THE SENATE
TWENTY-FOURTH LEGISLATURE, 2008
STATE OF HAWAII

S.B. NO. 2858 S.D. 1

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 provide 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 human services 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 and 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) Federally qualified health centers or rural health clinics that provide services under a contract with a medicaid managed care organization (MCO) shall receive estimated quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the federally qualified health center or rural health clinic receives from MCO(s) (excluding managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 (BIPA) prospective payment system methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of federally qualified health center or rural health clinic submitted claims during the prior calendar quarter, federally qualified health centers or rural health clinics shall receive the difference between the combination of payments the federally qualified health center or rural health clinic receives from estimated supplemental quarterly payments

and payments received from MCO(s) (excluding managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) and payments the federally qualified health center or rural health clinic would have received under the BIPA prospective payment system methodology. Balances due from the federally qualified health center shall be recouped from the next quarter's estimated supplemental payment.

(b) The federally qualified health center or rural health clinic shall file an annual settlement report summarizing patient encounters within one hundred fifty days following the end of a calendar year in which supplemental payments are received from the department. The total amount of supplemental and MCO payments received, excluding managed care risk pool accruals or, distributions or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards, by the federally qualified health center or rural health clinic shall be reviewed against the amount that the actual number of visits provided under the federally qualified health center's or rural health clinic's contract with the MCO(s) would have yielded under the

prospective payment system. The department shall also receive financial records from the MCO. As part of this review, the department may request additional documentation from the federally qualified health center or rural health clinic and the MCO to resolve differences between MCO and provider records. Upon conclusion of the review, the department shall calculate a final payment that is due to or from the participating federally qualified health center or rural health clinic. The department shall notify the participating federally qualified health center or rural health clinic of the balance due to or from the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's calculation of the balance due to or from the federally qualified health center or rural health clinic.

(c) An alternative supplemental managed care payment methodology other than the one set forth herein may be implemented as long as 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

increases or decreases in the scope of services furnished by a participating federally qualified health center or rural health clinic, provided that:

(1) The federally qualified health center or rural health clinic notifies the department in writing of any changes to the scope of services and the reasons for those changes within sixty days of the effective date of the changes;

(2) The federally qualified health center or rural health clinic submits data, documentation, and schedules that substantiate any changes in services and the related adjustment of reasonable costs following medicare principles of reimbursement.

(3) The federally qualified health center or rural health clinic proposes a projected adjusted rate within one hundred and fifty days of the changes to the scope of services. This proposed projected adjusted rate is subject to departmental approval. The proposed projected adjusted rate shall be calculated based on a consolidated basis where the federally qualified health center or rural health clinic takes all costs for the center that would include 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 costs 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 one hundred twenty days of its receipt of the projected adjusted rate and all additional documentation requested by the department, the department shall notify the federally qualified health center or rural health clinic of its acceptance 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, which shall be effective from the date of the change in scope of services through the date that a rate is calculated based on the first full fiscal year that includes the change in scope of services. The department shall review the calculated rate of the

first full fiscal year cost report if the change of scope of service is reflected in more than six months of the report. For those federally qualified health centers or rural health clinics in which the change of scope of services is in effect for six months or less of the cost report fiscal year, the next full fiscal year cost report also is required. The department shall review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report shall be adjusted to the Medical Economic Index of the second year report. Each report shall be weighted based on the number of patient encounters;

(4) Upon receipt of the cost reports, the prospective payment system rate shall be adjusted following a review by the department or its designated agent of the cost reports 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 prospective payment system rate adjustment, a change in scope of services provided by a federally qualified health center or rural health clinic means the following:

(A) The addition of a new service (such as adding dental services or any other medicaid covered 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 type, intensity, duration, or amount of service resulting from a change in applicable technology and medical practice used;

(E) An increase in service intensity, duration, or amount of service resulting from changes in the types of patients served, including but not limited to populations with human immunodeficiency virus, acquired immunodeficiency

syndrome, 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 a rural health clinic or one of its sites;

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

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

(7) No change in costs shall, in and of itself, be considered a scope of service change unless the cost is allowable under medicaid principles of reimbursement and the net change in the federally qualified health center's or rural health clinic's per visit rate equals

or exceeds three per cent for the affected federally qualified health center or rural health clinic site. For federally qualified health centers or rural health clinics that filed consolidated cost reports for multiple sites to establish their baseline prospective payment system rates, the net change of three per cent shall be applied to the average per visit rate of all the sites of the federally qualified health center or rural health clinic for purposes of calculating the costs associated with a scope of service change. For the purposes of this sections "net change" means the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year; 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, as the case may be.

§346-D Federally qualified health center or rural health clinic visit. (a) Services eligible for prospective payment system reimbursement are those services that are furnished by a

federally qualified health center or rural health clinic that are:

(1) Within the legal authority of federally qualified health center to deliver, as defined in Section 1905 of the Social Security Act;

(2) Actually provided by the federally qualified health center, either directly or under arrangements;

(3) Covered benefits under the medicaid program, as defined in Section 4231 of the State Medicaid Manual and the Hawaii medicaid state plan;

(4) Provided to a recipient eligible for medicaid benefits;

(5) Delivered exclusively by health care professionals, including physicians, physician's assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and other persons acting within the lawful scope of their license or certificate to provide services;

(6) Provided at the federally qualified health center's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of

residence, including long term care facilities, or at another medical facility; and

(7) Within the scope of services provided by the State under its fee-for-service medicaid program and its QUEST program, on and after August 1994, and 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 other services such as dental or behavioral health. Medicaid may pay for a maximum of one visit per day for each of these services in addition to one medical visit.

(c) A federally qualified health center or rural health clinic that provides prenatal services, delivery services, and post natal services may elect to bill medicaid separately for

the services and thereby receive a global payment; or it may bill for such prenatal and post natal services as a federally qualified health center or rural health clinic and be paid the per visit prospective payment system reimbursement for the services. However, payment to the federally qualified health center or rural health clinic for inpatient delivery services shall not be eligible for prospective payment system reimbursement."

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.

SECTION 5. This Act shall take effect upon approval; provided that approval of the state plan is received by the Centers for Medicare and Medicaid Services.

Report Title:
Federally-Qualified Health Centers; Rural Clinics; Payments

Description:
Establishes a process whereby community health centers and rural health clinics will receive supplemental medicaid payments and seek modifications to their scope of services. (SD1)