THE SENATE
TWENTY-FOURTH LEGISLATURE, 2008
STATE OF HAWAII

JAN 22 2008

S.B. NO. 2858

A BILL FOR AN ACT

RELATING TO MEDICAID.

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

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

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

(1) Establishes a timeline by which the department of health shall reconcile managed care supplemental payments;

(2) 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;

(3) Specifies a process through which these providers may file for a new rate due to "change of scope;" and

(4) Identifies services that are required to be reimbursed under the prospective payment system.

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

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

"**§346-A Centers for Medicare & Medicaid Services approval.** The department shall implement sections 346-B, 346-C, and 346-D, subject to approval of the state plan by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

qualified health center or rural health clinic, prior to the end of the one hundred twenty-day period, of its reasons for rejecting the report. The federally qualified health center or rural health clinic shall have ninety days to correct and resubmit the final settlement report. If no written rejection by the department is made within one hundred twenty days, the department shall proceed to finalize the reports within one hundred twenty days of the date of receipt to determine if a reimbursement is due to, or payment due from, the reporting federally qualified health center or rural health clinic. Upon conclusion of the review, and no later than two hundred ten days following initial receipt of the report for final settlement, the department shall calculate a final reimbursement that is due to, or payment due from, the reporting federally qualified health center or rural health clinic. The payment amount shall be calculated using the methodology described in this section. No later than at the end of the two hundred ten-day period, the department shall notify the reporting federally qualified health center or rural health

clinic of the reimbursement due to, or payment due from, the reporting federally qualified health center or rural health clinic. Where payment is due to the reporting federally qualified health center or rural health clinic, the department shall make full payment to the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's calculation of the reimbursement due to, or payment due from, the reporting federally qualified health center or rural health clinic. All notices of program reimbursement or payment due shall be issued by the department within one year from the initial report for final settlement's receipt date, or within one year of the resubmission date of a corrected report for final settlement, whichever is later;

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

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

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

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

§346-C Federally qualified health center or rural health clinic; adjustment for changes to scope of services. Prospective payment system rates may be adjusted for any adjustment in the scope of services furnished by a participating federally qualified health center or rural health clinic; provided that:

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

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

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

for the center which would be composed of both the costs included in the base rate as well as the additional costs, as long as the federally qualified health center or rural health clinic had filed its baseline cost report based on total consolidated costs. A net change in the federally qualified health center's or rural health clinic's rate shall be calculated by subtracting the federally qualified health center's or rural health clinic's previously assigned prospective payment system rate from its projected adjusted rate. Within ninety days of its receipt of the projected adjusted rate, the department shall notify the federally qualified health center or rural health clinic of its approval or rejection of the projected adjusted rate. Upon approval by the department, the federally qualified health center or rural health clinic shall be paid the projected rate for the period from the effective date of the change in scope of services through the date that a rate is calculated based on the submission of a cost report. The cost report shall be prepared in the same manner and method as those submitted to establish the

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

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

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

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

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

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

(C) A change in service resulting from either remodeling or relocation;

(D) A change in types, intensity, duration, or amount of service resulting from a change in applicable technology and medical practice used;

(E) An increase in service intensity or duration, or amount of service resulting from changes in the types of patients served, including but not limited to populations with HIV, AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations;

(F) A change in service resulting from a change in the provider mix of a federally qualified health center or rural health clinic or one of its sites;

(G) Changes in operating costs due to capital expenditures associated with any modification of the scope of service described in this paragraph, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practice;

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

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

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

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

§346-D Federally qualified health center or rural health clinic; visit. (a) Services eligible for prospective payment system reimbursement include:

(1) Services that are:

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

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

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

and

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

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

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

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

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

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

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

SECTION 4. New statutory material is underscored.

S.B. NO. 2858

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

INTRODUCED BY:

S.B. NO. 2858

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.