an annual reconciliation with clinics for services provided to Medicaid recipients, it does not currently do so for services provided by FQHCs/RHCs to CHIP subscribers.
- **Minnesota:** Has a combination CHIP program and utilizes MCOs heavily in providing services to both Medicaid and CHIP subscribers. MCO contracts require them to reimburse FQHCs/RHCs at the same rates paid to other providers, and the state then pays a supplemental amount to each FQHC and RHC. Minnesota already uses the Medicaid PPS rate for CHIP subscribers since the benefit package for both Medicaid and CHIP is the same.

- **New Mexico:** Has a Medicaid expansion CHIP program and utilizes managed care contracts with FQHCs/RHCs. New Mexico does a PPS supplemental payment to FQHCs/RHCs for services provided to both Medicaid and CHIP subscribers; rates are essentially the same for both programs as they are based primarily on age and gender.

These responses reveal the individualized approaches states have taken in implementing their CHIP programs and in complying with the PPS requirements in their Medicaid programs. Some states, primarily those with Medicaid expansion CHIP programs, may already be in compliance with the new PPS requirements for their CHIP programs, but for many states, especially those with separate or combination CHIP programs and utilizing a managed care program design like California, the PPS reimbursement approach for CHIP services is entirely new. Given the absence of CMS guidance to date on implementing this requirement, information from other states is likely to change over time as they revise their current reimbursement arrangements to comply with the new PPS requirement.

Effective Date

Complying with CHIPRA Section 503 will require a change in state statute. CHIPRA (Section 3(b)) specifies that provisions requiring a state law change will be effective on "the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment". For California, this effective date is January 1, 2011². For states that do not need state statute change to conform, the effective date is October 1, 2009. (Please see Attachment B for the language of Section 3(b).)

OPTIONS FOR CONSIDERATION

CHIPRA requires MRMIB to change from the current reimbursement approach for FQHCs/RHCs. The following section highlights the options staff has identified for discussion with the Board.

In evaluating these options, MRMIB staff kept the following criteria in mind:

- ✓ Ease of implementation
- ✓ Efficiency
- ✓ Cost to HFP
- ✓ Incentives
- ✓ Effect on managed care approach
- ✓ Effect on rate negotiations
- ✓ Ease of enforcement

² Pending CMS clarification; the implementation date may be later for some MCO requirements.

Option 1: Use DHCS to Implement an Approach Similar to Medi-Cal

MRMIB could choose to contract with DHCS to implement the PPS requirements in the same way the state currently implements PPS for the Medi-Cal Program. MRMIB staff has had several conversations with DHCS staff to discuss how this option could be implemented. Medi-Cal staff has provided MRMIB a draft analysis and estimates there would be costs for one-time system modifications, staffing (i.e. additional auditors) and ongoing transaction costs. MRMIB staff is reviewing the analysis and will determine estimated costs if the Board is interested in pursuing this option.

Advantages:

- ✓ *Ease of implementation, efficiency, effect on rate negotiations, and ease of enforcement*

DHCS already has a mechanism in place for implementing the PPS requirements, reimbursing FQHCs/RHCs, and monitoring clinic and MCO compliance. Although there would be implementation issues to resolve, they are relatively minor since DHCS has had several years to develop and refine the PPS reimbursement process. DHCS auditors are familiar with the majority of FQHCs/RHCs, since most of them contract with Medi-Cal; conversely, most clinics are familiar with the reimbursement and reconciliation process developed by Medi-Cal. This option would have no impact on rate negotiations between MRMIB and MCOs.

Disadvantages:

- ✓ *Cost to HFP, incentives, and effect on managed care approach*

MRMIB would be required to reimburse DHCS for their development, implementation and ongoing transaction costs. This approach would require staff resources to draft and implement an interagency agreement, and to monitor deliverables and compliance with PPS-related activities. This option also shifts the financial relationship between MRMIB and FQHCs/RHCs from a managed care reimbursement approach to a direct, more fee-for-service approach. There may also be some incentive for MCOs to attempt to negotiate lower than average rates with FQHCs/RHCs, knowing that the difference between contracted rates and actual costs would be made up by the "wrap-around" payment. However, this would be a clear violation of statute and contracting requirements.

Option 2: Require MCOs to Implement

MRMIB could opt to re-negotiate the rates paid to MCOs so that the increased reimbursement rates paid to FQHCs/RHCs, and the calculations required to implement the PPS, are passed through to MRMIB in the form of rate increases. The direct costs of implementing the PPS reimbursement approach would then be borne by MCOs contracting with FQHCs/RHCs, and incorporated into the rates paid by MCOs for services provided by these clinics to HFP subscribers.

This is similar to the approach the Florida State Legislature has taken, enacting the following language in state statute: "Effective October 1, 2009, payments for services provided to enrollees by federally qualified health centers and rural health clinics under this section shall be reimbursed using the Medicaid Prospective Payment System as provided for under s. 2107 (e)(1)(d) of the Social Security Act. If such services are paid for by health insurers or health care providers under contract with the Florida Healthy Kids Corporation [Florida's CHIP], such entities are responsible for this payment." (SB 1658, 2009, Enrolled)

Advantages:

- ✓ *Effect on managed care approach*

Under this option, MCOs would be the entities responsible for calculating the PPS rates for each FQHC/ RHC and reimbursing these clinics for their costs. Once MRMIB re-negotiates the rates with MCOs, the MCOs bear all the financial risks—just as in the current managed care structure of the HFP.

Disadvantages:

- ✓ *Ease of implementation, efficiency, cost to HFP, incentives, effect on rate negotiations, and ease of enforcement*

Implementation and enforcement could actually be a greater burden on MRMIB under this option, since it would require contract re-negotiation and extensive contract monitoring with all the MCOs participating in the HFP. It would be inefficient in that it duplicates the Medi-Cal model and requires MRMIB staff to develop expertise in areas Medi-Cal has already developed.

This option could increase contractual rates significantly—in Florida, rates increased up to 10% in areas of the state with substantial utilization of FQHCs/RHCs for CHIP services. On the other hand, MCOs in California could refuse to participate if MRMIB insisted on negotiating rate increases deemed insufficient by participating health plans. Additionally, this option could create a disincentive for MCOs to contract with FQHCs/RHCs for services, since the MCOs would bear the financial risk for any miscalculations between the rates they negotiate with MRMIB and the PPS rate they must pay the clinics.

This option would create particular implementation challenges given the use of the Family Value Plans as a core element of the rate negotiation process. MRMIB staff is not at all sure MCOs would be willing to accept the additional financial risks given the state's current fiscal crisis.

Finally, it is unclear whether CMS will approve this approach to complying with the PPS requirements in CHIPRA, since the state does not have direct control over reimbursing FQHCs and RHCs for their costs.

Option 3: Require AV to Implement

MRMIB could choose to contract with the HFP administrative vendor (AV) to develop and implement the process for reimbursing FQHCs/RHCs and calculating the PPS rate. The AV could then reconcile, once a year, between the interim reimbursement rates and the actual PPS rate, and conduct the requisite audits. This option is similar to Option 1, except that instead of using the Medi-Cal model, MRMIB would contract with the HFP AV for implementation, oversight and enforcement of the PPS reimbursement approach.

Advantages:

- ✓ *Cost to HFP and effect on rate negotiations*

MRMIB would re-create the Medi-Cal model with the HFP AV. Experience has demonstrated that including tasks in the AV contract has been cost effective and provides opportunities to include performance standards, etc. Additionally, this option would have no negative effect on rate negotiations between MRMIB and MCOs participating in the program.

Disadvantages:

- ✓ *Ease of implementation, efficiency, incentives, effect on managed care, and ease of enforcement*

This option appears to present most of the disadvantages present in the first two options. MRMIB would be required to reimburse the AV for their development, implementation and ongoing transaction costs. This approach would require staff resources to draft and implement a contract amendment with the AV, and to monitor deliverables and compliance with PPS-related activities. This option also shifts the financial relationship between MRMIB (through the AV) and FQHCs/RHCs from a managed care reimbursement approach to a direct, more fee-for-service approach. As in Option 1, there may also be some incentive for MCOs to attempt to negotiate lower than average rates with FQHCs/RHCs, knowing that the difference between contracted rates and actual costs would be made up by the "wrap-around" payment. However, this would be a clear violation of statute and contracting requirements. This option would also be inefficient in that it duplicates the Medi-Cal model and requires both MRMIB and the AV staff to develop expertise in areas Medi-Cal has already developed.

The advantages of each of these options are summarized in the table below (next page).

CRITERIA:	OPTION 1: Medi-Cal to Implement	OPTION 2: MCOs to Implement	OPTION 3: AV to Implement
Ease of implementation	✓		
Efficiency	✓		
Cost to HFP			✓
Incentives			
Effect on managed care approach		✓	
Effect on rate negotiations	✓		✓
Ease of enforcement	✓		

✓ = Advantage of this option

SUMMARY

This issue brief has identified the options for complying with federal CHIPRA requirements to reimburse FQHCs/RHCs using the PPS reimbursement approach. Based on a review of the advantages and disadvantages of the options described above, MRMIB staff recommends Option 1, the Medi-Cal-like approach, as the best option to pursue in discussions with the Administration, state Legislature, and stakeholders regarding implementing the CHIPRA PPS requirement.

If the Board feels it has sufficient information to select this as a preferred option, MRMIB staff further recommends that the Board direct it to develop an implementation approach in more detail for this option.

If the Board feels that more information is needed in order to identify a preferred option, MRMIB staff recommends that specific questions be discussed so that staff may return to the Board with information that will assist the Board in selecting a preferred option.

H.R.2

Children's Health Insurance Program Reauthorization Act of 2009 (Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 503. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) Application of Prospective Payment System-

(1) IN GENERAL- Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 501(c)(2) is amended by inserting after subparagraph (C) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

(D) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

(2) EFFECTIVE DATE- The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2009.

(b) Transition Grants-

(1) APPROPRIATION- Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2009, \$5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(D) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) MONITORING AND REPORT- The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2011, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

H.R.2

Children's Health Insurance Program Reauthorization Act of 2009 (Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 3. GENERAL EFFECTIVE DATE; EXCEPTION FOR STATE LEGISLATION; CONTINGENT EFFECTIVE DATE; RELIANCE ON LAW.

(a) General Effective Date.--Unless otherwise provided in this Act, subject to subsections (b) through (d), this Act (and the amendments made by this Act) shall take effect on April 1, 2009, and shall apply to child health assistance and medical assistance provided on or after that date.

(b) Exception for State Legislation.--In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(c) Coordination of CHIP Funding for Fiscal Year 2009.-- Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11), 2104(k), or 2104(l) of the Social Security Act, as amended by section 201 of Public Law 110-173, to provide allotments to States under CHIP for fiscal year 2009--

(1) any amounts that are so appropriated that are not so allotted and obligated before April 1, 2009 are rescinded; and

(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

**Medi-Cal Implementation of PPS Supplemental Payments in Managed Care Counties
Welfare and Institutions Code Section 14087.325**

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

(b) Except as otherwise provided in this section, managed care subcontracts offered to a federally qualified health center or a rural health clinic, as defined in Section 1396d(l)(1) of Title 42 of the United States Code, by a local initiative, county organized health system, as defined in Section 12693.05 of the Insurance Code, commercial plan, as defined in subdivision (h) of Section 53810 of Title 22 of the California Code of Regulations, or a health plan contracting with a geographic managed care program, as defined in subdivision (g) of Section 53902 of Title 22 of the California Code of Regulations, shall be on the same terms and conditions offered to other subcontractors providing a similar scope of service. Any beneficiary, subscriber, or enrollee of a program or plan who affirmatively selects, or is assigned by default to, a federally qualified health center or rural health clinic under the terms of a contract between a plan, government program, or any subcontractor of a plan or program, and a federally qualified health center or rural health clinic, shall be assigned directly to the federally qualified health center or rural health clinic, and not to any individual provider performing services on behalf of the federally qualified health center or rural health clinic.

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

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

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

difference between the center's or clinic's revenue from the plan and the center's or clinic's cost-based reimbursement or the center's or clinic's prospective payment rate.

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

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

(g) On or before September 30, 2002, the director shall conduct a study of the actual and projected impact of the transition from a cost-based reimbursement system to a prospective payment system for federally qualified health centers and rural health clinics. In conducting the study, the director shall evaluate the extent to which the prospective payment system stimulates expansion of services, including new facilities to expand capacity of the centers, and the extent to which actual and estimated prospective payment rates of federally qualified health centers and rural health clinics for the first five years of the prospective payment system are reflective of the cost of providing services to Medi-Cal beneficiaries. Clinics may submit cost reporting information to the department to provide data for the study.

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

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

