Reimbursement for Dental Services in a Community Setting

A Resource Guide for Federally Qualified Health Centers

CPCA
California Primary Care Association
Health Care Access for All

Center for Oral Health
Collaboration Innovation Advocacy

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Center for Oral Health

The Center for Oral Health (COH), formerly the Dental Health Foundation was founded in 1985. COH is a California-based non-profit organization dedicated to promoting public oral health, with a focus on children and other vulnerable populations. COH collaborates with national, state, and local partners to develop innovative community-based strategies for improving oral health. COH has offices in Northern and Southern California.

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California Primary Care Association (CPCA) is the statewide leader and recognized voice representing the interests of California community clinics and health centers and their patients. CPCA represents more than 800 not-for-profit community clinics and health centers (CCHCs) who provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians, who might otherwise not have access to health care.

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The Need for Community Based Dental Care

Poor oral health is a serious national health problem and untreated tooth decay affects 53 million children and adults across America. The Surgeon General has described oral and dental diseases as a “silent epidemic” and has highlighted the link between oral health and general health and well being. Pain and suffering due to oral diseases cause problems with overall health as well as with basic functions such as eating, speaking and learning. Dental diseases disproportionately affect children and low income populations. Poor children are more likely to have dental caries than children in higher income families, and that decay is more severe.

Although California provides dental coverage for low-income children through the Medi-Cal dental program, many are still not receiving care. In addition to health insurance coverage, families need care that is timely, geographically accessible, and culturally competent. Early preventive dental care is still a new concept for many people and parents often do not seek this out for their children. Although the American Dental Association recommends that children be seen by a dentist by their first birthday or first tooth, most parents delay care until much later. One way to increase preventive care for children is through the provision of dental services in schools, WIC sites, Head Start programs and other locations in the community. By expanding services to reach people in the communities where they live, great strides can be made in improving oral health.

Health centers are ideally situated to address this unique challenge. Federally Qualified Health Centers (FQHCs) were created to bring comprehensive health services to underserved populations and to develop services in response to community needs. Health centers are often the main healthcare provider of services in rural and low-income neighborhoods and are able to provide a myriad of primary medical care, behavioral health care, and dental services.

Many health centers are responding to the oral health needs in their communities by bringing dental services to WIC programs, schools and other community sites. These locations offer excellent venues for engaging families who might not otherwise seek out preventive dental services. By providing early care, health centers are able to prevent dental disease and the result is better health outcomes for the communities that they serve.

This guide has been developed as a resource for health centers that are developing these innovative oral health programs. The information provided is intended to assist health centers in navigating the many Federal and State laws, regulations, and policies so that they will be able to create sustainable oral health programs in underserved communities across the state.
Background and Brief History of Health Centers

The health center movement began with the creation of the migrant health center program, followed by the neighborhood health center demonstration projects initiated in 1965 as part of President Johnson's War on Poverty. It was recognized that by addressing untreated health problems of the poor, the economic burden of these communities could be reduced.

Health centers were envisioned as comprehensive health service programs oriented towards the needs of the vulnerable and underserved. Health centers have made great strides in eliminating barriers to health care for these populations, ensuring continuity and quality of care, promoting the use of preventive services, and increasing community participation. Health centers are unique in providing access to a wide range of medical and non-medical services, and in their mission to serve all, regardless of ability to pay.

Section 330 of the Public Health Service Act defines a health center as a non-profit organization that provides primary and preventive health care services for uninsured and underserved populations in collaboration with other community providers. The Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA), is charged with developing and administering all section 330 funding opportunities. A “health center” is a type of provider defined by the Medicare and Medicaid statutes and includes all Federally Qualified Health Centers (organizations receiving grants under section 330 of the Public Health Service Act – also known as FQHCs), certain tribal organizations, and organizations with “FQHC Look-Alike” designation. There are a variety of types of organizations that may receive 330 grants, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs. School-Based Health Centers are eligible for funding as well and are awarded under the Community Health Center program. A few county health departments and public hospitals are also funded as public entities through section 330.

For more than 45 years, health centers have provided comprehensive, culturally competent, and quality primary health care services to those in need. The U.S. Office of Management and Budget has ranked the health center program as one of the ten most effective federal programs. Today, there are more than 1,250 health centers that operate in more than 8,000 communities throughout the country. Despite major growth and numerous challenges over the past 45 years, the mission has remained the same—the provision of high-quality primary and preventive health care services to people in rural and urban medically underserved areas.
Federal Expectations for Community-Based Services

Resource: Policy Information Notice (PIN) 98-23, "Health Center Program Expectations" – outline of FQHC expectations and responsibilities

Federal guidance on FQHC expectations makes clear that FQHC services must extend to off-site locations in order to ensure access to the communities they serve. Bureau of Primary Health Care Policy Information Notice 98-23 states that: “Health centers must provide services at locations and times that ensure services are accessible to the community being served... in locations ranging from homeless shelters to migrant farm worker camps to public housing communities to schools.”

“FQHC services must extend to off-site locations in order to ensure access to the communities they serve.”

Public Health Service Act Section 330 defines a health center as “an entity that serves a population that is medically underserved.”

PIN 98-23 also specifies that health centers “must collaborate appropriately with other health care and social service providers in their area... to ensure the effective use of limited health center resources, providing a comprehensive array of services for clients...” This suggests that the BPHC is well aware that not all services can or should occur within the physical site of a health center. Therefore health centers are charged with coordinating care services in their communities.

Moreover, PIN 98-23 expands upon the statute in Section 330 of the Public Health Service Act. Section 330 defines a health center as “an entity that serves a population that is medically underserved.” PIN 98-23 states that underserved populations “includes all people who face barriers in accessing services because they have difficulty paying for services ... and includes people who have disparities in their health status.”
Health centers are expected by BPHC to provide services at locations that ensure services are accessible to the community being served (PIN 98-23). As a result, many health centers offer services outside the traditional clinic setting, such as homeless shelters, migrant farmworker camps, public housing, and schools.

WIC sites are another important venue for health centers to serve the underserved population in their service area. Children who are in the WIC program are from families at or below 185 percent of the federal poverty level (FPL). This population is consistent with the economic demographics of the vast majority of people served by the health centers. Eighty-four percent of all FQHC patients in California are at or below 200 percent of the FPL. This means that the vast majority of children ages five years and under served at health centers are eligible for WIC services.

Dental services are required services of health centers. As mandated by Section 330 (b)(1) and reiterated in PIN 98-23, health centers are required to provide specified primary care services, including pediatric dental screenings and preventive dental services for children. PIN 98-23, in part, states: “all health center programs must provide, directly or through contracts or cooperative arrangements, basic health services including: primary care; … well child services; immunizations against vaccine-preventable diseases; … eye, ear and dental screening for children; family planning services and preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.” (See Appendix A for additional information from Section 330 of the U.S. Public Health Service Act.) So bringing oral health services to WIC sites is an important step for health centers to effectively fulfill their federal mandate and reach their target population.
Payment for Health Centers

Prospective Payment System

This section was taken from “Federally Qualified Health Centers and State Health Policy: A Primer for California”. Mary Takach and Elizabeth Osius, National Academy for State Health Policy, July 2009.

In 2001, federal law required states to reimburse FQHCs using an all-inclusive, per-visit, prospective payment system (PPS). The base rate is set using each FQHC’s reasonable cost of providing Medicaid-covered services. Subsequent years’ payments are adjusted annually, using the Medicare Economic Index (MEI) for primary care.

In California, starting in 2001, health centers had their rates set based on their actual costs in 2000 or their first year of operation. In 2003, Senate Bill 36 (Chapter 527, Statutes of 2003) also set into place a process allowing for adjustment of FQHC reimbursement rates to account for changes in costs associated with an increase or decrease in scope of services.

As a result of the PPS system health centers are paid on a per-visit basis rather than on a per-service basis. The PPS rate is an average amount of how much each visit costs a health center. The rate is an all-inclusive rate and does not change based on the procedure or service provided. Medi-Cal pays the health center that rate for each eligible medical and/or dental visit by a Medi-Cal beneficiary. Eligible visits are those that include a Medi-Cal covered service during the visit. Health centers receive no payment from Medi-Cal for services provided to uninsured patients.

Requirements for providing dental services:

- HRSA Scope of Project
  - Service
  - Location
- Target Population
- Licensed or intermittent primary care clinic
- Face-to-face visit by a dentist or billable hygienist
Reduction of Medi-Cal Adult Dental Services

In July 2009 California eliminated most dental benefits for the majority of adult Medicaid beneficiaries. Dental services for most children, however, remain a covered benefit under the Medi-Cal program. Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009), the budget trailer bill that was passed in February 2009, contained a provision for the exclusion from coverage of specific optional benefits under the Medi-Cal program, including adult dental services (with some exceptions), acupuncture, audiology, chiropractic, optometric and optician, podiatry, psychology and speech therapy services, effective July 1, 2009. This policy affects most Medi-Cal beneficiaries who are 21 years of age and older. The only adult dental coverage that remains is pregnancy-related dental services, comprehensive coverage for residents of Intermediate Care Facilities (ICF) and Skilled Nursing Facilities (SNF) and Federally Required Adult Dental Services (FRADS).¹

This does not affect eligible beneficiaries of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (i.e. - individuals who are younger than 21 years of age with full-scope Medi-Cal). So Medi-Cal beneficiaries under the age of 21 remain eligible for dental services. Therefore, dentists who are employed by or contract with the health centers to provide FQHC services will generate a PPS billable encounter when providing a face-to-face covered dental service to children enrolled in full-scope Medi-Cal.

(Please see Appendix C for additional information from the Welfare and Institutions Code.)

¹ For a complete list of Federally Required Adult Dental Services (FRADS) and other elements of the elimination of optional benefits, see Denti-Cal Bulletin Volume 25, Number 22, May 2009 at www.denti-cal.ca.gov
FQHC Visit Definition

The PPS rate is paid for each encounter, defined by the Health Resources and Services Administration (HRSA) as “a documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the patient.” To be included as a visit, services rendered must be documented in a chart in the possession of the FQHC.

(Please see Appendix B for additional information on Welfare and Institution Code Section 14132.100.)

Health centers provide a variety of dental services at different locations. The service design is developed in response to the location and the needs of the community. Since WIC sites serve children under the age of five, dental services at these locations focus on preventive care and oral health education for the family.

Generally, the following services are provided at WIC sites:

- Dental exam
- Fluoride varnish application
- Toothbrush prophylaxis
- Risk assessment

Although FQHCs do not bill Denti-Cal for dental services they provide, Denti-Cal's Provider Handbook (http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=ProvManual) governs what dental procedures are billable by FQHCs. According to the Denti-Cal program, an examination by a dentist only, a fluoride varnish application by a dentist or hygienist, and a toothbrush prophylaxis by a dentist or hygienist are all covered benefits for Medi-Cal beneficiaries under 21 years old.

In the Denti-Cal program, a Registered Dental Hygienist in Alternative Practice (RDHAP) may also bill for a fluoride varnish application and toothbrush prophylaxis. A dental risk assessment is considered part of an examination and so is not a separately covered benefit under Denti-Cal. Therefore, there is no PPS reimbursement for an FQHC visit when the only service provided is a dental risk assessment. PPS reimbursement at the per visit rate will be available only when the risk assessment is provided in conjunction with any of the other named WIC Project services.

Special Considerations

- In order for an FQHC to bill for the services of a dental hygienist or a Registered Dental Hygienist in Alternative Practice, the site must apply to DHCS for a PPS rate change.
- An FQHC can only bill for one dental encounter per day. Multiple encounters with different dental professionals that take place on the same day constitute a single visit.
- Multiple services on the same day also constitute a single visit. Therefore, if a dentist working with an FQHC performs a dental exam and fluoride varnish application on a child enrolled in Medi-Cal on the same day, only one PPS reimbursable encounter will result.
Federal HRSA Scope of Project Issues to Consider

Resource: Defining Scope of Project and Policy for Requesting Changes (PIN 2008-01)

HRSA must approve the services and activities undertaken by health centers as the health center’s federal “scope of project.” The scope of project is defined as “the approved service sites, services, providers, service area(s) and target population(s) which are supported (wholly or in part) under the total section 330 grant-related project budget.” FQHC look-alikes must also operate under a HRSA-approved scope of project.

HRSA approval of activities as a health center’s scope of project is very important because it:

- Identifies the services and sites that are eligible for PPS reimbursement
- Extends Federal Tort Claims Act (FTCA) coverage, the medical malpractice insurance for health centers and their employees;
- Provides the site information which enables health centers to purchase discounted drugs under the section 340B Drug Pricing Program;
- Defines the approved sites for State Medicaid Agencies to calculate reimbursement rates under the Prospective Payment System (PPS);
- Defines the approved sites for the Centers for Medicare and Medicaid Services to determine a health center’s FQHC Medicare rate.

Service Area under Scope of Project


A service area or “catchment” area is defined in PIN 2008-01 as “the area in which the majority of the health center’s patients reside.” The health center program’s authorizing statute requires that each grantee periodically review its catchment area to:

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellites) are available and accessible to the residents of the area promptly and as appropriate;
(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and
(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area’s physical characteristics, its residential patterns, its economic and social grouping, and available transportation.
Target Population under Scope of Project

The target population is defined in PIN 2008-01 as “an underserved population from within the established service area to which [the FQHC] will direct its services.” The health centers participating in the WIC Project are required to make services available to all residents of the health center’s service area, regardless of the individual’s ability to pay. The demographic, income, insurance status, and other information on the service area and target population should be recorded in the FQHC’s approved scope of project.

Service Sites under Scope of Project

A service site is defined in PIN 2008-01 as “any location where a grantee, either directly or through a sub-recipient or established arrangement, provides primary health care services to a defined service area or target population.” The PIN continues to explain that a service site may provide all primary care services or “may provide a single service such as oral or mental health services, based on the identified needs of the community/population.” This permits health centers to provide services at other sites and with other providers through formal written arrangement, and shows that it is not necessary for each site/provider included in the FQHC’s scope of project to offer all required primary health care services.

In order for sites to be approved under a health center’s federal scope of project, the following conditions must be met:

- Health center encounters are face-to-face contacts between patients and providers;
- Providers exercise independent judgment in the provision of services to the patient;
- Services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and
- Services are provided on a regularly scheduled basis. (Note: there is no minimum number of hours per week that services must be available at an individual site as long as the services are regular)

The third bullet point above is included to highlight that the health center’s governing board must approve all services that are approved under scope.

In the Scope of Project PIN, HRSA reminds grantees that required services are defined for the organization/entity and not for the individual site. Therefore, it is not required that all services within an approved scope of project be available at every service site. However, patients must have reasonable access to the full array of services offered by the health center. Moreover, health centers must assure that services are provided in a culturally and linguistically appropriate manner based on the target population. In addition, HRSA reminds grantees that all approved services must be made available equally to all patients regardless of their ability to pay and available through a sliding fee scale.
Submitting Federal Change in Scope Requests

If the community service site is not already listed in Form 5B of the FQHC’s approved scope of project, then the FQHC would be required to get prior approval to add a service site. Likewise, if the FQHC does not already have dental services listed as an approved service, then the FQHC would need to add dental services to its scope of project. As with all requests for scope of project changes, the health center must demonstrate that the change can be accomplished without additional 330 funds. In addition, the Board of Directors must approve the change in scope and document such approval in the Board minutes. Health centers must consult first with their HRSA Project Officer and must submit any change in scope request at least 60 days in advance of the desired implementation date. The request is submitted via the HRSA Electronic Hand Book (EHB).

For additional health center sites that provide a single service, the health center must show that the new site is in a location that allows reasonable access to all of the other services offered by the health center corporation.

As with all scope of project changes, the health center must demonstrate, by submitting a revised project budget, that the change in scope will result in either breaking even or generating new revenue. New revenue generated as a result of a new service or site must be invested in activities that further the mission of the health center.

Finally, if there is any potential for service area overlap by adding a new site or broadening its service area, the health center should attempt to secure letters of support from any health centers, or explain why such support could not be secured (see Service Area Overlap PIN 2007-09).

HRSA has made a commitment to make final decisions to change in scope requests within 60 days with the effective date of approval occurring no earlier than the date of receipt of a request for prior approval.
Providing Services as an Intermittent Clinic

California Health and Safety (H&S) Code Section 1200 requires primary care clinics, specialty clinics, and psychology clinics to be licensed through the authority of the California Department of Public Health (CDPH) Licensing & Certification Program (L&C). The L&C Program utilizes standards defined in state and federal law and regulations to evaluate health facility compliance. Primary care clinics include community clinics and free clinics

(Please see Appendix D for the full definition in H&S Code 1204(a).)

The licensing and certification process is intended to both ensure public safety at community clinics, and to prevent fraud and abuse of the Medi-Cal and Medicare billing systems. L&C’s Central Applications Unit located in Sacramento is responsible for initial review of all licensing applications. Applications deemed complete are then passed to one of 15 regional district offices that perform site surveys, investigate complaints, and issue licenses if all requirements have been met. There are numerous regulations that clinics must meet in order to obtain a license. These include building standards, drug storage and administration, administrative matters, basic services and staffing in order to obtain a license. At a minimum, the clinic must make the following documents available for review during the licensing survey: clinic policies and procedures, transfer agreements, service agreements, written administrative policies, employee records, employee health examinations and health records, a disaster response plan, and a quality assurance evaluation process.

There are a number of clinic types that are explicitly exempt from primary care clinic licensure. H&S Code Section 1206 provides a comprehensive list of those types of entities exempt from licensure. Among those included on the exemption list are intermittent clinics. Intermittent clinic have also been referred to as “satellite sites” or “satellite clinics.” However, for purposes of this discussion, they shall be referred to as intermittent clinics. An intermittent clinic is defined as follows:

H&S 1206

(h) A clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 20 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.

Thus, according to the statute, an intermittent clinic site must meet the following standards:

1) Is operated by a licensed primary care clinic
2) Is only open for limited services of no more than 20 hours of services/week
3) Meets the administrative regulations and requirements relevant to fire & life safety
In addition organizations are required to inform DHCS of all intermittent clinic sites.

**Intermittent Clinics Must be Operated by a Licensed Primary Care Clinic**

In order to verify that the intermittent site is operated by a licensed primary care clinic, it is recommended that health centers have a lease or Memorandum of Understanding (MOU) in place with the host site that clearly identifies the clinic space and hours of operation.

The MOU should specify the following:

- Clearly identify clinic space and hours of operation
  - May include a floor plan with clinic space highlighted
- Identify that the clinic has control of the operations of that space during the clinic hours
  - To qualify as an “intermittent clinic,” the FQHC must “operate” the site
- Indicate the cost, start date and length of agreement

**Intermittent Clinics Can Only be Open for Limited services of no more than 20 Hours per Week**

- Patient access to the clinic must be 20 hours or less in any given week
- Staff may be present at the site during additional hours to complete charting, administrative tasks, clean-up, etc.
- Documentation (for audit purposes) should include:
  - Photograph of posted hours
  - Patient schedule

**Intermittent Clinics Must Meet the Administrative Regulations and Requirements Relevant to Fire & Life Safety**

- Fire clearance (presumed based on fire safety notation in statute)

**Medi-Cal and Medicare at the Intermittent Clinic Site**

Intermittent clinics retain the ability to bill for Medi-Cal services under their “parent” clinic’s provider number, since they are technically operating as an extension of the licensed full-time site. For health centers, intermittent sites also then retain the ability to bill for Medi-Cal services at the parent clinic’s PPS rate. The Medicare program, however, requires all sites, including intermittent sites, to individually enroll as Medicare institutional providers.

The Medi-Cal program requires notification of the operation of an intermittent clinic site, and this can be done by submitting a letter to Provider Enrollment Division. The letter should be on the parent clinic letterhead and state the intermittent clinic hours of operation, address, and a statement that the clinic is staffed and supplied by the parent clinic. The Medi-Cal program retains the right to inspect
intermittent clinics relative to billing issues. For compliance purposes to the extent possible, clinics should maintain a copy of the fire clearance, policies and procedures, and patient records at the intermittent site.

While there is no formal licensing process outlined in the law for the initiation of an intermittent site, and although not required, some health centers have chosen to notify their L&C District Office when opening an intermittent site so that this information might be included in their file.

In conclusion, health centers seeking to provide services at community based sites may operate these locations as intermittent sites if they meet all of the standards and requirements outlined above pursuant to Section 1200 of the Health & Safety Code and Title 22 of the California Code of Regulations.
Federal Tort Claims Act Consideration

As mentioned in the Scope of Project concerns, all activities, sites, and providers must be approved under the scope of project in order to qualify for coverage under the Federal Tort Claims Act (FTCA). In general, “covered individuals”—governing board members, officers, employees, and certain contractors—are protected even when they leave the “covered entity” or health center. However, providers who are contracted by the health center and are not working full time (at least 32.5 hours per week), are not covered. For example, if a contract dentist works less than full-time and provides approved services at an approved site, the dentist would not be covered under FTCA, but the health center would remain covered. Dentists who volunteer to provide services for the FQHC are also not covered under FTCA. It is important, therefore, to obtain additional liability coverage for volunteer and part-time providers.

Health centers must include the “intermittent clinic” in their Quality Improvement (QI) policies and activities, including documentation in the QI plan, QI committee minutes, and Board meeting minutes. The FTCA application (initial or renewal) must also include the providers from the “intermittent clinic” site.

It is very important for FTCA coverage that all activities and services to be performed by covered employees be documented in their job/position descriptions. FTCA-covered employees must establish a patient-provider relationship to meet the FTCA requirement of providing services to health center patients. This is established when individuals access care for initial or follow-up visits at approved sites, (even if they are not permanent residents of the service area or are only receiving care temporarily), or triage services are provided by telephone or in person (even when the patient is not yet registered with the health center). Please review the discussion on Scope of Project. As long as Scope of Project requirements are met, community-based services at intermittent sites will constitute a patient-provider relationship because clients will access care at an approved site.

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2 There is an exception for providers who are practicing in the fields of family practice, internal medicine, general pediatrics, or obstetrics and gynecology, in which case they are covered even if they are only working part-time for the health center.
State-Level DHCS Scope of Service Considerations

The California Department of Health Care Services (DHCS) requires that health centers submit a PPS rate change request for some service changes. However it is unlikely that the activities associated with community-based services will substantiate the need for completing a scope of service change and rate change at the state level because it is assumed that most health centers will utilize staff working with an FQHC site that is currently providing services to a similar population. In addition, it is unlikely that this activity will result in a net change that exceeds 1.75 percent for the affected FQHC site.

(Please see Appendix E for additional information on DHCS Scope of Service Considerations.)

Conclusion

By following the guidance outlined in this handbook health centers will be able to receive reimbursement for community-based dental services. This will allow health centers to develop innovative oral health programs in response to community needs and ensure their long-term sustainability. As dental services are expanded to additional WIC sites and other community locations, there will be improvement in the oral health outcomes for low-income children in California.
Appendix A – Definition of a Health Center and Required Services

Resource: 330 (a) and (b) of Section of the U.S. Public Health Service Act

(a) Definition of health center.

(1) In general. For purposes of this section, the term "health center" means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements --
(A) required primary health services (as defined in subsection (b)(1)); and
(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2)) necessary for the adequate support of the primary health services required under subparagraph (A); for all residents of the area served by the center (hereafter referred to in this section as the "catchment area").

(2) Limitation. The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (g), (h), or (i).

(b) Definitions. For purposes of this section:

(1) Required primary health services.
(A) In general. The term "required primary health services" means—
(i) basic health services which, for purposes of this section, shall consist of—
(I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
(II) diagnostic laboratory and radiologic services;
(III) preventive health services, including—
(aa) prenatal and perinatal services;
(bb) appropriate cancer screening;
(cc) well-child services;
(dd) immunizations against vaccine-preventable diseases;
(ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol;
(ff) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
(gg) voluntary family planning services; and

(hh) preventive dental services;

(IV) emergency medical services; and

(V) pharmaceutical services as may be appropriate for particular centers;

(ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services);

(iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;

(iv) services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and

(v) education of patients and the general population served by the health center regarding the availability and proper use of health services.

(B) Exception. With respect to a health center that receives a grant only under subsection (g), the Secretary, upon a showing of good cause, shall--

(i) waive the requirement that the center provide all required primary health services under this paragraph; and

(ii) approve, as appropriate, the provision of certain required primary health services only during certain periods of the year.

(emphasis added)
Appendix B – Definition of an FQHC Reimbursable Encounter Under Medi-Cal

Resource: Welfare and Institution Code Section 14132.100(g)

14132.100.

(g) (1) An FQHC or Rural Health Clinic (RHC) "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice.

(B) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice for the purposes of establishing its FQHC or RHC rate shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.
(C) An FQHC or RHC that does not provide dental hygienist or dental hygienist in alternative practice services, and later elects to add these services, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).
Appendix C – Reduction of Medi-Cal Dental Benefits for Most Adult Medi-Cal Beneficiaries

Resource: Welfare and Institutions Code Section 14131.10

14131.10.

(a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

(B) Acupuncture services.

(C) Audiology services and speech therapy services.

(D) Chiropractic services.

(E) Optometric and optician services, including services provided by a fabricating optical laboratory.

(F) Podiatric services.

(G) Psychology services.

(H) Incontinence creams and washes.

(2) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state, are covered.

(3) Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.

(c) The optional benefit exclusions do not apply to either of the following:

(1) Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(d) This section shall only be implemented to the extent permitted by federal law.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(f) This section shall be implemented on the first day of the month following 90 days after the operative date of this section.
Appendix D: Definition of a Community Clinic and Free Clinic

H&S 1204(a)

(A) A “community clinic” means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient’s ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A “free clinic” means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.
Appendix E – Definition and Requirements for Filing a Scope of Service Change with the State

Resource: Welfare and Institutions Code Section 145132.100(e)(2) & (3)

California Welfare & Institutions Code Section 14132.100(e)(2) defines a scope-of-service change as:

- The addition of a new FQHC/RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC/RHC service that is incorporated in the baseline rate.
- A change in service due to amended regulatory requirements or rules.
- A change in service resulting from relocating or remodeling an FQHC or RHC.
- A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.
- An increase in service intensity attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.
- Any changes in any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, or in the provider mix of an FQHC or RHC or one of its sites.
- Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.
- Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.
- Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(emphasis added)

California’s Welfare & Institutions Code Section 14132.100(e)(3)(B) clarifies that no change in costs shall, in and of itself, 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 FQHC or RHC services.
(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.
(C) The change in the scope-ofervices 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 rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(emphasis added)