LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME LEINAALA FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

House Committee on Finance

H.B. 2795, HD1, RELATING TO MEDICAID

Testimony of Chiyome Leinaala Fukino, M.D.
Director of Health

February 25, 2008, 1:45 p.m.

Department's Position: The Department of Health defers to the Department of Human Services regarding the provisions of this measure as it is the appropriate agency for the purposes it envisions.

Fiscal Implications: Not applicable.

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

In addition to deferring to the Department of Human Services, the Department of Health recommends the following correction to this measure:

Section 1, Item (1): striking department of health and replacing it with department of human services.

Thank you for this opportunity to testify on this measure.

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 25, 2008

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 2795, H.D.1 - RELATING TO MEDICAID**
Hearing: Monday, February 25, 2008, 1:45 p.m.
Conference Room 308, State Capitol

PURPOSE: The purpose of this bill 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 clinics will receive supplemental Medicaid payments and seek modifications to their scope of services.

DEPARTMENT'S POSITION: The Department of Human Services and the Hawaii Primary Care Association (HPCA) have been meeting to discussed the proposed amendments to the Hawaii Administrative Rules (HAR) and have reached agreement on a draft as captured in H.B. 2795 H.D.1. A State Plan Amendment (SPA) will be submitted to the Federal Centers for Medicare and Medicaid Services (CMS) as soon as projected costs for the additional requested services are received from the FQHCs.

Both DHS and HPCA are in agreement that no supplemental funds are required for DHS to implement the proposed amendments to the HAR.

Also, on page 2, lines 1-3, cites the Department of Health as the reconciling agency. DHS is the appropriate agency for this bill because this is a Medicaid reimbursement issue and this bill proposes to amend chapter 346.

Thank you for the opportunity to comment on this bill.

Hawai'i Primary Care Association
345 Queen Street, Suite 601 Honolulu, HI 96813
Tel (808) 536-8442 Fax (808) 524-0347

To: **The House Committee on Finance**
The Hon. Marcus R. Oshiro, Chair
The Hon. Marilyn B. Lee, Vice Chair

Testimony in Support of House Bill 2795, HD 1
Relating to Public Health
Submitted by Beth Giesting, CEO
February 25, 2008, 1:45 p.m. agenda, Room 308

The Hawai'i Primary Care Association strongly endorses this measure which will address required changes for the Medicaid prospective payment system (PPS) for Federally Qualified Health Centers. Please note that no additional appropriation is needed to implement this bill.

Med-QUEST Rules. Since 2001, the federal government has required that Federally Qualified Health Centers (FQHCs, otherwise known as Community Health Centers) be paid under a "prospective payment system," or PPS. Subsequently, Med-QUEST Division established rules to administer PPS, but they turned out to be so inadequate or vague that they are in fact harmful to Community Health Centers. The Hawai'i Primary Care Association has worked with the Department of Human Services to amend their rules, most intensively since December 2004 when Director Koller told us that she would expedite changes to them. Since that time we have pursued rule revision with three Med-QUEST Division Directors, submitted at least seven drafts of rules with changes that were requested by the Department, and followed up through countless letters, phone calls, and meetings. In 2006, the Department was ordered in the settlement of a suit brought against them by AlohaCare to work with the Hawai'i Primary Care Association to modify the PPS rules. All this has been to no avail. However, due to Legislative consideration of our several PPS bills this session we have been able to meet with the Med-QUEST Administration and now agree on language to correct the rules. The requested amendments to HB 2795 (attached) are extensive and address the following issues:

Payment Timeline. Because most of Hawai'i's Medicaid enrollees are in the QUEST managed care program, the State is obligated to reconcile and pay the difference between what the FQHCs were paid by the managed care plans and what they should have been paid under PPS. According to a 2007 case in federal court in Maryland, a state needs to ensure that FQHCs are paid in full within four months of delivery a service. The State is currently out of compliance with the Maryland decision but our proposed amendments to the bill describe how that will be addressed.

Change in Scope. Hawai'i depends on Community Health Centers to grow, expand, meet regulatory requirements, improve facilities, and acquire and use up-to-date health information technology. All these expansions and improvements will change the cost of delivering care. Under federal law, the rules for PPS need to include a straightforward and fair methodology for calculating rate changes that are necessitated by such changes in the scope of a FQHC's service. However, Hawai'i's current rules establish a procedure for calculating rate changes based on change of scope that is virtually impossible to use. This bill addresses that shortcoming by substituting a workable formula for calculating new PPS rates when FQHCs change the scope of their services.

Payment for Perinatal Care. Some of Hawai'i's FQHCs provide perinatal and delivery services; care that is in scarce supply for Med-QUEST beneficiaries. However, Med-QUEST insists upon reimbursing these services by means of a "global" rate that consolidates reimbursement for out-patient prenatal care and inpatient deliveries into a single lump sum payment. This global rate does not adequately reimburse FQHCs

for the costs of providing the PPS-eligible out-patient portion of prenatal care. Proposed amendments would permit FQHCs to bill for prenatal services and, in so doing, remove economic disincentives for FQHCs to provide much needed prenatal care to expectant mothers who are Med-QUEST beneficiaries.

We would like to emphasize several important points about this proposed legislation:

- First, we are not asking for the State to pay for any services that are not already included in the State Medicaid Plan. This bill only implements changes in the Med-QUEST payment formula that are necessary for the State to comply with the federal requirement that it make timely payments to FQHCs that fully cover the costs of providing services to Medicaid beneficiaries, both now and in the future.
- Second, the State is not currently in compliance with federal law on a PPS reconciliation timeline or with the settlement agreement that was filed in the United States District Court for the District of Hawai'i in 2006 that required the State to work with the Hawai'i Primary Care Association and the FQHC to develop new, workable PPS rules.
- Third, we acknowledge that PPS rules would ordinarily be changed by Administrative action. However, after years of unsuccessful efforts to achieve workable rules to implement the federally-mandated PPS reimbursement methodology through administrative channels, the Hawai'i Primary Care Association and Hawai'i's FQHCs no longer believe that administrative action, by itself, is a reliable means of resolving the growing financial crisis that the lack of usable rules has created for the State's FQHCs. The Community Health Centers are a primary source of care for many people in Hawai'i who are economically disadvantaged and either must rely on the QUEST program to pay for their medical care or are simply uninsured. We have a duty to our patients to take aggressive action when it is needed to maintain our ability to provide that care. Our support for this bill is a response to that duty.

We are very grateful for the opportunity to testify in favor of this measure which is one of the most important and cost-effective actions the Legislature can take to support Hawai'i's health care system.

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.

HOUSE OF REPRESENTATIVES
TWENTY-FOURTH LEGISLATURE,
2008
STATE OF HAWAII

H.B. NO. 2795

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~~ 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 & 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.~~

(a) FQHCs or RHCs that provide services under a contract with a Medicaid managed care organization (MCO) will receive estimated quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC or RHC 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 FQHC or RHC would have received under the BIPA PPS methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of FQHC or RHC submitted claims during the prior calendar quarter, FQHCs or RHCs will receive the difference between the combination of payments the FQHC or RHC 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 FQHC or RHC would have received under the BIPA PPS methodology. Balances due from the FQHC shall be recouped from the next quarter's estimated supplemental payment.

~~(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.~~

(b) The FQHC or RHC must 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 FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHCs' or RHCs' contract with the MCO(s) would have yielded under PPS. The Department shall also receive financial records from the MCO. As part of this review, the Department may request additional documentation from the FQHC or RHC 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 FQHC or RHC. The Department shall notify the participating FQHC or RHC of the balance due to or from the FQHC or RHC. Such notice of program reimbursement shall include the Department's calculation of the balance due to or from the FQHC or RHC.

(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 FQHC or RHC 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;~~

increases or decreases in the scope of services furnished by a participating FQHC or RHC; provided that:

(1) The FQHC or RHC 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 such changes.

(2) The FQHC or RHC 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 FQHC or RHC proposes a projected adjusted rate within one hundred and fifty days of the changes to 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 FQHC or RHC 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 FQHC or RHC had filed its baseline costs report based on total consolidated costs. A net change in the FQHC's or RHC's rate shall be calculated by subtracting the FQHC's or RHC's previously assigned PPS 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 FQHC or RHC of its acceptance or rejection of the projected adjusted rate. Upon approval by the Department, the FQHC or RHC shall be paid the projected rate effective the date the change in scope of services through the date that a rate is calculated based on the first full fiscal years which include change in scope of services as required by section 17-1740.1-13(b)(1). The Department will 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 FQHCs or RHCs 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 is also required. The Department will review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report will be adjusted to the MEI of the second year report. Each report will be weighted based on number of patient encounters.

(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;~~ report(s) required by section 17-1740.1-13(b)(1), the PPS rate will 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 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:~~

(6) For purposes of PPS rate adjustment, a change in scope of services provided by a FQHC or RHC 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;~~ 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 (PPS) rate, or a deletion of a service that is incorporated in the baseline PPS 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~~

(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;

(H) Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services described in section 17-1740.1-15, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the FQHC or RHC.

~~(6) 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~~

(7) No change in costs will, 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 FQHC's or RHC's per visit rate equals or exceeds three (3) percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish their baseline PPS rates, the net change of three (3) percent shall be applied to the average per visit rate of all the sites of the FQHC or RHC for purposes of calculating the costs associated with a scope of

service change. "Net change" means the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year.

(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;~~

~~(A) 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~~

are those services that are furnished by a FQHC or RHC that are:

(A) Within the legal authority of an FQHC to deliver, as defined in Section 1905 of the Social Security Act;

(B) Actually provided by the FQHC, either directly or under arrangements;

(C) Covered benefits under the Medicaid program, as defined in Section 4231 of the State Medicaid Manual and the Hawaii Medicaid State Plan;

(D) Provided to a recipient eligible for Medicaid benefits;

(E) Delivered exclusively by health care professionals (a physician, a physician's assistant, a nurse practitioner, a nurse midwife, a clinical social worker or a clinical psychologist) and other persons acting within the lawful scope of their license or certificate to provide services; and

(F) Provided at the FQHC'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

(G) 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."~~

(3) A FQHC or RHC that provides prenatal services, delivery services and post natal services, may elect to bill Medicaid separately for such services and thereby receive a global payment, or it may bill for such prenatal and post natal services as a FQHC or RHC and be paid the per visit PPS reimbursement for such services, however, payment to the FQHC or RHC for inpatient delivery services shall not be eligible for PPS 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 of the state plan by the Centers for Medicare and Medicaid services.

INTRODUCED BY: _____

Testimony in Support of HB 2795 HD 1: Relating to Medicaid
Submitted to: Committee on Finance
Hearing Date/Time: February 25, 2008/1:45 pm

February 23, 2008
Submitted by: Richard P. Bettini, Chief Executive Officer
Waianae Coast Comprehensive Health Center
Contact: 696-1457

The Waianae Coast Comprehensive Health Center strongly supports HB2795 HD 1 which would establish a timeline for the Department of Human Services to complete the federally mandated requirement to established reasonable rules and a timetable for a Prospective Payment Medicaid System.

The Health Center is pleased that recent discussions between the Department of Human Services and community health centers has resolved the majority of concerns that health centers have been raising over the past years.

Although we remain confident that a final resolution will be accomplished, we ask the Committee on Finance to continue to hold the Department of Human Services accountable to a full resolution and implementation of federal mandates related to prospective payment.

Mahalo.

West Hawaii Community Health Center, Inc.

Ola Ke Ola Waena O Hawai`i Komohana

75-5751 Kuakini Highway, Suite 101A • Kailua-Kona, HI 96740 • phone (808) 326-5629

To: **The House Committee on Finance**
The Hon. Marcus Oshiro, Chair
The Hon. Marilyn Lee, Vice Chair

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

Submitted by Richard Taaffe, Executive Director

As the Executive Director of the West Hawaii Community Health Center, we strongly support this measure. More than a third of the patients who use the West Hawaii Community Health Center are covered by Med-QUEST. However, because most of our other patients are uninsured, 55% of our patient revenue comes from Med-QUEST.

We ask the legislature to pass this bill because it will fix Med-QUEST rules to clarify processes for when and how much West Hawaii Community Health Center and other health centers are paid. As a business we rely on these rules to plan, expand, and carry-out our services.

Thank you for the opportunity to support this measure which is so important to my health center and the people we care for.

WAIKIKI HEALTH CENTER

REACHING OUT FROM THE HEART OF WAIKIKI.

TO: House Committee on Finance,
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

FROM: Sheila Beckham
Executive Director

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. At Waikiki Health Center, PPS payments account for 41% of our total revenue.

This bill will ensure that we get paid in a timely way for our services. It will also ensure that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will:

- Make us better providers for all of our patients
- Help us expand to provide more services to more people

Likewise, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.

Phone: (808) 553-5038
Fax: (808) 553-5194

MOLOKA'I COMMUNITY HEALTH CENTER

Post Office Box 2040
Kaunakakai, Hawaii 96748

To: **House Committee on Finance,**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: L. Jina Lee, Lawler, Executive Director, Molokai Community Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Molokai Community Health Center PPS payments account for 20% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

As you aware, federally qualified health centers have a proven history of providing high quality comprehensive health care to the uninsured and underinsured, while maximizing resources. Community health center such as Molokai Ohana Health Care, Inc. provide an array of services to address the needs of this high risk population. In Molokai, these services include medical, dental, behavioral, social, case management, outreach, and enrollment programs. Molokai Ohana Health Care, Inc. greatly depends on our PPS, which support the higher cost of providing health care in this remote island.

Our PPS reimbursement, not only provides funding to continue these needed services, but enhances the services given to uninsured patients. In Molokai, these funds are used to help support medication, x-ray, and laboratory services for our uninsured patients. These clinical services often lead to decrease uncompensated emergency room visits and early detection of chronic illness, reducing the over all health care cost in Hawaii.

Once again, Molokai Ohana Health Care, Inc. strongly supports the protection the federally qualified health center's PPS program. Without the PPS program, Molokai Ohana Health Care, Inc. will not be fiscally solvent to provide and expand the current level of quality comprehensive health care in the island of Molokai.

Thank you for the opportunity to testify in strong support of this bill.

Phone: (808) 553-5038
Fax: (808) 553-5194

MOLOKA'I COMMUNITY HEALTH CENTER

Post Office Box 2040
Kaunakakai, Hawaii 96748

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: Jane Woolsey RN, Director of Nursing, Molokai Community Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Molokai Community Health Center PPS payments account for 20% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

As you aware, federally qualified health centers have a proven history of providing high quality comprehensive health care to the uninsured and underinsured, while maximizing resources. Community health center such as Molokai Ohana Health Care, Inc. provide an array of services to address the needs of this high risk population. In Molokai, these services include medical, dental, behavioral, social, case management, outreach, and enrollment programs. Molokai Ohana Health Care, Inc. greatly depends on our PPS, which support the higher cost of providing health care in this remote island.

Our PPS reimbursement, not only provides funding to continue these needed services, but enhances the services given to uninsured patients. In Molokai, these funds are used to help support medication, x-ray, and laboratory services for our uninsured patients. These clinical services often lead to decrease uncompensated emergency room visits and early detection of chronic illness, reducing the over all health care cost in Hawaii.

Once again, Molokai Ohana Health Care, Inc. strongly supports the protection the federally qualified health center's PPS program. Without the PPS program, Molokai Ohana Health Care, Inc. will not be fiscally solvent to provide and expand the current level of quality comprehensive health care in the island of Molokai.

Thank you for the opportunity to testify in strong support of this bill.

NISTRATION:
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KALIHI-PALAMA HEALTH CENTER
Hale Ho'ola Hou – House of New Life

Date: February 25, 2008

To: House Committee on Finance,
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: Emmanuel Kintu, Executive Director
Kalihi-Palama Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Kalihi-Palama Health Center PPS payments account for **45%** of our operating revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.

Bay Clinic, Inc.

224 Haili Street, Building B • Hilo, HI 96720 • Tel: (808) 961-4071 • Fax: (808) 961-5167

To: House Committee on Finance,
The Honorable Marcus Oshiro, Chair

From: Paul Strauss, Chief Executive Officer, Bay Clinic, Inc.

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

Bay Clinic strongly supports this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenue source that Community Health Centers have. For Bay Clinic, nearly **50%** of our medical visits are reimbursed at PPS payment rates.

This bill will ensure that our health centers will be paid for services rendered in a timely way and that the payment amounts will allow for the consideration of expansion of services and facilities, updates in technology, and response to regulatory requirements. This in turn will strengthen our statewide network of community health centers in continuing to meet the growing healthcare needs of our respective communities.

Thank you for the opportunity to testify in strong support of this bill.

Date: February 25, 2008

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: David D Derauf MD MPH
Executive Director
Kokua Kalihi Valley

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. PPS payments account for approximately 1/3 of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. Ordinarily, the legislature does not need to get involved in this kind of dispute. But perhaps because of high staff turn-over at DHS, this issue has dragged on simply too long. It is not fair that the health centers be asked to bear the burden of the failure to put in to place clear procedures that follow federal guidelines for so many years! It is time to move on, and the legislature can see that that happens.

Thank you for the opportunity to testify in strong support of this bill.

Hamakua Health Center, Inc.

45-549 Plumeria Street
Honokaa, Hawaii 96727

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

Submitted by Susan B. Hunt, MHA, Executive Director

The Hamakua Health Center, Inc. strongly endorses this measure and appreciates the Legislature's long history of support for community health centers. Now more than ever, our health center is vitally important to the overall capacity of our strained health care system. The population in the North Hilo, Hamakua and North Kohala Districts is aging and more frequently experiencing complicated and expensive chronic conditions. Four primary care private practices in our service area have closed since June 2006 leaving patients no where to turn in many cases but Hamakua Health Center's two clinics. One third of the HHC patient population has substance abuse and behavioral health problems. Hospitals and clinicians are sending uninsured patients to us because of the cost associated with uncompensated care.

Hamakua Health Center relies on a complex array of federal, state, and private funding to support our programs. The single most important source of health center funding is the Med-QUEST program, which includes one third of the revenue for our health center. The Prospective Payment System (PPS) for health centers covers most of the costs of care for Med-QUEST patients; more than half of these funds are supplied by the federal government.

PPS has been around since 2001 and is crucial to the financing of community health centers but critical rules and procedures for its implementation have still not been developed. This bill would 1) define the process and timeline under which CHCs would be paid, essential to dependable cash flow; 2) establish a clear procedure to determine if a change in a CHC's payment rate is needed to reflect additions in services or new costs related to operations; and 3) define which of the many CHC services are subject to PPS rules and which are not.

I am very grateful for the opportunity to testify in favor of this measure. We believe that providing support to FQHCs is one of the most important actions the Legislature can take to support Hawai'i's health care system.

Jim Kastner

41-829 Kakaina Street

Waimanalo HI 96795

Date: February 25, 2008

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: Jim Kastner, Board of Director and Patient of Waimanalo Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Waimanalo Health Center PPS payments account for 35% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government. Thank you for the opportunity to testify in strong support of this bill.

DEBORAH SMITH
41-1160 Waikupanaha Street
Waimanalo, HI 96795

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: Deborah Smith, Board of Director and Patient of Waimanalo Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Waimanalo Health Center PPS payments account for 35% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.

VERONICA TOMOOKA
45-705 Kuakua Place
Kaneohe, HI 96744

To: House Committee on Finance,
The Honorable Marcus Oshiro, Chair

From: Veronica Tomooka, Staff Member and Patient of
Waimanalo Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Waimanalo Health Center PPS payments account for 35% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.

ANDREW JAMILA, JR.
41-640 Poalima Street
Waimanalo, HI 96734

Date: February 25, 2008

To: **House Committee on Finance**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: Andrew Jamila, Jr., Board of Director and Patient of Waimanalo Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I strongly support this bill which will put into statute clarifying rules for the Medicaid Prospective Payment System. Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Waimanalo Health Center PPS payments account for 35% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people, and, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.

Philip H. Kinnicutt
341 Iliaina Street
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808-254-4534
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To: **House Committee on Finance,**
The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair

From: «GreetingLine», Board Member, Waikiki Health Center

Testimony in Support
House Bill 2795, Relating to Medicaid

Monday, 02-25-08 at 1:45 pm in House conference room 308

I am a member of the Board of Directors of the Waikiki Health Center and I strongly support this bill, which will put into statute clarifying rules for the Medicaid Prospective Payment System.

Payment (PPS) for services provided to Med-QUEST patients is the single most important revenues source that Community Health Centers have. For Waikiki Health Center PPS payments account for 41% of our total revenue.

This bill will ensure that we get paid in a timely way for our services and that payment amounts adapt to changes we need to expand, change, keep facilities and technologies up to date, and meet regulatory requirements. While fixing the PPS rules is certainly good for all the federally-qualified health centers in Hawaii, we believe it is also good for the state because adequate and timely payments will make us better providers for all of our patients, help us expand to provide more services to more people.

Importantly, because it is the Medicaid program, more than half the funding will come from the federal government.

Thank you for the opportunity to testify in strong support of this bill.