
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 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
18 and underinsured residents by creating a process whereby



1 community health centers and rural health clinics will receive
2 supplemental medicaid payments and seek modifications to their
3 scope of services. This Act also provides an appropriation to
4 adequately pay federally qualified community health centers for
5 services for the uninsured.

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

9 **§346-A Centers for Medicare and Medicaid Services**

10 **approval.** The department shall implement sections 346-B, 346-C,
11 and 346-D, subject to approval of the state plan by the Centers
12 for Medicare and Medicaid Services.

13 **§346-B Federally qualified health centers and rural health**
14 **clinics; reconciliation of managed care supplemental payments.**

15 (a) Federally qualified health centers or rural health clinics
16 that provide services under a contract with a medicaid managed
17 care organization (MCO) shall receive estimated quarterly state
18 supplemental payments for the cost of furnishing such services
19 that are an estimate of the difference between the payments the
20 federally qualified health center or rural health clinic receives
21 from MCO(s) (excluding managed care risk pool accruals,
22 distributions, or losses, or any pay-for-performance bonuses or



1 other forms of incentive payments such as quality improvement
2 recognition grants and awards) and payments the federally
3 qualified health center or rural health clinic would have
4 received under the Benefits Improvement and Protection Act of
5 2000 (BIPA) prospective payment system methodology. Not more
6 than one month following the beginning of each calendar quarter
7 and based on the receipt of federally qualified health center or
8 rural health clinic submitted claims during the prior calendar
9 quarter, federally qualified health centers or rural health
10 clinics shall receive the difference between the combination of
11 payments the federally qualified health center or rural health
12 clinic receives from estimated supplemental quarterly payments
13 and payments received from MCO(s) (excluding managed care risk
14 pool accruals, distributions, or losses, or any pay-for-
15 performance bonuses or other forms of incentive payments such as
16 quality improvement recognition grants and awards) and payments
17 the federally qualified health center or rural health clinic
18 would have received under the BIPA prospective payment system
19 methodology. Balances due from the federally qualified health
20 center shall be recouped from the next quarter's estimated
21 supplemental payment.



1 (b) The federally qualified health center or rural health
2 clinic shall file an annual settlement report summarizing
3 patient encounters within one hundred fifty days following the
4 end of a calendar year in which supplemental payments are
5 received from the department. The total amount of supplemental
6 and MCO payments received, excluding managed care risk pool
7 accruals or, distributions or losses, or any pay-for-performance
8 bonuses or other forms of incentive payments such as quality
9 improvement recognition grants and awards, by the federally
10 qualified health center or rural health clinic shall be reviewed
11 against the amount that the actual number of visits provided
12 under the federally qualified health centers' or rural health
13 clinics' contract with the MCO(s) would have yielded under the
14 prospective payment system. The department shall also receive
15 financial records from the MCO. As part of this review, the
16 department may request additional documentation from the
17 federally qualified health center or rural health clinic and the
18 MCO to resolve differences between MCO and provider records.
19 Upon conclusion of the review, the department shall calculate a
20 final payment that is due to or from the participating federally
21 qualified health center or rural health clinic. The department
22 shall notify the participating federally qualified health center



1 or rural health clinic of the balance due to or from the
2 federally qualified health center or rural health clinic. The
3 notice of program reimbursement shall include the department's
4 calculation of the balance due to or from the federally
5 qualified health center or rural health clinic.

6 (c) An alternative supplemental managed care payment
7 methodology other than the one set forth herein may be
8 implemented as long as the alternative payment methodology is
9 consented to in writing by the federally qualified health center
10 or rural health clinic to which the methodology applies.

11 **§346-C Federally qualified health center or rural health**
12 **clinic; adjustment for changes to scope of services.**

13 Prospective payment system rates may be adjusted for any
14 increases or decreases in the scope of services furnished by a
15 participating federally qualified health center or rural health
16 clinic, provided that:

17 (1) The federally qualified health center or rural health
18 clinic notifies the department in writing of any
19 changes to the scope of services and the reasons for
20 those changes within sixty days of the effective date
21 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. The federally qualified
6 health center or rural health clinic proposes a
7 projected adjusted rate within one hundred and fifty
8 days of the changes to the scope of services. This
9 proposed projected adjusted rate is subject to
10 departmental approval. The proposed projected adjusted
11 rate shall be calculated based on a consolidated basis
12 where the federally qualified health center or rural
13 health clinic takes all costs for the center that would
14 include both the costs included in the base rate, as
15 well as the additional costs, as long as the federally
16 qualified health center or rural health clinic had
17 filed its baseline costs report based on total
18 consolidated costs. A net change in the federally
19 qualified health center's or rural health clinic's rate
20 shall be calculated by subtracting the federally
21 qualified health center's or rural health clinic's
22 previously assigned prospective payment system rate



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



1 total costs of the first year report shall be adjusted
2 to the Medical Economic Index of the second year
3 report. Each report shall be weighted based on number
4 of patient encounters;

5 (3) Upon receipt of the cost reports, the prospective
6 payment system rate shall be adjusted following a
7 review by the fiscal agent of the cost reports and
8 documentation;

9 (4) Adjustments shall be made for payments for the period
10 from the effective date of the change in scope of
11 services through the date of the final adjustment of
12 the prospective payment system rate;

13 (5) For the purposes of prospective payment system rate
14 adjustment, a change in scope of services provided by
15 a federally qualified health center or rural health
16 clinic means the following:

17 (A) The addition of a new service (such as adding
18 dental services or any other medicaid covered
19 service) that is not incorporated in the baseline
20 prospective payment system rate, or a deletion of
21 a service that is incorporated in the baseline
22 prospective payment system rate;



- 1 (B) A change in service resulting from amended
2 regulatory requirements or rules;
- 3 (C) A change in service resulting from either
4 remodeling or relocation;
- 5 (D) A change in type, intensity, duration, or amount
6 of service resulting from a change in applicable
7 technology and medical practice used;
- 8 (E) An increase in service intensity, duration, or
9 amount of service resulting from changes in the
10 types of patients served, including but not
11 limited to populations with human
12 immunodeficiency virus, acquired immunodeficiency
13 syndrome, or other chronic diseases, or homeless,
14 elderly, migrant, or other special populations;
- 15 (F) A change in service resulting from a change in
16 the provider mix of a federally qualified health
17 center or a rural health clinic or one of its
18 sites;
- 19 (G) Any changes in the scope of a project approved by
20 the federal Health Resources and Services
21 Administration where the change affects a covered
22 service; or



1 (H) Changes in operating costs due to capital
2 expenditures associated with a modification of the
3 scope of any of the services, including new or
4 expanded service facilities, regulatory
5 compliance, or changes in technology or medical
6 practices at the federally qualified health center
7 or rural health clinic;

8 (6) No change in costs shall, in and of itself, be
9 considered a scope of service change unless the cost is
10 allowable under medicaid principles of reimbursement
11 and the net change in the federally qualified health
12 center's or rural health clinic's per visit rate equals
13 or exceeds three per cent for the affected federally
14 qualified health center or rural health clinic site.
15 For federally qualified health centers or rural health
16 clinics that filed consolidated cost reports for
17 multiple sites to establish their baseline prospective
18 payment system rates, the net change of three per cent
19 shall be applied to the average per visit rate of all
20 the sites of the federally qualified health center or
21 rural health clinic for purposes of calculating the
22 costs associated with a scope of service change. For



1 the purpose of this sections "net change" means the per
2 visit change attributable to the cumulative effect of
3 all increases or decreases for a particular fiscal
4 year; and

5 (7) All references in this subsection to "fiscal year"
6 shall be construed to be references to the fiscal year
7 of the individual federally qualified health center or
8 rural health clinic, as the case may be.

9 **§346-D Federally qualified health center or rural health**
10 **clinic visit.** (a) Services eligible for prospective payment
11 system reimbursement are those services that are furnished by a
12 federally qualified health center or rural health clinic that
13 are:

- 14 (1) Within the legal authority of federally qualified
15 health center to deliver, as defined in Section 1905
16 of the Social Security Act;
- 17 (2) Actually provided by the federally qualified health
18 center, either directly or under arrangements;
- 19 (3) Covered benefits under the medicaid program, as
20 defined in Section 4231 of the State Medicaid Manual
21 and the Hawaii medicaid state plan;



- 1 (4) Provided to a recipient eligible for medicaid
2 benefits;
- 3 (5) Delivered exclusively by health care professionals,
4 including physicians, physician's assistants, nurse
5 practitioners, nurse midwives, clinical social
6 workers, clinical psychologists, and other persons
7 acting within the lawful scope of their license or
8 certificate to provide services;
- 9 (6) Provided at the federally qualified health center's
10 practice site, a hospital emergency room, in an
11 inpatient setting, at the patient's place of
12 residence, including long term care facilities, or at
13 another medical facility; and
- 14 (7) Within the scope of services provided by the State
15 under its fee-for-service medicaid program and its
16 QUEST program, on and after August 1994, and as
17 amended from time to time.
- 18 (b) Contacts with one or more health professionals and
19 multiple contacts with the same health professional that take
20 place on the same day and at a single location constitute a
21 single encounter, except when one of the following conditions
22 exists:



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

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

9 (c) A federally qualified health center or rural health
10 clinic that provides prenatal services, delivery services, and
11 post natal services may elect to bill medicaid separately for
12 the services and thereby receive a global payment; or it may
13 bill for such prenatal and post natal services as a federally
14 qualified health center or rural health clinic and be paid the
15 per visit prospective payment system reimbursement for the
16 services. However, payment to the federally qualified health
17 center or rural health clinic for inpatient delivery services
18 shall not be eligible for prospective payment system
19 reimbursement."

20 SECTION 3. (a) Notwithstanding any law to the contrary,
21 reports for final settlement under section 346-B, Hawaii Revised
22 Statutes, for each calendar year shall be filed within one



1 hundred fifty days from the date the department of human
2 services adopts forms and issues written instructions for
3 requesting a settlement under that section.

4 (b) All payments owed by the department of human services
5 shall be made on a timely basis.

6 SECTION 4. A federally qualified health center or rural
7 health clinic shall submit a prospective payment system rate
8 adjustment request under section 346-C, Hawaii Revised Statutes,
9 within one hundred fifty days of the beginning of the calendar
10 year occurring after the department of human services first
11 adopts forms and issues written instructions for applying for a
12 prospective payment system rate adjustment under section 346-C,
13 Hawaii Revised Statutes, if, during the prior fiscal year, the
14 federally qualified health center or rural health clinic
15 experienced a decrease in the scope of services; provided that
16 the federally qualified health center or rural health clinic
17 either knew or should have known it would result in a
18 significantly lower per-visit rate. As used in this section,
19 "significantly lower" means an average rate decrease in excess
20 of three per cent.

21 Notwithstanding any law to the contrary, the first full
22 fiscal year's cost reports shall be deemed to have been



1 submitted in a timely manner if filed within one hundred fifty
2 days after the department of human services adopts forms and
3 issues written instructions for applying for a prospective
4 payment system rate adjustment for changes to scope of service
5 under section 346-C, Hawaii Revised Statutes.

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

- 9 (1) Primary medical;
- 10 (2) Dental;
- 11 (3) Behavioral health care; and
- 12 (4) Ancillary services, including:
 - 13 (A) Education;
 - 14 (B) Follow-up;
 - 15 (C) Outreach; and
 - 16 (D) Pharmacy services.

17 Distribution of funds may be on a "per-visit" basis, taking into
18 consideration need on all islands.

19 SECTION 6. There is appropriated out of the general
20 revenues of the State of Hawaii the sum of \$ or so
21 much thereof as may be necessary for fiscal year 2008-2009 to



1 the department of health for direct medical care to the
2 uninsured.

3 The sum appropriated shall be expended by the department of
4 health for the purposes of this Act.

5 SECTION 7. In codifying the new sections added by section
6 2 of this Act, the revisor of statutes shall substitute
7 appropriate section numbers for the letters used in designating
8 the new sections in this Act.

9 SECTION 8. New statutory material is underscored.

10 SECTION 9. This Act shall take effect on July 1, 2008;
11 provided that section 2 of this Act shall take effect upon
12 approval of the state plan by the Centers for Medicare and
13 Medicaid Services.



Report Title:

Federally-Qualified Health Centers; Rural Clinics; Payments

Description:

Ensures continued community-based primary care for the uninsured, underinsured, or medicaid recipients by helping the community health center system to remain financially viable and stable in the face of the increasing needs of these populations.
(SD1)

