THE SENATE
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

S.B. NO. 973 S.D. 2

A BILL FOR AN ACT

RELATING TO PUBLIC HEALTH.

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. However, over the years, the federally qualified health centers and rural health centers have experienced a tremendous increase in usage. Adding to the strain placed on these facilities are:

(1) The ever-evolving nature and complexity of the services provided;

(2) Inadequate procedures through which medicaid payment and changes in the scope of services provided are addressed; and

(3) The lack of adequate funding to pay for services for the uninsured.

The purpose of this Act is to ensure that the community health center system remains financially viable and stable in the face of the increasing needs of the population of uninsured and underinsured residents by creating a process whereby

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

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

"**§346-A Federally qualified health centers and rural health centers; reconciliation of payments.** (a) Reconciliation of payments to a federally qualified health center or a rural health center 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 their initial receipt dates. If a report is rejected, the department shall notify the federally qualified health center or rural health center no later than at the end of the one hundred twenty-day period, of its reasons for rejecting the report. The federally qualified health center or rural health center 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 their date of receipt to determine if a reimbursement is due to or payment due from the reporting federally qualified health center or rural health center. 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 center. 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 center of the reimbursement due to, or payment due from the reporting federally qualified health center or rural health center, and where payment is due to the reporting federally qualified health center or rural health center, the department shall make full payment to the federally qualified health center or rural health center. 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 center. 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 center 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, whereupon an opportunity for an administrative hearing under chapter 91 shall be afforded. 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 center, 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 center.

(b) An alternative supplemental managed care payment methodology other than the one set forth in this section may be

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

§346-B Federally qualified health center or rural health center; 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 center; 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) A projected adjusted rate is proposed that is approved by the department. The federally qualified health center or rural health center must propose a projected adjusted rate to which the department must agree. The

proposed projected adjusted rate shall be calculated on a consolidated basis, where the federally qualified health center or rural health center takes all costs for the facility which would bring in both the costs included in the base rate as well as the additional costs for the change, as long as the federally qualified health center or rural health center had filed its baseline cost report based on total consolidated costs. From this calculated rate, the department may disallow per cent of the rate increase, to account for cost increases associated with normal inflation increase of costs included in the base rate. Within ninety days of its receipt of the projected adjusted rate, the department shall notify the federally qualified health center or rural health center of its approval or rejection of the projected adjusted rate. Upon approval by the department, the federally qualified health center or rural health center 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 submittal of cost reports.

Cost reports shall be prepared in the same manner and method as those submitted to establish the proposed projected adjusted rate and shall cover the first two full fiscal years that include the change in scope of services. The department's decision on the prospective payment system rate adjustment may be appealed if the medicaid impact is $10,000 or more, whereupon an opportunity shall be afforded for an administrative hearing under chapter 91. 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 center, or agency that is a party to the contested case proceeding to be reviewed;

(4) Upon receipt of the cost reports for the first two full fiscal years 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 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 this section, a change in scope of services provided by a federally qualified health center or rural health center means any of 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 regulatory 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, 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 a rural health center 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;

(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 center 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 center, as the case may be.

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

(1) Services that are:

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

(B) 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;

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

(A) A face-to-face encounter between a federally qualified health center or rural health center patient and a health professional. For purposes of this subparagraph: "health professional" means a physician, physician assistant, advanced practice registered nurse or nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or visiting nurse. "Physician" has a meaning consistent with title 42 Code of Federal Regulations section 405.2401, or its successor, and includes the following:

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

(ii) A podiatrist licensed under chapter 463E;

(iii) An optometrist licensed under chapter 459;

(iv) A chiropractor licensed under chapter 442;

(v) A dentist licensed under chapter 448; or

(vi) A dental hygienist licensed under chapter 447;

(B) Preventive services, mental health services, home health services, family planning services, prenatal and postnatal care services, (but excluding delivery services which shall be reimbursed separately from and in addition to the prospective payment system reimbursement for prenatal and postnatal care services) respiratory care services, home pharmacy services, and early periodic screening, diagnosis, and treatment services, when provided by a licensed or qualified health professional who is an employee of, or a contractor to the federally qualified health center or rural health center pursuant to rules adopted by the department; or

(C) Adult day health care services, when these adult day health care services are provided pursuant to rules adopted by the department and when at least

four or more hours of adult day health care services per day are provided; and

(3) 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:

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

(B) The patient has one or more visits for other services such as dental, behavioral health, or optometry. Medicaid shall pay for a maximum of one visit per day for each of these services in addition to one medical visit."

SECTION 3. (a) Notwithstanding any laws to the contrary, reports for final settlement under section 346-A, Hawaii Revised Statutes, for each calendar year shall be filed within one hundred fifty days from the date the department of human services adopts forms and issues written instructions for requesting a settlement under that section.

(b) All payments owed by the department of human services shall be made within two hundred ten days from the department's initial receipt of the report for final settlement as specified in the section 2 of this Act; provided that the department of human services shall not be required to reimburse services that do not qualify for medicare matching funds or reimbursement.

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

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

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

(1) Primary medical;

(2) Dental;

(3) Behavioral health care; and

(4) Ancillary services, including:

(A) Education;

(B) Follow-up;

(C) Outreach; and

(D) Pharmacy services.

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

SECTION 6. There is appropriated out of the general revenues of the State of Hawaii the sum of $, or so

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

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

SECTION 7. 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 8. New statutory material is underscored.

SECTION 9. This Act shall take effect on July 1, 2020.

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 underinsured. (SD2)