State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

March 30, 2018

Ms. Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT (SPA) 18-003: ADDS MFT AS A BILLABLE PROVIDER AND MAKES CHANGES TO REIMBURSEMENT POLICIES FOR FQHCS AND RHCS

Dear Ms. Sam-Louie:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 18-003 for your review and approval. This SPA proposes to add marriage and family therapists (MFTs) as a new Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) billable provider under Medi-Cal, pursuant to Assembly Bill (AB) 1863 (Chapter 610, Statutes of 2016) and clarifies existing language in the State Plan by making changes to the reimbursement policies for FQHCs and RHCs.

Medi-Cal services provided at FQHCs and RHCs are paid on a "per-visit" basis. A visit is defined as a face-to-face encounter between a patient of a FQHC or RHC and qualified health care professionals. Currently, MFTs provide covered mental health services at FQHCs and RHCs, but cannot bill on a per-visit basis. SPA 18-003 will add MFTs to the list of qualified health care professionals whose services are billable on a per-visit basis effective January 1, 2018.

In addition to adding MFT as a billable provider type, DHCS is proposing to clarify existing language in the current State Plan and make changes to the reimbursement policies for FQHCs and RHCs.

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SPA 18-003 proposes to clarify the following:

1. Scope of Service Rate Adjustment – The proposed SPA will clarify guidelines to submit a Change of Scope of Services Request (CSOSR) under the State Plan. The key clarifications are:

    - The definition of the change in the type, intensity, duration or amount of services,
    - Provider must wait a full fiscal year from the scope of service change before a CSOSR is submitted,
    - When the scope of service change occurs, the change will be compared to the preceding fiscal year,
    - Circumstances when CSOSR for an Electronic Health Record (EHR) system (medical or dental) cost can be submitted.

2. Minimum Productivity Standards used in the rate setting process for a new facility and/or CSOSR - The proposed SPA confirms the use of the minimum productivity standards (number of total visits per year) when setting the Prospective Payment System (PPS) rate for a new facility and/or CSOSR. The minimum productivity standards will be applied to (contracted or employed) physicians, nurse practitioners, physician assistants, and midwives.

3. Rate setting effective date - The proposed SPA clarifies effective dates for rate setting of new, relocated, intermittent, and mobile FQHC and RHC sites.

4. Dental Hygienist (DH) or Dental Hygienist in Alternative Practice (DHAP) - The proposed SPA requires an FQHC or RHC to submit a CSOSR in order to bill for DH or DHAP services on a per-visit basis. The FQHC or RHC must provide DH or DHAP services for a full fiscal year prior to submitting a CSOSR.

There are other proposed technical updates to the State Plan that are not highlighted above, such as updating the full name of the Department of Health Care Services (DHCS) and the number of hours that intermittent services sites are allowed to operate.

The effective date for the proposed SPA 18-003 will be January 1, 2018.

DHCS published the proposed SPA 18-003 for a 30-day public comment period ending on March 23, 2018. All comments received by closing have been reviewed by DHCS, and were addressed or incorporated into the proposed SPA 18-003.

Additionally, Indian Health Programs and Urban Indian Organizations were notified by means of a Trial Organizational Summary, detailing the provisions of the proposed SPA

on February 22, 2018, and were also given the opportunity to comment on this proposal. A copy of the notice is also enclosed.

If you have any questions, please contact Lindy Harrington, Deputy Director, Health Care Financing at (916) 322-4831 or via e-mail at lindy.harrington@dhcs.ca.gov.

ORIGINAL SIGNED

State Medicaid Director

Enclosures

cc:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 003

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Welfare & Institutions Code 14132.100; Benefits Improvement and Protection Act of 2000

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ Budget Neutral
b. FFY 2019 $ Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page 6C, E, G, L, L.1, L.2, L.3, L.4, L.5, M, R, R.1, R.2, R.3, R.4, R.5, S, U, W
Limitations on Attachment 3.1-A Page 3b
Limitations on Attachment 3.1-A Page 3d
Limitations on Attachment 3.1-B Page 3b
Limitations on Attachment 3.1-B Page 3d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page 6C, E, G, L, M, R, S, U
Limitations on Attachment 3.1-A Page 3b
Limitations on Attachment 3.1-A Page 3d
Limitations on Attachment 3.1-B Page 3b
Limitations on Attachment 3.1-B Page 3d

10. SUBJECT OF AMENDMENT
ADDS MFT AS A BILLABLE PROVIDER AND MAKES CHANGES TO REIMBURSEMENT POLICIES FOR FQHCS AND RHCS

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED

ORIGINAL SIGNED

State Medicaid Director

15. DATE SUBMITTED
March 30, 2018

16. RETURN TO

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

For Box 11 "OTHER, As Specified" : Please note: The Governor's Office does not wish to review the State Plan Amendment.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan (continued).	9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State who is acting within the scope of his/her license Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit. Psychology services are covered in RHCs for all Medi-Cal beneficiaries. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy. Federally required adult dental services are covered in RHCs for all Medi-Cal beneficiaries.	

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license 6. Comprehensive Perinatal Services Program (CPSP) practitioner services 7. Licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license 8. Clinical psychologist who is authorized to practice psychology service by the State and who is acting within the scope of his/her license 9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State who is acting within the scope of his/her license Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit. Psychology services are covered in FQHCs for all Medi-Cal beneficiaries.	

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NO CHANGES TO PAGE 6, 6A, 6B, 6B.1

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 licensed and/or certified practitioners who are able to render covered services in accordance with their scope of practice as identified in California statute.

NO CHANGES TO PAGE 6D

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 D.2(a) was calculated using a visit definition 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 DHCS. DHCS 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 no more than 30 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 1st of each year, for services furnished on and after that date, DHCS 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 1842(i)(4) of the Act) as published in the Federal Register for that calendar year.

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

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

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 1, 2001, until the payment methodology described in this Section E became effective for the

NO CHANGES TO PAGE 6F

For example, if an 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 an FQHC or a RHC has a December 31st fiscal year end, the period determining the first MEI increase was June 30, 2000 through April 1, 2001. As in the previous example, the period determining the second MEI increase was April 1, 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 no more than 30 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 1, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHCS will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.1 (c), above).

F. Alternative Payment Methodology for an Existing FQHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DHCS 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 DHCS 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

NO CHANGES TO PAGE 6H, I, J, K

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(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 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 D.4.

(c) The per visit rate calculated in accordance with paragraph J.3 (b) above, will be subject to the following:

1. Minimum productivity standards are used to help determine the average cost per FQHC or RHC patient visit, reimbursed at the PPS rate. The minimum productivity standards require 3,200 visits per full-time equivalent (FTE) physician and 2,600 visits per FTE nurse practitioner, physician assistant, or certified nurse midwife (NP, PA and CNM) per year, based on a 40 hour work week (2,080 hours per annum). The following healthcare staff are not subject to minimum productivity standards: Dentist, Registered Dental Hygienist (RHD), Doctors of Podiatric (DPM), Doctors of Optometry (OD), Doctors of Chiropractic (DC), Psychiatrist, Clinical Psychology (CP), License Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT), Licensed Acupuncturists, and Comprehensive Perinatal Health Workers.

2. The FTE on the cost report is a productive FTE that is defined as, “the time spent seeing patients or scheduled to see patients.” All hours that a physician, NP, PA, and CNM spend seeing patients or are scheduled to see patients must be included in the productive FTE calculation. The productive FTE does not include any hours for non-productive activites when a provider is not seeing patients or scheduled to see patients.

    (i) “Productive Time” is defined as time spent seeing patients or scheduled to see patients. It does not include non-productive time. The facility must report its FTE on the cost report for physicians and NPs, PAs and CNMs which is all the time spent seeing patients or scheduled to see patients. All activities related to the provision of health care, such as, but not limited to, reviewing test results, authorizing refills, care-related emails, and follow up calls, are included in the time scheduled to see patients and must be included in the FTE on the cost report.

    (ii) “Non-productive Time” is defined as time that is spent not seeing patients or scheduled to see patients, such as, but not limited to, administrative time, paid time off (PTO), continuing medical education (CME), teaching activities, and other training and meetings, that occur when the physician, NP, PA or CNM is not seeing patients or scheduled to see patients.

(iii) "Administrative Time" is defined as time spent on activities related to the overall administration of the clinic and performed when not seeing patients or scheduled to see patients, which includes, but may not be limited to, the following types of activities: medical protocol evaluation and implementation, ensuring compliance with state and federal statutes and regulations, resource allocation, utilization review, quality assurance and improvement, planning and administrative meetings, supervisory oversight and coordination between clinic departments, teaching, and inventory control.

(iv) The FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify each physician, NP, PA and CNM Productive Time, Administrative Time and Non-productive Time. Adequate documentation requires accurate and sufficient detail that is capable of verification by an auditor of the hours spent rendering Productive Time, Administrative Time and Non-productive time.

(v) The FQHC or RHC may apply for an exemption to the minimum productivity standards requirement by submitting an exemption request to DHCS. The request must be supported with verifiable documentation demonstrating that the FQHC's or RHC's unique circumstance(s) that prevents the clinic from meeting the minimum productivity standards. Exemption requests shall include the following documentation, as applicable:

A. The specific reason(s) for the exemption and the number of times the specific reason(s) occurred that prevented the clinic from meeting the minimum productivity standards.

B. An explanation of why the FQHC or RHC believes that good cause for an exemption will continue in future years.

C. If the specific reason(s) for an exemption is related to longer than the minimum productive standard visit time, the FQHC or RHC must submit verifiable documentation of the time spent seeing the patients and scheduled to see patients at the time the visits occurred. The documentation submitted must be capable of being audited and be in sufficient detail to allow for the verification of the actual time spent.

D. If the specific reason(s) for an exemption is not related to time spent on patient visits, the clinic must submit documentation in sufficient detail so that DHCS may audit the occurrence of the specific reason(s) for the exemption and when the specific reason(s) occurred. The documentation must demonstrate the specific occurrence or permanent circumstances that negatively affect the utilization of a clinic.

E. The same documentation in A-D above is required for all fiscal year(s) subsequent to the rate setting fiscal year to determine if the reason for the exemption continues to exist, and still result in the inability to meet the minimum productivity standards. The subsequent year review is limited to complete fiscal year(s), including any portion of a fiscal year that has occurred since the cost reporting year up to the time the audit occurs.

(d) For purposes of initial rate setting or change in scope of service requests, the FQHC's or RHC's total visits shall be calculated as follows:

The FQHC's or RHC's total visit count will be calculated by adding the number of visits allocated to health care staff subject to the minimum productivity standard adjustment plus the actual number of visits rendered by health care staff that are not subject to the minimum productivity standards. For example, consider a facility that has 2.4 physican FTE's, 3.0 NP FTEs, 0.8 CNM FTEs, and 1.5 clinical psychologist FTEs. The minimum productivity standard would require the facility to have 17,560 ((2.4 x 3,200) + (3.0 x 2,600) + (0.8 x 2,600)) visits plus the actual clinical psychologist visits. If the total number of physican, NP, and CNM visits in the rate setting or change in scope of service year did not equal or exceed 17,560, the visit count would be increased to 17,560. The total visits would include the 17,560 and the actual number of clinical psychologist visits.

4. If a new facility does not respond within 30 days of DHCS' 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), DHCS 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 (1) a new facility under Section J.1; (2) an intermittent service site that is exempt from licensure that is established or affiliated with an FQHC; (3) a mobile unit that is established or affiliated with an FQHC or RHC; or (4) an FQHC or RHC that relocates to a new site, is retroactive to the later of the date that the FQHC or RHC was federally qualified as an FQHC or RHC, or the date DHCS was notified of the new FQHC's or RHC's or intermittent clinic's or mobile unit's existence or relocation.

(a) In order for a newly licensed FQHC or RHC under section J.1 to receive a retroactive effective date to the date the licensed FQHC or RHC was first federally qualified as an FQHC or RHC, it must submit a complete Initial Rate Setting Application Package to DHCS within 90 days from the date of the federal written notification of approval. Otherwise, the newly licensed FQHC's or RHC's effective date will be the date that its Initial Rate Setting Application Package is received by DHCS.

Except for an intermittent clinic, if an FQHC or RHC is exempt from licensure, its effective date will be the date the FQHC or RHC obtains both (1) the licensing

entity's notice of exemption from licensure and (2) the federal written notification of approval. In order to receive this effective date, the FQHC or RHC that is exempt from licensure must submit a complete Initial Rate Setting Application Package to DHCS within 90 days from the date of the federal written notification of approval. Otherwise, the effective date will be the date the Initial Rate Setting Application Package is received by DHCS.

If a newly licensed FQHC or RHC or an FQHC or RHC that is exempt from licensure elects to use its written conditional federal approval to set its effective date, the FQHC or RHC must submit a complete Initial Rate Setting Application to DHCS within 90 days from the written conditional federal approval date. Otherwise, the effective date will be the date the Initial Rate Setting Application Package is received by DHCS.

(b) An intermittent site may receive the retroactive effective date to the date the intermittent site was first federally qualified as an FQHC site, if it notifies DHCS of its affiliation with an FQHC within 90 days from the date of the written notification of federal approval.

If the FQHC elects to use its written conditional federal approval to set the effective date, the FQHC must submit a complete Initial Rate Setting Application to DHCS within 90 days from the date of the written conditional federal approval.

(i) If the FQHC fails to meet the 90-day requirement or fails to obtain the applicable federal approval for the intermittent site, the effective date for the intermittent site shall be the date:

(1) The intermittent site was first federally qualified as an FQHC site, or

(2) The date the FQHC notifies DHCS that the intermittent site was established, or

(3) The date the intermittent clinic site was added on the establishing FQHC's clinic license issued by the licensing entity, whichever is later.

(ii) RHCs can not have affiliated intermittent service sites.

(c) The PPS rate for the mobile unit shall be set in accordance with Section E.2.

(i) In order for a licensed FQHC or RHC mobile unit that affiliates with another FQHC or RHC to receive a retroactive effective date to the date the licensed affiliated mobile unit was first federally qualified as an FQHC or RHC, it must notify DHCS of the establishment of its mobile unit's affiliation within 90 days from the date of the federal written notification of federal approval as an FQHC or RHC.

(ii) If an FQHC or RHC mobile unit is exempt from licensure, its effective date will be the date the FQHC or RHC obtains both (1) the licensing entity's notice of

(iii) exemption from licensure and (2) the federal written notification of approval. In order to receive this effective date, the FQHC or RHC that is exempt from licensure must notify DHCS of the establishment of its mobile unit's affiliation within 90 days from the date of the federal written notification of federal approval. Otherwise, the effective date will be the date the FQHC or RHC notifies DHCS of the establishment of its mobile unit's affiliation.

If an FQHC or RHC mobile unit elects to use its written notification of conditional federal approval to add the mobile unit to set the mobile unit's effective date, the FQHC or RHC must submit a complete Initial Rate Setting Application to DHCS within 90 days from the date of the written notification of conditional federal approval.

(iii) If an FQHC or RHC mobile unit fails to meet the 90 day requirement, or fails to obtain the applicable federal agency approval for the mobile unit, the effective date for the mobile unit shall be the date:

(1) The mobile unit was first federally qualified as an FQHC or RHC, or

(2) The FQHC or RHC notified the Department that the mobile unit is an affiliate of an FQHC or RHC, or

(3) The mobile unit is licensed by the licensing entity, whichever is later.

(iv) If a mobile unit is an intermittent clinic exempt from licensure, see paragraph J.5.b.

(d) In order for the FQHC or RHC, that relocates to a new site, to receive a retroactive effective date to the date that the licensed FQHC or RHC was first federally qualified as an FQHC or RHC at the new location, it must not elect to treat the relocation as a change in scope of service under Section K; and must submit a complete Initial Rate Setting Application Package to DHCS within 90 days from the date of federal written notification of approval as an FQHC or RHC at the new location. If the FQHC or RHC does not submit a complete Initial Rate Setting Application within 90 days from the time the FQHC or RHC was first federally qualified at the new location, or fails to receive the applicable federal approval for the new location, its effective date will be the date of the licensed FQHC's or RHC's written federal approval, only if, the new site's per-visit rate is less than the previous site's per visit rate. Otherwise, the effective date will be the date the Initial Rate Setting Application Package is received by DHCS. The per-visit rate at the relocated site must be set in accordance with Section J.

If a relocated FQHC or RHC elects to use its written notification of conditional federal approval to set its effective date, the FQHC or RHC must submit a complete Initial Rate Setting Application to DHCS within 90 days from the conditional approval date. Otherwise, the effective date will be the date the Initial Rate Setting Application Package is received by DHCS.

(e) 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 no more than 30 hours per week or in mobile facilities.

(f) DHCS 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, DHCS will require all FQHCs or RHCs to submit to DHCS 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 DHCS 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 by DHCS.

K. Scope of Service Rate Adjustments *(This Section shall be operative for all Change in Scope of Service Requests filed on or before December 30, 2018.)*

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:

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

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

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

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

   (d) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 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 1.75 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

NO CHANGES TO PAGE 6N, O, P, Q

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 DHCS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHCS. 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.

K. Scope of Service Rate Adjustments *(This Section shall be operative for all Change in Scope of Service Requests filed on or after December 31, 2018.)*

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:

1. A change in costs, in and of itself, does not qualify as a change in scope of service, unless all of the following apply:

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

   In order to qualify for a change in scope of service for an increase in cost, the FQHC or RHC must have an increase in services as defined in paragraph C.1. A change in scope of services occurs when there is an increase in the costs attributable to an increase in the scope of services defined in paragraph C.1. when compared in the aggregate. For example, if a clinic files a change in the scope of services to add a podiatrist, which is considered a physician service under C.1., the Department will determine if there is an increase in the cost and services of all types of physician

services by comparing the physician services of the full year of change to the total physician services of last full year with no podiatrist cost or services.

In order to qualify for a change in scope of service for a decrease in cost, the FQHC or RHC must have a decrease in the scope of services as defined in paragraph C.1, and meet the requirements of paragraph K.4.

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

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

(i) A change in "type, intensity, duration and amount of services" is:

A. The addition of a new service, as defined in paragraph C.1, that requires adding new professional staff to perform the new service, and the new service was not previously provided by the FQHC or RHC.

B. The deletion of an entire service, defined in paragraph C.1, that the FQHC or RHC currently performs.

(ii) The following are not in and of themselves considered a change in "type, intensity, duration, or amount of services":

A. A change in ownership;

B. The addition or reduction of staff relating to an existing service;

C. A change in office hours; or

D. An increase in the number of encounters.

(d) The FQHC or RHC must implement the change in scope of service continuously for a full fiscal year (12 months) before it can submit a change in scope of service request.

(i) The increase or decrease in cost and service required by paragraph K.1.(a) shall be determined by comparing the first full twelve (12) month fiscal year when the change occurred to the immediate, preceding full fiscal year without the change. At the request of DHCS, the FQHC or RHC must submit supporting documentation, showing the full 12 months of activity in the fiscal year the change occurred and the immediately preceding fiscal year without the change. Supporting documentation may include, but is not limited to, financial records, payroll reports, timecards, employment or other contracts, utilization reports.

(e) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 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 1.75 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 the first full fiscal year (12 months) when the change occurred compared to the immediately preceding 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. All change in scope-of-service requests must comply with the productivity standards referenced in Section J. Subject to the conditions set forth in Section K subparagraphs 1.(a) - (e) above, a change in scope-of-service means any of the following:

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

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

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

   (d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic. Once the cost of an electronic medical records and/or electronic dental records system is included in an FQHC's or RHC's per-visit rate, the FQHC or RHC may not apply for an adjustment to its per-visit rate solely due to a subsequent acquisition or upgrade of the electronic medical and/or dental records system.

   DHCS will consider a second change in scope only for the addition of an electronic dental records system, even if the FQHC or RHC had a change in scope for the electronic medical records system.

   (e) An increase in the intensity type, amount, or duration of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

   (f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C.1.

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. Before the FQHC or RHC can submit a request for a change in scope of service, the change in the scope of service must have already been in place for a full fiscal year (12 months). Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's first full fiscal year in which the change occurred.

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 K if, 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. The determination of whether a 2.5 percent decrease exists is a comparison of the per-visit rate in effect before the decrease in the scope of service, with the calculated PPS rate of the first full fiscal year (12 months) after the decrease in the scope of service occurred.

(a) A decrease in the scope of service occurs when any activity, function or space, included in the FQHC's or RHC's per-visit rate is deleted, discontinued or eliminated.

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 DHCS.

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) If DHCS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHCS 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 amount 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, an FQHC or RHC has a:

      (i) Newly established per-visit rate of $150.00,

      (ii) Current PPS per-visit rate of $125.00,

      (iii) July 1, 2018, to June 30, 2019, first full fiscal year and a

      (iv) Scope-of-service change date of February 15, 2018.

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

      (v) $25.00 is the difference between the newly established per- visit rate ($150.00) and the current PPS rate ($125.00),

      (vi) $20.00 is the 80 percent adjustment amount ($25.00 X 80 percent),

      (vii) $145.00 is the newly established PPS rate ($125.00 + $20.00),

      (viii) July 1, 2018, is the date the $145.00 rate becomes effective.

      (ix) The MEI will be applied to the PPS rate established in calendar year 2019 and subsequent fiscal years on the first day of October that is after the particular FQHC's or RHC's fiscal year.

7. A written request under Section K must be made to DHCS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHCS. 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), DHCS 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 amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount 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 amount calculated under the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amount 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 amount 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 amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount 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 be 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, DHCS 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, DHCS 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.

NO CHANGES TO PAGE 6T

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 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 shall be requested. After a scope-of-service change to add the additional service has been approved, 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 Section N.

(c) For purposes of 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 number of services provided in given year that are compensated using the PPS reimbursement rate.

(d) For purposes of 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) above 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).

NO CHANGES TO PAGE 6V

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.