California Board of PSYCHOLOGY

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MEMORANDUM

DATE	April 26, 2018
TO	Board of Psychology
FROM	 Jason Glasspiegel Central Services Coordinator
SUBJECT	Agenda Item #21(b)(1)(F): SB 1125 (Atkins) Federally Qualified Health Center and Rural Health Clinic Services

Background:
Currently, a patient of a federally qualified health center (FQHC) or rural health clinic (RHC) can only see one healthcare practitioner (aside from a dentist) in a day.

This bill would allow Medi-Cal reimbursement for a patient receiving medical services at an FQHC or RHC, to receive both medical services and also to obtain mental health services on the same day they receive the medical services.

Location: Senate

Status: 3/12/2018 - Set for hearing April 25.

Votes: 4/25/2018 Senate Health (9-0-0)

Action Requested:
The Policy and Advocacy Committee recommends that the Board **Support** SB 1125 as this bill would allow Medi-Cal patients receiving services at FQHCs and RHCs to receive mental health services on the same day as they get other health care services, which would increase access to mental health care for these consumers.

Attachment A: Analysis of SB 1125 (Atkins)
Attachment B: SB 1125 (Atkins) Text
Attachment C: Senate Health Analysis

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2018 Bill Analysis

Author:	Bill Number:	Related Bills:
Atkins	SB 1125	
Sponsor:	**Version:**	
Steinberg Institute California Health+ Advocates	Introduced	
Subject:		
Federally qualified health center and rural health clinic services		

SUMMARY

This bill would allow Medi-Cal reimbursement for a patient receiving medical services at a federally qualified health center (FQHC) or rural health clinic (RHC), to receive both medical services and also to obtain mental health services on the same day they receive the medical services.

RECOMMENDATION

SUPPORT – This bill would allow Medi-Cal patients receiving services at FQHCs and RHCs to receive mental health services on the same day as they get other health care services, which would increase access to mental health care for these consumers. For this reason, The Policy and Advocacy Committee recommends a Support position on SB 1125 (Atkins).

REASON FOR THE BILL

According to the author, in California, if a patient receives treatment through Medi-Cal at a community health center from both a medical provider and a mental health specialist on the same day, the State Department of Health Care Services will only reimburse the center for one "visit", meaning both providers can't be adequately reimbursed for their time and expertise. A patient must seek mental health treatment on a subsequent day in order for that treatment to be reimbursed as a second "visit."

Other Boards/Departments that may be affected:

☐ Change in Fee(s) ☐ Affects Licensing Processes ☐ Affects Enforcement Processes

☐ Urgency Clause ☐ Regulations Required ☐ Legislative Reporting ☐ New Appointment Required

Policy & Advocacy Committee Position:	**Full Board Position:**
☒ Support ☐ Support if Amended	☐ Support ☐ Support if Amended
☐ Oppose ☐ Oppose Unless Amended	☐ Oppose ☐ Oppose Unless Amended
☐ Neutral ☐ Watch	☐ Neutral ☐ Watch
Date: 4/19/2018	Date: _____
Vote: 3-0-0	Vote: _____

This statute creates an undue financial barrier for community centers, known as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), preventing them from treating their patients in a comprehensive manner in the same day.

The author notes that this barrier doesn't exist for similar health services. The federal Medicare program allows for same-day billing of behavioral health and medical services and California allows FQHC and RHCs to bill for two separate Medi-Cal "visits" if a patient sees both a primary care provider and a dental provider on the same day. In addition, the federal government encourages states to allow FQHCs and RHCs to bill for care provided by a primary care specialist and mental health specialist in the same day as two separate visits in recognition of the value comprehensive care generates.

The author believes it is inexplicable that California has refused to change its Medi-Cal billing statute to align with federal policy and its own state policy regarding dental care. Emergency rooms are too often a costly point of entry for mental health services, and we see the fallout of untreated mental illness on our streets, our jails, and our communities.

ANALYSIS

Access to care
Currently, a patient of an FQHC or RHC can only see one healthcare practitioner (aside from a dentist) in a day. This creates unnecessary barriers to treatment for these low-income patients that have work, families, sometimes have to take public transportation, and have to travel long distances for services.

This bill will allow an FQHC or RHC to be reimbursed by Medi-Cal if a patient has a "medical visit" (a face-to-face encounter between a patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner, as defined in Title 22 of the California Code of Regulations (CCR) Section 51179.7, or providing comprehensive perinatal services) and "another health visit" (face-to-face encounter between a patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner, as defined in 22 CCR 51179.7, or providing comprehensive perinatal services) in the same day. A maximum of two visits in one day can be reimbursed. Currently, only dental visits and medical visits can be completed in the same day.

Allowing patients of FQHC's and RHC's to see a mental health provider and a medical provider on the same day, will increase the likelihood that patients can start or continue receiving mental health services at these clinics.

LEGISLATIVE HISTORY

SB 323 (Mitchell, Chapter 540, Statutes of 2017) authorizes FQHCs and RHCs to provide Drug Medi-Cal services pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and the county or county designee, or DHCS, as specified, and would set forth the reimbursement requirements for these services. Authorizes an FQHC or RHC to provide specialty mental health services to Medi-Cal beneficiaries as part of a mental health plan's provider network pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and one or more mental health plans. Prohibits the costs associated with providing Drug Medi-Cal services or specialty mental health services from being included in the FQHC's or RHC's per-visit PPS rate, and would require the costs associated with providing Drug Medi-Cal services or specialty mental health services to be adjusted out of the FQHC's or RHC's clinic base PPS rate as a scope-of-service change if the costs associated with providing Drug Medi-Cal services or specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as specified.

SB 1150 (Hueso and Correa of 2014) would have required Medi-Cal reimbursement to FQHC and RHCs for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health provider or dental provider. SB 1150 was held on the Senate Appropriations suspense file.

AB 1445 (Chesbro of 2010) was substantially similar to SB 1150. AB 1445 was held on the Senate Appropriations suspense file.

SB 260 (Steinberg of 2007) would have allowed FQHCs and RHCs to bill separately for same day medical and mental health visits. SB 260 was vetoed by Governor Schwarzenegger. In his veto message, Governor Schwarzenegger stated that SB 260 would increase General Fund pressure at a time of continuing budget challenges, and that allowing separate billing for mental health services would lead to increased costs that our state could not afford.

OTHER STATES' INFORMATION
Not Applicable

PROGRAM BACKGROUND
The Board advances quality psychological services for Californians by ensuring ethical and legal practice and supporting the evolution of the practice. To accomplish this, the Board regulates licensed psychologists, psychological assistants, and registered psychologists.

This bill would have no impact on the Board of Psychology's operations or programs, but could potentially benefit its licensees and recipients of psychological services.

FISCAL IMPACT
Not Applicable

ECONOMIC IMPACT
This bill could result in additional funding for FQHC's and RHC's which could create additional opportunities for mental health providers to serve these communities.

LEGAL IMPACT
Not Applicable

APPOINTMENTS
Not Applicable

SUPPORT/OPPOSITION

Support:
California Health+ Advocates (co-sponsor)
The Steinberg Institute (co-sponsor)
Alliance of Catholic Health Care
American Academy of Pediatrics, California
Association of California Healthcare Districts
California Academy of Family Physicians
California Consortium of Addiction Programs and Professionals
California Coverage and Health Initiatives
California Dental Hygienists' Association
California Medical Association
California Psychological Association
California School Employees Association
Children Now
Corporation for Supportive Housing
County Behavioral Health Directors Association of California
County Health Executives Association of California
Disability Rights California
Housing California
Local Health Plans of California
Los Angeles LGBT Center
Mental Health America of California
National Alliance on Mental Illness-California
National Association of Social Workers, California Chapter
Planned Parenthood Affiliates of California
Private Essential Access Community Hospitals
Providence St. Joseph Health
Silicon Valley Leadership Group
Tenet Healthcare
The Jed Foundation
Urban Counties of California
Western Center on Law and Poverty
2020 Mom

Opposition:
None on File

ARGUMENTS

Proponents:
This bill is jointly sponsored by the California Health+ Advocates (CH+A) and the Steinberg Institute, which write that this bill will help FQHCs and RHCs better provide integrated behavioral health services to patients by allowing reimbursement for mental health services provided on the same day as medical services. CH+A states that patients qualify for Medi-Cal based on having low-income, and often come from a background of economic hardship that makes getting to a health center difficult in the first place. By requiring a 24 hour gap in services between referral from primary care and being seen by a mental health provider, many of these patients are not able to follow through and receive care, resulting in costly visits down the line. CH+A states California is one of only a handful of states that do not allow for mental and physical health visits on the same day as same day visits for medical and mental health care are currently authorized in 32 state Medicaid programs, including Washington, Oregon, Nevada, and Arizona. Allowing for patients to access care in the primary care setting helps to lower the overall cost of care to the health system by lowering emergency room utilization, preventing illnesses from escalating into more serious conditions, and improving quality of life for the patients we serve. The Steinberg Institute argues allowing Medi-Cal beneficiaries to access medical and mental health care on the same day improves the overall patient experience and ensures access to brain health services, which is especially important for low-income clients who experience transportation challenges, child care issues or trouble getting off of work. Allowing beneficiaries to access medical and mental health care on the same day improves the overall patient experience and brings the state closer to fully integrated care.

Opponents: None on File

California LEGISLATIVE INFORMATION

SB-1125 Federally qualified health center and rural health clinic services. (2017-2018)

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of “visit” set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) 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. 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.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) 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.

(F) Any changes in any of the services described in subdivision (a) or (b), 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 subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) 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 services defined in subdivisions (a) and (b), as applicable.

(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 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 rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall 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.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 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.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, 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 an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (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 shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision ~~(l).~~ *(m)*. These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or 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 ~~physician and surgeon,~~ *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 practitioner, as defined in Section 51179.7 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, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC 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 or marriage and family therapists 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's 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, a dental hygienist in alternative practice, or a marriage and family therapist 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, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, ~~no later than~~ *by* July 1, 2018, a visit shall include a marriage and family therapist.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall 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, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit 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. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to 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 ~~enrollment approval,~~ *provider number,* and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(l) (1) For purposes of this subdivision, the following definitions shall apply:

(A) "Another health visit" means a face-to-face encounter between an FQHC or RHC patient and a clinical psychologist, licensed clinical social worker, marriage and family therapist, dentist, dental hygienist, or registered dental hygienist in alternative practice.

(B) "Medical visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services.

(2) A maximum of two visits, as defined in subdivision (g), taking place on the same day at a single location shall be reimbursed when one or more of the following conditions exists:

(A) After the first visit the patient suffers illness or injury requiring additional diagnosis or treatment.

(B) The patient has a medical visit and another health visit.

(3) (A) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of encounters with more than one health professional that take place on the same day at a single location as constituting a single visit for purposes of establishing its FQHC or RHC rate shall apply, by January 1, 2020, for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, the FQHC or RHC shall bill a medical visit and another health visit that take place on the same day at a single location as separate visits.

(B) The department, by July 1, 2019, shall develop and adjust all appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates.

(C) An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this paragraph shall not constitute a change in scope of service within the meaning of subdivision (e).

(D) An FQHC or RHC that applies for an adjustment to its rate pursuant to this paragraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

(4) The department, by January 15, 2019, shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this subdivision.

~~(l)~~ *(m)* Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-in-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions shall apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

~~(m)~~ *(n)* Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of

activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-in-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

~~(n)~~ *(o)* FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

~~(o)~~ *(p)* The ~~department~~ *department, by March 30, 2019,* shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

~~(p)~~ *(q)* The department shall implement this section only to the extent that federal financial participation is available.

~~(q)~~ *(r)* Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions ~~(l)~~ *(m)* and ~~(m)~~ *(n)* by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of subdivisions ~~(l)~~ *(m)* and ~~(m),~~ *(n),* including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 1125
AUTHOR: Atkins
VERSION: February 13, 2018
HEARING DATE: April 25, 2018
CONSULTANT: Scott Bain

SUBJECT: Federally qualified health center and rural health clinic services

SUMMARY: Requires Medi-Cal reimbursement to Federally Qualified Health Centers and Rural Health Clinics for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health or dental provider.

Existing law:

1) Establishes the Medi-Cal program as California's Medicaid program, administered by the Department of Health Care Services (DHCS), which provides comprehensive health care coverage for low-income individuals. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are covered benefits under the Medi-Cal program. [WIC §14000 et seq., §14132]

2) Requires FQHCs and RHCs to be reimbursed on a per-visit basis. Defines a "visit" as a face-to-face encounter between an FQHC or RHC patient and the following health care providers: a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, podiatrist, dentist, optometrist, chiropractor, comprehensive perinatal services practitioner providing comprehensive perinatal services, a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, 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. [WIC §14132.100]

3) Requires FQHC and RHC per-visit rates to be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in federal law. [WIC §14132.100]

4) Permits FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Requires rate changes based on a change in the scope of services provided by an FQHC or RHC to be evaluated in accordance with Medicare reasonable cost principles. [WIC §14132.100]

5) Authorizes FQHCs and RHCs to receive reimbursement from county specialty mental health plans and through Drug Medi-Cal outside of the regular Medi-Cal reimbursement structure that applies to FQHCs and RHCs. [WIC §14132.100]

This bill:

1) Requires an FQHC or RHC to apply, by January 1, 2020, for an adjustment to its per-visit rate for purposes of establishing its FQHC or RHC rate if the FQHC/RHC currently includes

the cost of encounters with more than one health professional that take place on the same day at a single location as constituting a single visit.

2) Requires, after the rate adjustment has been approved by DHCS, the FQHC or RHC to bill a medical visit and another health (mental health or dental visit) visit that take place on the same day at a single location as separate visits.

    a) Defines "another health visit" as a face-to-face encounter between an FQHC or RHC patient and a clinical psychologist, licensed clinical social worker, marriage and family therapist, dentist, dental hygienist, or registered dental hygienist in alternative practice.

    b) Defines a "medical visit" as a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner providing comprehensive perinatal services.

3) Requires a maximum of two visits taking place on the same day at a single location of an FQHC or a RHC to be reimbursed when one or more of the following conditions exists:

    a) After the first visit the patient suffers illness or injury requiring additional diagnosis or treatment; or,
    b) The patient has a medical visit and another health visit.

4) Requires DHCS, by July 1, 2019, to develop and adjust all appropriate forms to determine which FQHCs or RHCs rates are adjusted, and to facilitate the calculation of the adjusted rates.

5) Prohibits an FQHC or RHC application for, or DHCS' approval of, a rate adjustment from constituting a change in scope of service within the meaning of existing law.

6) Permits an FQHC or RHC that applies for a rate adjustment under this bill to continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

7) Requires DHCS, by January 15, 2019, to submit a state plan amendment (SPA) to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this bill.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, public awareness of mental health and substance use disorders (SUD) is growing, with much of it driven by the homelessness and the opioid epidemics. We see the outcome of untreated mental illness on our streets, our jails, and our communities. This is unacceptable. Community-based primary care, like that provided by FQHCs and RHCs, is often the first line of defense for detection and treatment of mental health and SUD issues. These health centers focus on "whole person care" by integrating care for their beneficiaries as much as possible. Unfortunately, if a patient receives treatment through Medi-Cal at an FQHC or RHC from both a medical provider and

a mental health specialist on the same day, the state will only reimburse the health center for one "visit," meaning both providers can't be adequately reimbursed for their time and expertise. A patient must seek mental health treatment on a subsequent day in order for that treatment to be reimbursed as a second "visit." This policy creates an unnecessary financial barrier for FQHCs and RHCs in their ability to provide integrated care in a timely manner. SB 1125 will put an end to this policy by allowing same-day billing in community clinics for both a medical provider and a mental health specialist and in doing so, will ensure that we are using the integrated health services available to our communities at their full potential.

2) *Background on FQHCs and RHCs.* FQHCs and RHCs are federal designated clinics that are required to serve medically underserved populations that provide primary care services. There are 1,040 FQHCs and approximately 283 RHCs in California. The number of FQHCs has grown significantly. In 2006, there were 476 FQHC service sites, which grew to 1007 in 2015. As the number of FQHC service sites has expanded and as Medi-Cal enrollment has grown, the number of Medi-Cal reimbursed FQHC visits has also increased, increasing 5.9 million in 2008 to 11.9 million in 2014.

   Medi-Cal reimbursement to FQHCs and RHCs is governed by state and federal law. FQHCs and RHCs are reimbursed by Medi-Cal on a cost-based per-visit rate under what is known as the prospective payment system (PPS). For Medi-Cal managed care plan patients, DHCS reimburses FQHCs and RHCs for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The Medi-Cal managed care wrap-around rate was established to reimburse providers for the difference between their PPS rate and their Medi-Cal managed care reimbursement rate. The rationale for the enhanced reimbursement is to ensure that FQHCs and RHCs do not use federal grant funds intended for uninsured and special needs populations to back-fill for potentially below-cost Medicare or Medi-Cal rates.

   The mean and median PPS rate paid to an FQHC ($207.98 and $182.23 respectively) and an RHC ($159.73 and $141.98 respectively) is considerably higher than the most common primary care visit fee-for-service reimbursement rates in Medi-Cal. Because FQHCs and RHCs are required to receive a cost-of-living adjustment to their rates (under the Medicare Economic Index) and because of their role in providing primary care access to the Medi-Cal population, FQHCs and RHCs have been exempted from the various Medi-Cal rate reductions enacted in 2008-2011.

3) *Billing for same day visits.* DHCS policy on same day visits at FQHCs and RHCs is in California's Medicaid State Plan. It states that encounters with more than one health professional and/or multiple encounters with the same health professional, which take place on the same day and at a single FQHC or RHC location, constitute a single visit, except that more than one visit may be counted on the same day in the following circumstances:

   a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment; or,
   b) When the clinic patient has a face-to-face encounter with a dentist or dental hygienist and then also has a face-to-facet encounter with another health professional or comprehensive perinatal services practitioner on the same date.

4) *FQHC alternative payment methodology pilot not going forward*. SB 147 (Hernandez, Chapter 760, Statutes of 2014) requires DHCS to authorize a three-year payment reform pilot project for FQHCs using an alternative payment methodology (APM) authorized under federal Medicaid law. SB 147 requires an FQHC participating in the pilot to receive a per

member per month payment for each of its APM enrollees from a Medi-Cal managed care health plan, instead of the wrap around payment FQHCs currently receive from DHCS. The proposed APM structure would have provided participating FQHCs the flexibility to deliver care in the most effective manner, without the more restrictive traditional billing structure in effect now. Under the APM, FQHCs would have been allowed to provide and/or expand upon the innovative forms of care which are not reimbursed under traditional volume-based PPS. Examples of non-traditional services could include but are not limited to: integrated primary and behavioral health visits on the same day, group visits, email visits, phone visits, community health worker contacts, case management, and care coordination across systems.

In February 2018, DHCS announced that the APM pilot would not go forward for the foreseeable future. DHCS had submitted a concept paper to CMS [prior to formally submitting a state plan amendment (SPA)] to get approval of the concept. CMS indicated the FQHC APM pilot proposal, as outlined by the concept paper and SB 147, would not comply with the federal APM requirement that payments under the APM would result in payment to the FQHC of an amount which is at least equal to the amount that would otherwise be required to be paid to the FQHC under the PPS reimbursement structure and that the state could not use a SPA as the exclusive vehicle for receiving federal approval. As an alternative, CMS suggested DHCS propose a waiver amendment to the state's existing 1115 waiver demonstration (Medi-Cal 2020), in addition to the APM SPA, to waive the requirement and allow for the prospective attestation by participating clinics. However, DHCS noted that this would require a change of state law.

5) *Prior legislation.* SB 323 (Mitchell, Chapter 540, Statutes of 2017) authorizes FQHCs and RHCs to provide Drug Medi-Cal services pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and the county or county designee, or DHCS, as specified, and would set forth the reimbursement requirements for these services. Authorizes an FQHC or RHC to provide specialty mental health services to Medi-Cal beneficiaries as part of a mental health plan's provider network pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and one or more mental health plans. Prohibits the costs associated with providing Drug Medi-Cal services or specialty mental health services from being included in the FQHC's or RHC's per-visit PPS rate, and would require the costs associated with providing Drug Medi-Cal services or specialty mental health services to be adjusted out of the FQHC's or RHC's clinic base PPS rate as a scope-of-service change if the costs associated with providing Drug Medi-Cal services or specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as specified.

   SB 1150 (Hueso and Correa of 2014) would have required Medi-Cal reimbursement to FQHC and RHCs for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health provider or dental provider. *SB 1150 was held on the Senate Appropriations suspense file.*

   AB 1445 (Chesbro of 2010) was substantially similar to SB 1150. *AB 1445 was held on the Senate Appropriations suspense file.*

   SB 260 (Steinberg of 2007) would have allowed FQHCs and RHCs to bill separately for same day medical and mental health visits. *SB 260 was vetoed by Governor Schwarzenegger. In his veto message, Governor Schwarzenegger stated that SB 260 would increase General*

Fund pressure at a time of continuing budget challenges, and that allowing separate billing for mental health services would lead to increased costs that our state could not afford.

6) *Support*. This bill is jointly sponsored by the California Health+ Advocates (CH+A) and the Steinberg Institute, which write that this bill will help FQHCs and RHCs better provide integrated behavioral health services to patients by allowing reimbursement for mental health services provided on the same day as medical services. CH+A states that patients qualify for Medi-Cal based on having low-income, and often come from a background of economic hardship that makes getting to a health center difficult in the first place. By requiring a 24 hour gap in services between referral from primary care and being seen by a mental health provider, many of these patients are not able to follow through and receive care, resulting in costly visits down the line. CH+A states California is one of only a handful of states that do not allow for mental and physical health visits on the same day as same day visits for medical and mental health care are currently authorized in 32 state Medicaid programs, including Washington, Oregon, Nevada, and Arizona. Allowing for patients to access care in the primary care setting helps to lower the overall cost of care to the health system by lowering emergency room utilization, preventing illnesses from escalating into more serious conditions, and improving quality of life for the patients we serve.

   The Steinberg Institute argues allowing Medi-Cal beneficiaries to access medical and mental health care on the same day improves the overall patient experience and ensures access to brain health services, which is especially important for low-income clients who experience transportation challenges, child care issues or trouble getting off of work. Allowing beneficiaries to access medical and mental health care on the same day improves the overall patient experience and brings the state closer to fully integrated care.

SUPPORT AND OPPOSITION:

Support: California Health+ Advocates (co-sponsor)
The Steinberg Institute (co-sponsor)
Alliance of Catholic Health Care
American Academy of Pediatrics, California
Association of California Healthcare Districts
California Academy of Family Physicians
California Consortium of Addiction Programs and Professionals
California Coverage and Health Initiatives
California Dental Hygienists' Association
California Medical Association
California Psychological Association
California School Employees Association
Children Now
Corporation for Supportive Housing
County Behavioral Health Directors Association of California
County Health Executives Association of California
Disability Rights California
Housing California
Local Health Plans of California
Los Angeles LGBT Center
Mental Health America of California
National Alliance on Mental Illness-California
National Association of Social Workers, California Chapter

Planned Parenthood Affiliates of California
Private Essential Access Community Hospitals
Providence St. Joseph Health
Silicon Valley Leadership Group
Tenet Healthcare
The Jed Foundation
Urban Counties of California
Western Center on Law and Poverty
2020 Mom

Oppose: None received

-- END --