
A BILL FOR AN ACT

RELATING TO MEDICAID.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that federally qualified
2 health centers comprise the best system of community-based
3 primary care for people who are uninsured, underinsured, or
4 medicaid recipients. Over the years, federally qualified health
5 centers and rural health clinics have experienced a tremendous
6 increase in usage and demand for additional services and
7 evolving technologies, and increased regulatory requirements.
8 Adding to the strain placed on these facilities are inadequate
9 procedures through which medicaid payments are made and changes
10 in the scope of services provided.

11 The purpose of this Act is to ensure that the community
12 health center system remains financially viable and stable to
13 meet the increasing and changing health care needs of the
14 population of uninsured and underinsured residents by creating
15 an appropriate process whereby community health centers and
16 rural health clinics will receive supplemental Medicaid payments
17 and seek modifications to their scope of services. Specifically,
18 this Act, among other things:



- 1 (1) Establishes a timeline by which the department of
2 health shall reconcile managed care supplemental
3 payments;
- 4 (2) Provides a clear definition of what conditions
5 constitute a "change of scope" for purposes of
6 increasing or decreasing rates paid to a federally
7 qualified health center or rural health clinic;
- 8 (3) Specifies a process through which these providers may
9 file for a new rate due to "change of scope;" and
- 10 (4) Identifies services that are required to be reimbursed
11 under the prospective payment system.

12 This Act also serves to ensure departmental compliance with
13 requirements in the federal Medicare, Medicaid, and SCHIP
14 Benefits Improvement and Protection Act of 2000.

15 SECTION 2. Chapter 346, Hawaii Revised Statutes, is
16 amended by adding four new sections to be appropriately
17 designated and to read as follows:

18 **"§346-A Centers for Medicare & Medicaid Services approval.**

19 The department shall implement sections 346-B, 346-C, and 346-D,
20 subject to approval of the state plan by the Centers for
21 Medicare and Medicaid Services.



1 §346-B Federally qualified health centers and rural health
2 clinics; reconciliation of managed care supplemental payments.

3 (a) Reconciliation of managed care supplemental payments to a
4 federally-qualified health center or a rural health clinic shall
5 be made by the following procedures:

6 (1) Reports for final settlement under this subsection
7 shall be filed within one hundred fifty days following
8 the end of a calendar year in which supplemental
9 managed care entity payments are received from the
10 department;

11 (2) All records that are necessary and appropriate to
12 document the settlement claims in reports under this
13 section shall be maintained and made available upon
14 request to the department;

15 (3) The department shall review all reports for final
16 settlement within one hundred twenty days of receipt.
17 The review may include a sample review of financial
18 and statistical records. Reports shall be deemed to
19 have been reviewed and accepted by the department if
20 not rejected in writing by the department within one
21 hundred twenty days of initial receipt. If a report
22 is rejected, the department shall notify the federally



1 qualified health center or rural health clinic, prior
2 to the end of the one hundred twenty-day period, of
3 its reasons for rejecting the report. The federally
4 qualified health center or rural health clinic shall
5 have ninety days to correct and resubmit the final
6 settlement report. If no written rejection by the
7 department is made within one hundred twenty days, the
8 department shall proceed to finalize the reports
9 within one hundred twenty days of the date of receipt
10 to determine if a reimbursement is due to, or payment
11 due from, the reporting federally qualified health
12 center or rural health clinic. Upon conclusion of the
13 review, and no later than two hundred ten days
14 following initial receipt of the report for final
15 settlement, the department shall calculate a final
16 reimbursement that is due to, or payment due from, the
17 reporting federally qualified health center or rural
18 health clinic. The payment amount shall be calculated
19 using the methodology described in this section. No
20 later than at the end of the two hundred ten-day
21 period, the department shall notify the reporting
22 federally qualified health center or rural health



1 clinic of the reimbursement due to, or payment due
2 from, the reporting federally qualified health center
3 or rural health clinic. Where payment is due to the
4 reporting federally qualified health center or rural
5 health clinic, the department shall make full payment
6 to the federally qualified health center or rural
7 health clinic. The notice of program reimbursement
8 shall include the department's calculation of the
9 reimbursement due to, or payment due from, the
10 reporting federally qualified health center or rural
11 health clinic. All notices of program reimbursement
12 or payment due shall be issued by the department
13 within one year from the initial report for final
14 settlement's receipt date, or within one year of the
15 resubmission date of a corrected report for final
16 settlement, whichever is later;

17 (4) A federally qualified health center or rural health
18 clinic may appeal a decision made by the department
19 under this subsection on the prospective payment
20 system rate adjustment if the Medicaid impact is
21 \$10,000 or more. Any person aggrieved by a final
22 decision and order shall be entitled to judicial



1 review in accordance with chapter 91 or may submit the
2 matter to binding arbitration pursuant to chapter
3 658A. Notwithstanding any provision to the contrary,
4 for the purposes of this paragraph, "person aggrieved"
5 shall include any federally qualified health center,
6 rural health clinic, or agency that is a party to the
7 contested case proceeding to be reviewed; and

8 (5) The department may develop a repayment plan to
9 reconcile overpayment to a federally qualified health
10 center or rural health clinic. The department shall
11 repay the federal share of any overpayment within
12 sixty days of the date of the discovery of the
13 overpayment.

14 (b) An alternative supplemental managed care payment
15 methodology that will make any federally qualified health center
16 or rural health clinic whole as required under the federal
17 Medicare, Medicaid, and SCHIP Benefits Improvement and
18 Protection Act of 2000, other than the one set forth in this
19 section, may be implemented provided the alternative payment
20 methodology is consented to in writing by the federally
21 qualified health center or rural health clinic to which the
22 methodology applies.



1 §346-C Federally qualified health center or rural health
2 clinic; adjustment for changes to scope of services.

3 Prospective payment system rates may be adjusted for any
4 adjustment in the scope of services furnished by a participating
5 federally qualified health center or rural health clinic;
6 provided that:

7 (1) The department is notified in writing of any changes
8 to the scope of services and the reasons for those
9 changes within sixty days of the effective date of
10 such changes;

11 (2) Data, documentation, and schedules are submitted to
12 the department that substantiate any changes in the
13 scope of services and the related adjustment of
14 reasonable costs following Medicare principles of
15 reimbursement;

16 (3) The federally qualified health center or rural health
17 clinic must propose a projected adjusted rate, subject
18 to mutual agreement with the department, within one
19 hundred and fifty days of the changes. The proposed
20 projected adjusted rate shall be calculated on a
21 consolidated basis, where the federally qualified
22 health center or rural health clinic takes all costs



1 for the center which would be composed of both the
2 costs included in the base rate as well as the
3 additional costs, as long as the federally qualified
4 health center or rural health clinic had filed its
5 baseline cost report based on total consolidated
6 costs. A net change in the federally qualified health
7 center's or rural health clinic's rate shall be
8 calculated by subtracting the federally qualified
9 health center's or rural health clinic's previously
10 assigned prospective payment system rate from its
11 projected adjusted rate. Within ninety days of its
12 receipt of the projected adjusted rate, the department
13 shall notify the federally qualified health center or
14 rural health clinic of its approval or rejection of
15 the projected adjusted rate. Upon approval by the
16 department, the federally qualified health center or
17 rural health clinic shall be paid the projected rate
18 for the period from the effective date of the change
19 in scope of services through the date that a rate is
20 calculated based on the submission of a cost report.
21 The cost report shall be prepared in the same manner
22 and method as those submitted to establish the



1 proposed projected adjusted rate and shall cover the
2 first full fiscal year that includes the change in
3 scope of services. A federally qualified health
4 center or rural health clinic may appeal a decision
5 made by the department under this subsection on the
6 prospective payment system rate adjustment if the
7 Medicaid impact is \$10,000 or more. Any person
8 aggrieved by the final decision and order shall be
9 entitled to judicial review in accordance with chapter
10 91 or may submit the matter to binding arbitration
11 pursuant to chapter 658A. Notwithstanding any
12 provision to the contrary, for the purposes of this
13 paragraph, "person aggrieved" shall include any
14 federally qualified health center, rural health
15 clinic, or agency that is a party to the contested
16 case proceeding to be reviewed;

17 (4) Upon receipt of the cost report for the first full
18 fiscal year reflecting the change in scope of
19 services, the prospective payment system rate shall be
20 adjusted following a review by the fiscal agent of the
21 cost report and documentation;



1 (5) Adjustments shall be made for payments for the period
2 from the effective date of the change in scope of
3 services through the date of the final adjustment of
4 the prospective payment system rate;

5 (6) For the purposes of this section, a change in scope of
6 services provided by a federally qualified health
7 center or rural health clinic means a change in the
8 type, intensity, duration, or amount of services
9 provided by a federally qualified health center or
10 rural health clinic or one of its sites. The increase
11 or decrease in the scope of service must reasonably be
12 expected to last at least one year. A change in scope
13 of service includes but is not limited to the
14 following:

15 (A) The addition of a new service that is not
16 incorporated in the baseline prospective payment
17 system rate, or a deletion of a service that is
18 incorporated in the baseline prospective payment
19 system rate;

20 (B) A change in service resulting from amended state
21 or federal requirements or rules;



- 1 (C) A change in service resulting from either
2 remodeling or relocation;
- 3 (D) A change in types, intensity, duration, or amount
4 of service resulting from a change in applicable
5 technology and medical practice used;
- 6 (E) An increase in service intensity or duration, or
7 amount of service resulting from changes in the
8 types of patients served, including but not
9 limited to populations with HIV, AIDS, or other
10 chronic diseases, or homeless, elderly, migrant,
11 or other special populations;
- 12 (F) A change in service resulting from a change in
13 the provider mix of a federally qualified health
14 center or rural health clinic or one of its
15 sites;
- 16 (G) Changes in operating costs due to capital
17 expenditures associated with any modification of
18 the scope of service described in this paragraph,
19 including new or expanded service facilities,
20 regulatory compliance, or changes in technology
21 or medical practice;



1 (H) Indirect medical education adjustments and any
2 direct graduate medical education payment
3 necessary to provide instrumental services to
4 interns and residents that are associated with a
5 modification of the scope of service described in
6 this paragraph; or

7 (I) Any changes in the scope of a project approved by
8 the federal Health Resources and Services
9 Administration where the change affects a covered
10 service;

11 (7) A federally qualified health center or rural health
12 clinic may submit a request for prospective payment
13 system rate adjustment for a change to its scope of
14 services once per calendar year based on a projected
15 adjusted rate; and

16 (8) All references in this subsection to "fiscal year"
17 shall be construed to be references to the fiscal year
18 of the individual federally qualified health center or
19 rural health clinic.

20 §346-D Federally qualified health center or rural health

21 clinic; visit. (a) Services eligible for prospective payment
22 system reimbursement include:



1 (1) Services that are:

2 (A) Provided to a recipient by a rural health clinic
3 at the clinic site, at the recipient's residence,
4 or at a hospital or other medical facility;

5 (B) Ambulatory, including evaluation and management
6 services, when furnished to a patient at a
7 long-term care facility, the patient's residence,
8 or at another institutional or off-site setting;
9 and

10 (C) Within the scope of services provided by the
11 State under its fee-for-service Medicaid program
12 and its health QUEST program, on and after August
13 1994 and as amended from time to time;

14 and

15 (2) A "visit", which, for the purposes of this section,
16 shall mean any encounter between a federally qualified
17 health center or rural health clinic patient and a
18 health professional as identified in the state plan as
19 amended from time to time.

20 (b) Contacts with one or more health professionals and
21 multiple contacts with the same health professional that take
22 place on the same day and at a single location constitute a



1 single encounter, except when one of the following conditions
2 exists:

3 (1) After the first encounter, the patient suffers illness
4 or injury requiring additional diagnosis or treatment;
5 or

6 (2) The patient makes one or more visits for dental or
7 behavioral health. Medicaid shall pay for a maximum
8 of one visit per day for each of these services in
9 addition to one medical visit.

10 (c) Should a patient see two health professionals on the
11 same day that result in additional diagnosis or treatment, this
12 constitutes two visits that may be billed on two separate claims
13 with remarks on both claims explaining the reason for both
14 visits."

15 SECTION 3. In codifying the new sections added by section
16 2 of this Act, the revisor of statutes shall substitute
17 appropriate section numbers for the letters used in designating
18 the new sections in this Act.

19 SECTION 4. New statutory material is underscored.



1 SECTION 5. This Act shall take effect upon approval of the
2 state plan by the Centers for Medicare and Medicaid services.

3

INTRODUCED BY: Josh Green

JAN 21 2008



Report Title:

Federally-Qualified Health Centers; Rural Clinics; Payments

Description:

Establishes a timeline by which the department of health shall reconcile managed care supplemental payments; provides a clear definition of what conditions constitute a "change of scope" for purposes of increasing or decreasing rates paid to a federally qualified health center or rural health clinic; specifies a process through which these providers may file for a new rate due to "change of scope;" and identifies services that are required to be reimbursed under the prospective payment system.

