THE SENATE
TWENTY-FOURTH LEGISLATURE, 2008
STATE OF HAWAII

S.B. NO. 2542 S.D. 2 H.D. 2

A BILL FOR AN ACT

RELATING TO PUBLIC HEALTH.

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

1 SECTION 1. The legislature finds that federally qualified
2 health centers provide the best system of community-based
3 primary care for people who are uninsured, underinsured, or
4 medicaid recipients. However, over the years, the federally
5 qualified health centers and rural health clinics have
6 experienced a tremendous increase in usage. Adding to the
7 strain placed on these facilities are the following:
8 (1) The ever-evolving nature and complexity of the
9 services provided;
10 (2) Inadequate procedures through which medicaid payment
11 and changes in the scope of services provided are
12 addressed; and
13 (3) The lack of adequate funding to pay for services for
14 the uninsured.
15 The purpose of this Act is to ensure that the community
16 health center system remains financially viable and stable in
17 the face of the increasing needs of the population of uninsured

1 and underinsured residents by creating a process whereby
2 community health centers and rural health clinics will receive
3 supplemental medicaid payments and seek modifications to their
4 scope of services. This Act also provides an appropriation to
5 adequately pay federally qualified community health centers for
6 services for the uninsured.
7 SECTION 2. Chapter 346, Hawaii Revised Statutes, is
8 amended by adding four new sections to be appropriately
9 designated and to read as follows:
10 "**§346-A Centers for Medicare and Medicaid Services**
11 **approval.** The department may implement sections 346-B, 346-C,
12 and 346-D, subject to approval of the Hawaii medicaid state plan
13 by the Centers for Medicare and Medicaid Services.
14 **§346-B Federally qualified health centers and rural health**
15 **clinics; reconciliation of managed care supplemental payments.**
16 (a) Federally qualified health centers or rural health clinics
17 that provide services under a contract with a medicaid managed
18 care organization shall receive estimated quarterly state
19 supplemental payments for the cost of furnishing such services
20 that are an estimate of the difference between the payments the
21 federally qualified health center or rural health clinic
22 receives from medicaid managed care organizations and payments

1 the federally qualified health center or rural health clinic
2 would have received under the Benefits Improvement and
3 Protection Act of 2000 prospective payment system methodology.
4 Not more than one month following the beginning of each calendar
5 quarter and based on the receipt of federally qualified health
6 center or rural health clinic submitted claims during the prior
7 calendar quarter, federally qualified health centers or rural
8 health clinics shall receive the difference between the
9 combination of payments the federally qualified health center or
10 rural health clinic receives from estimated supplemental
11 quarterly payments and payments received from medicaid managed
12 care organizations and payments the federally qualified health
13 center or rural health clinic would have received under the
14 Benefits Improvement and Protection Act of 2000 prospective
15 payment system methodology. Balances due from the federally
16 qualified health center shall be recouped from the next
17 quarter's estimated supplemental payment.
18 (b) The federally qualified health center or rural health
19 clinic shall file an annual settlement report summarizing
20 patient encounters within one hundred fifty days following the
21 end of a calendar year in which supplemental payments are
22 received from the department. The total amount of supplemental

1 and medicaid managed care organization payments received by the
2 federally qualified health center or rural health clinic shall
3 be reviewed against the amount that the actual number of visits
4 provided under the federally qualified health centers' or rural
5 health clinics' contract with the medicaid managed care
6 organization would have yielded under the prospective payment
7 system. The department shall also receive financial records
8 from the medicaid managed care organization. As part of this
9 review, the department may request additional documentation from
10 the federally qualified health center or rural health clinic and
11 the medicaid managed care organization to resolve differences
12 between medicaid managed care organization and provider records.
13 Upon conclusion of the review, the department shall calculate a
14 final payment that is due to or from the participating federally
15 qualified health center or rural health clinic. The department
16 shall notify the participating federally qualified health center
17 or rural health clinic of the balance due to or from the
18 federally qualified health center or rural health clinic. The
19 notice of program reimbursement shall include the department's
20 calculation of the balance due to or from the federally
21 qualified health center or rural health clinic.

1 (c) For the purposes of this section, the payments
2 received from medicaid managed care organizations exclude
3 managed care risk pool accruals, distributions, or losses, or
4 any pay-for-performance bonuses or other forms of incentive
5 payments such as quality improvement recognition grants and
6 awards.
7 (d) An alternative supplemental managed care payment
8 methodology other than the one set forth herein may be
9 implemented as long as the alternative payment methodology is
10 consented to in writing by the federally qualified health center
11 or rural health clinic to which the methodology applies.
12 **§346-C Federally qualified health center or rural health**
13 **clinic; adjustment for changes to scope of services.** (a)
14 Prospective payment system rates may be adjusted for any
15 increases or decreases in the scope of services furnished by a
16 participating federally qualified health center or rural health
17 clinic, provided that:
18 (1) The federally qualified health center or rural health
19 clinic notifies the department in writing of any
20 changes to the scope of services and the reasons for
21 those changes within sixty days of the effective date
22 of the changes;

1 (2) The federally qualified health center or rural health
2 clinic submits data, documentation, and schedules that
3 substantiate any changes in services and the related
4 adjustment of reasonable costs following medicare
5 principles of reimbursement; and
6 (3) The federally qualified health center or rural health
7 clinic proposes a projected adjusted rate within one
8 hundred and fifty days of the changes to the scope of
9 services.
10 (b) The projected adjusted rate proposed under subsection
11 (a)(3) shall be subject to departmental approval. The proposed
12 projected adjusted rate shall be calculated on a consolidated
13 basis based on all costs for the federally qualified health
14 center or rural health clinic that include both the costs
15 included in the base rate, as well as the additional costs;
16 provided that the federally qualified health center or rural
17 health clinic filed its baseline costs report based on total
18 consolidated costs. A net change in the federally qualified
19 health center's or rural health clinic's rate shall be calculated
20 by subtracting the federally qualified health center's or rural
21 health clinic's previously assigned prospective payment system
22 rate from its projected adjusted rate.

1 (c) Within one hundred twenty days of its receipt of the
2 projected adjusted rate and all additional documentation
3 requested by the department, the department shall notify the
4 federally qualified health center or rural health clinic of its
5 acceptance or rejection of the projected adjusted rate. Upon
6 approval by the department, the federally qualified health center
7 or rural health clinic shall be paid the projected rate, which
8 shall be effective from the date of the change in scope of
9 services through the date that a rate is calculated based upon
10 the first full fiscal year that includes the change in scope of
11 services.
12 (d) The department shall review the calculated rate of the
13 first full fiscal year cost report if the change of scope of
14 services is in effect for more than six months of the report.
15 The department shall also review the next full fiscal year cost
16 report for those federally qualified health centers or rural
17 health clinics for which the change of scope of services is in
18 effect for six months or less of the cost report fiscal year.
19 The department shall review the calculated inflated weighted
20 average rate of these two cost reports. The total costs of the
21 first-year report shall be adjusted to the Medical Economic Index

1 of the second-year report. Each report shall be weighted based
2 upon the number of patient encounters.
3 (e) Upon receipt of the cost reports, the prospective
4 payment system rate shall be adjusted following a review by the
5 fiscal agent of the cost reports and documentation. Adjustments
6 shall be made for payments for the period from the effective
7 date of the change in scope of services through the date of the
8 final adjustment of the prospective payment system rate.
9 (f) No change in costs, in and of itself, shall be
10 considered a change in scope of services unless the cost is
11 allowable under medicaid principles of reimbursement and the net
12 change in the federally qualified health center's or rural health
13 clinic's per-visit rate equals or exceeds three per cent for the
14 affected federally qualified health center or rural health clinic
15 site. For purposes of calculating the costs associated with a
16 scope of services change for federally qualified health centers
17 or rural health clinics that filed consolidated cost reports for
18 multiple sites to establish their baseline prospective payment
19 system rates, the net change of three per cent shall be applied
20 to the average per-visit rate of all the sites of the federally
21 qualified health center or rural health clinic.
22 (g) For the purposes of this section:

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2 "Change in scope of services" means:

3 (1) The addition of a new service, such as adding dental
4 services or any other medicaid covered service, that is
5 not incorporated in the baseline prospective payment
6 system rate or a deletion of a service that is
7 incorporated in the baseline prospective payment system
8 rate;

9 (2) A change in service resulting from amended regulatory
10 requirements or rules;

11 (3) A change in service resulting from either remodeling
12 or relocation;

13 (4) A change in type, intensity, duration, or amount of
14 service resulting from a change in applicable
15 technology and medical practice used;

16 (5) An increase in service intensity, duration, or amount
17 of service resulting from changes in the types of
18 patients served, including but not limited to
19 populations with human immunodeficiency virus,
20 acquired immunodeficiency syndrome, or other chronic
21 diseases, or homeless, elderly, migrant, or other
22 special populations;

1 (6) A change in service resulting from a change in the
2 provider mix of a federally qualified health center or
3 a rural health clinic or one of its sites;
4 (7) Any changes in the scope of a project approved by the
5 federal Health Resources and Services Administration
6 where the change affects a covered service; or
7 (8) Changes in operating costs due to capital expenditures
8 associated with a modification of the scope of any of
9 the services, including new or expanded service
10 facilities, regulatory compliance, or changes in
11 technology or medical practices at the federally
12 qualified health center or rural health clinic.
13 "Fiscal year" means the fiscal year of the individual
14 federally qualified health center or rural health clinic, as the
15 case may be.
16 "Net change" means the per-visit change attributable to the
17 cumulative effect of all increases or decreases for a particular
18 fiscal year.
19 **§346-D Federally qualified health center or rural health**
20 **clinic visit.** (a) Services eligible for prospective payment
21 system reimbursement are those services that are furnished by a

1 federally qualified health center or rural health clinic that
2 are:
3 (1) Within the legal authority of a federally qualified
4 health center to deliver, as defined in Section 1905
5 of the Social Security Act;
6 (2) Actually provided by the federally qualified health
7 center, either directly or under arrangements;
8 (3) Covered benefits under the medicaid program, as
9 defined in Section 4231 of the State Medicaid Manual
10 and the Hawaii medicaid state plan;
11 (4) Provided to a recipient eligible for medicaid
12 benefits;
13 (5) Delivered exclusively by health care professionals,
14 including physicians, physician's assistants, nurse
15 practitioners, nurse midwives, clinical social
16 workers, clinical psychologists, and other persons
17 acting within the lawful scope of their license or
18 certificate to provide services;
19 (6) Provided at the federally qualified health center's
20 practice site, in a hospital emergency room, in an
21 inpatient setting, at the patient's place of

1 residence, including long-term care facilities, or at
2 another medical facility; and
3 (7) Within the scope of services provided by the State
4 under its fee-for-service medicaid program and its
5 QUEST program, as amended from time to time, on or
6 after August 1994.
7 (b) Contacts with one or more health professionals and
8 multiple contacts with the same health professional that take
9 place on the same day and at a single location constitute a
10 single encounter, except when one of the following conditions
11 exists:
12 (1) After the first encounter, the patient suffers illness
13 or injury requiring additional diagnosis or treatment;
14 or
15 (2) The patient makes one or more visits for other
16 services such as dental or behavioral health.
17 Medicaid may pay for a maximum of one visit per day
18 for each of these services in addition to one medical
19 visit.
20 (c) A federally qualified health center or rural health
21 clinic that provides prenatal services, delivery services, and
22 post-natal services may elect to bill medicaid separately for

1 the services and thereby receive a global payment; or it may
2 bill for such prenatal and post-natal services as a federally
3 qualified health center or rural health clinic and be paid the
4 per-visit prospective payment system reimbursement for the
5 services. However, payment to the federally qualified health
6 center or rural health clinic for inpatient delivery services
7 shall not be eligible for prospective payment system
8 reimbursement."
9 SECTION 3. (a) Notwithstanding any law to the contrary,
10 reports for final payment under section 346-B, Hawaii Revised
11 Statutes, for each calendar year shall be filed within one
12 hundred fifty days from the date the department of human
13 services adopts forms and issues written instructions for
14 requesting a final payment under that section.
15 (b) All payments owed by the department of human services
16 shall be made on a timely basis.
17 SECTION 4. A federally qualified health center or rural
18 health clinic shall submit a prospective payment system rate
19 adjustment request under section 346-C, Hawaii Revised Statutes,
20 within one hundred fifty days of the beginning of the calendar
21 year occurring after the department of human services first
22 adopts forms and issues written instructions for applying for a

1 prospective payment system rate adjustment under section 346-C,
2 Hawaii Revised Statutes, if, during the prior fiscal year, the
3 federally qualified health center or rural health clinic
4 experienced a decrease in the scope of services; provided that
5 the federally qualified health center or rural health clinic
6 either knew or should have known the rate adjustment would
7 result in a significantly lower per-visit rate. As used in this
8 paragraph, "significantly lower" means an average rate decrease
9 in excess of three per cent.

10 Notwithstanding any law to the contrary, the first full
11 fiscal year's cost reports shall be deemed to have been
12 submitted in a timely manner if filed within one hundred fifty
13 days after the department of human services adopts forms and
14 issues written instructions for applying for a prospective
15 payment system rate adjustment for changes to scope of service
16 under section 346-C, Hawaii Revised Statutes.

17 SECTION 5. The department of health may provide resources
18 to nonprofit, community-based health care providers for direct
19 medical care for the uninsured, including:

20 (1) Primary medical;

21 (2) Dental;

22 (3) Behavioral health care; and

1 (4) Ancillary services, including:
2 (A) Education;
3 (B) Follow-up;
4 (C) Outreach; and
5 (D) Pharmacy services.
6 Distribution of funds may be on a "per-visit" basis, taking into
7 consideration need on all islands.
8 SECTION 6. There is appropriated out of the general
9 revenues of the State of Hawaii the sum of $ or so
10 much thereof as may be necessary for fiscal year 2008-2009 to
11 the department of health for direct medical care to the
12 uninsured.
13 The sum appropriated shall be expended by the department of
14 health for the purposes of this Act.
15 SECTION 7. 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 8. New statutory material is underscored.
20 SECTION 9. This Act shall take effect on January 1, 2050;
21 provided that section 2 of this Act shall take effect upon

1 approval of the Hawaii medicaid state plan by the Centers for
2 Medicare and Medicaid Services.

S.B. NO. 2542
S.D. 2
H.D. 2

Report Title:
Public Health; Federally Qualified Health Centers

Description:
Establishes a process that enables community health centers and rural health clinics to receive supplemental Medicaid payments and seek modifications to their scope of services. Appropriates funds to adequately pay federally qualified community health centers for direct medical care services for the uninsured. Effective 1/1/50. (SB2542 HD2)