

JAN 19 2007

---

# 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 are the best system of community-based primary  
3 care for people who are uninsured, underinsured, or medicaid  
4 recipients. However, over the years, the federally qualified  
5 health centers and rural health clinics have experienced a  
6 tremendous increase in usage. Adding to the strain placed on  
7 these facilities are:

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 under-insured 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 three new sections to be appropriately  
8 designated and to read as follows:

9 "§346-A Federally qualified health centers and rural  
10 health centers; reconciliation of payments. (a) Reconciliation  
11 of payments to a federally qualified health center or a rural  
12 health center shall be made by the following procedures:

- 13 (1) Reports for final settlement under this subsection  
14 shall be filed within one hundred fifty days following  
15 the end of a calendar year in which supplemental  
16 managed care entity payments are received from the  
17 department;
- 18 (2) All records that are necessary and appropriate to  
19 document the settlement claims in reports under this  
20 section shall be maintained and made available upon  
21 request to the department;



1       (3) The department shall review all reports for final  
2       settlement within ninety days of receipt. The review  
3       may include a sample review of financial and  
4       statistical records. Reports shall be deemed to have  
5       been reviewed and accepted by the department if not  
6       rejected in writing by the department within ninety  
7       days of their initial receipt dates. If a report is  
8       rejected, the department shall notify the federally  
9       qualified health center or rural health center no  
10      later than at the end of the ninety-day period, of its  
11      reasons for rejecting the report. The federally  
12      qualified health center or rural health center shall  
13      have ninety days to correct and resubmit the final  
14      settlement report. If no written rejection by the  
15      department is made within ninety days, the department  
16      shall proceed to finalize the reports within one  
17      hundred and twenty days of their date of receipt to  
18      determine if a reimbursement is due to or payment due  
19      from the reporting federally qualified health center  
20      or rural health center. Upon conclusion of the  
21      review, and no later than two hundred and ten days  
22      following initial receipt of the report for final



1 settlement, the department shall calculate a final  
2 reimbursement that is due to, or payment due from the  
3 reporting federally qualified health center or rural  
4 health center. The payment amount shall be calculated  
5 using the methodology described in this section. No  
6 later than at the end of the two hundred and ten-day  
7 period, the department shall notify the reporting  
8 federally qualified health center or rural health  
9 center of the reimbursement due to, or payment due  
10 from the reporting federally qualified health center  
11 or rural health center, and where payment is due to  
12 the reporting federally qualified health center or  
13 rural health center, the department shall make full  
14 payment to the federally qualified health center or  
15 rural health center. The notice of program  
16 reimbursement shall include the department's  
17 calculation of the reimbursement due to, or payment  
18 due from the reporting federally qualified health  
19 center or rural health center. All notices of program  
20 reimbursement or payment due shall be issued by the  
21 department within one year from the initial report for  
22 final settlement's receipt date, or within one year of



1           the resubmission date of a corrected report for final  
2           settlement;

3           (4) A federally qualified health center or rural health  
4           center may appeal a decision made by the department  
5           under this subsection on the prospective payment  
6           system rate adjustment if the medicaid impact is  
7           \$10,000 or more, whereupon an opportunity for an  
8           administrative hearing under chapter 91 shall be  
9           afforded. Any person aggrieved by the final decision  
10           and order shall be entitled to judicial review in  
11           accordance with chapter 91 or may submit the matter to  
12           binding arbitration pursuant to chapter 658A.

13           Notwithstanding any provision to the contrary, for the  
14           purposes of this paragraph "person aggrieved" shall  
15           include any federally qualified health center, rural  
16           health center, or agency that is a party to the  
17           contested case proceeding to be reviewed; and

18           (5) The department may develop a repayment plan to  
19           reconcile overpayment to a federally qualified health  
20           center or rural health center.

21           (b) An alternative supplemental managed care payment  
22           methodology other than the one set forth herein may be



1 implemented as long as the alternative payment methodology is  
2 consented to in writing by each federally qualified health  
3 center or rural health center to which the methodology applies.

4 **§346-B Federally qualified health center or rural health**  
5 **center; adjustment for changes to scope of services.**

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

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

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

19 (3) A projected adjusted rate is proposed which is  
20 approved by the department. The proposed projected  
21 adjusted rate shall be calculated on a consolidated  
22 basis that includes both the costs included in the



1 base rate and the additional costs of the change in  
2 the scope of services; provided that the federally  
3 qualified health center or rural health center had  
4 filed its baseline cost reports based on total  
5 consolidated costs. Within ninety days of its receipt  
6 of the projected adjusted rate, the department shall  
7 notify the federally qualified health center or rural  
8 health center of its approval or rejection of the  
9 projected adjusted rate. Upon approval by the  
10 department, the federally qualified health center or  
11 rural health center shall be paid the projected rate  
12 for the period from the effective date of the change  
13 in scope of services through the date that a rate is  
14 calculated based on the submittal of cost reports.  
15 Cost reports shall be prepared in the same manner and  
16 method as those submitted to establish the proposed  
17 projected adjusted rate and shall cover the first two  
18 full fiscal years that include the change in scope of  
19 services. The department's decision on the  
20 prospective payment system rate adjustment may be  
21 appealed if the medicaid impact is \$10,000 or more,  
22 whereupon an opportunity shall be afforded for an



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

11 (4) Upon receipt of the costs reports for the first two  
12 full fiscal years reflecting the change in scope of  
13 services, the prospective payment system rate shall be  
14 adjusted following a review by the fiscal agent of the  
15 cost reports and documentation;

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

20 (6) For the purposes of this section a change in scope of  
21 services provided by a federally qualified health





1 center or rural health center means any of the

2 following:

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

8 (B) A change in service resulting from amended  
9 regulatory requirements or rules;

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

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

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

21 (F) A change in service resulting from a change in  
22 the provider mix of a federally qualified health



- 1           center or a rural health center or one of its  
2           sites;
- 3           (G) Changes in operating costs due to capital  
4           expenditures associated with any modification of  
5           the scope of service described in this paragraph;
- 6           (H) Indirect medical education adjustments and any  
7           direct graduate medical education payment  
8           necessary to provide instrumental services to  
9           interns and residents that are associated with a  
10          modification of the scope of service described in  
11          this paragraph; or
- 12          (I) Any changes in the scope of a project approved by  
13          the federal health resources and services  
14          administration where the change affects a covered  
15          service;
- 16          (7) A federally qualified health center or rural health  
17          center may submit a request for prospective payment  
18          system rate adjustment for a change to its scope of  
19          services once per calendar year based on a projected  
20          adjusted rate; and
- 21          (8) All references in this subsection to "fiscal year"  
22          shall be construed to be references to the fiscal year



1 of the individual federally qualified health center or  
2 rural health center, as the case may be.

3 **§346-C Federally qualified health center or rural health**  
4 **center visit.** Services eligible for prospective payment system  
5 reimbursement include:

6 (1) Services that are:

7 (A) Ambulatory, including evaluation and management  
8 services when furnished to a patient at a  
9 federally qualified health center site, hospital,  
10 long-term care facility, the patient's residence,  
11 or at another institutional or off-site setting;  
12 and

13 (B) Within the scope of services provided by the  
14 State under its fee-for-service medicaid program  
15 and its health QUEST program, on and after August  
16 1994;

17 (2) A "visit" which for the purposes of this section shall  
18 mean any of the following:

19 (A) A face-to-face encounter between a federally  
20 qualified health center or rural health center  
21 patient and a health professional. For purposes  
22 of this subparagraph: "Health professional"



1           means a physician, physician assistant, advanced  
2           practice registered nurse or nurse practitioner,  
3           certified nurse midwife, clinical psychologist,  
4           licensed clinical social worker, or visiting  
5           nurse. "Physician" has a meaning consistent  
6           with title 42 Code of Federal Regulations section  
7           405.2401, or its successor, and includes the  
8           following:

9           (i) Physician or osteopath licensed under  
10           chapter 453 or chapter 460 respectively, to  
11           practice medicine and surgery;

12           (ii) A Podiatrist licensed under chapter 463E;

13           (iii) An optometrist licensed under chapter 459;

14           (iv) A chiropractor licensed under chapter 442;

15           or

16           (v) A dentist licensed under chapter 448;

17           (B) Preventive services, mental health services, home  
18           health services, family planning services,  
19           prenatal and postnatal care services, (but  
20           excluding delivery services which shall be  
21           reimbursed separately from and in addition to the  
22           prospective payment system reimbursement for



1           prenatal and postnatal care services) respiratory  
 2           care services, home pharmacy services, and early  
 3           periodic screening, diagnosis, and treatment  
 4           services, when provided by a licensed or  
 5           qualified health professional who is an employee  
 6           of, or a contractor to the federally qualified  
 7           health center or rural health center pursuant to  
 8           rules adopted by the department; or

9           (C) Adult day health care services, when these adult  
 10           day health care services are provided pursuant to  
 11           rules adopted by the department and when at least  
 12           four or more hours of adult day health care  
 13           services per day are provided;

14           and

15           (3) Multiple encounters by a patient with the same health  
 16           professional that take place on the same day and at a  
 17           single location constitute a single visit, except when  
 18           the patient, after the first encounter, suffers  
 19           illness or injury that requires additional diagnosis  
 20           or treatment."

21           SECTION 3. (a) Notwithstanding any laws to the contrary,  
 22 reports for final settlement under section 346-A, Hawaii Revised



1 Statutes, for calendar year 2006 shall be filed within one  
2 hundred and fifty days from the date the department of human  
3 services adopts forms and issues written instructions for  
4 requesting a settlement under that section.

5 (b) Retroactive reimbursements owed by the department of  
6 human services for calendar year 2006 under section 346-A,  
7 Hawaii Revised Statutes, shall be made prior to the end of  
8 fiscal year 2007-2008.

9 SECTION 4. A federally qualified health center or rural  
10 health center shall submit a prospective payment system rate  
11 adjustment request under section 346-B within one hundred and  
12 fifty days of the beginning of the calendar year occurring after  
13 the department of human services first adopts forms and issues  
14 written instructions for applying for a prospective payment  
15 system rate adjustment under section 346-B, Hawaii Revised  
16 Statutes, if, during the prior fiscal year, the federally  
17 qualified health center or rural health center experienced a  
18 decrease in the scope of services; provided that the federally  
19 qualified health center or rural health center either knew or  
20 should have known it would result in a significantly lower per  
21 visit rate. As used in this paragraph, "significantly lower"  
22 means an average rate decrease in excess of 1.75 per cent.



1 Notwithstanding any law to the contrary, the first two full  
2 fiscal years' cost reports shall be deemed to have been  
3 submitted in a timely manner if filed within one hundred and  
4 fifty days after the department of human services adopts forms  
5 and issues written instructions for applications for a  
6 prospective payment system rate adjustment for changes to scope  
7 of service under section 346-B.

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

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

19 Distribution of funds may be on a "per visit" basis, taking into  
20 consideration need on all islands.

21 SECTION 6. There is appropriated out of the general  
22 revenues of the State of Hawaii the sum of \$ or so much



1 thereof as may be necessary for fiscal year 2007-2008 to the  
2 department of health for direct medical care to the 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 1 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, 2007.

11

INTRODUCED BY: Amiel J. Lopez





**Report Title:**

Public Health; Federally Qualified Health Centers

**Description:**

Ensures the community health care system remains financially viable in the face of population growth, uninsured, and under-insured.

