LINDA LINGLE
GOVERNOR

LATE
Testimony

LILLIAN B. KOLLER
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

January 30, 2008

MEMORANDUM

TO: Honorable Josh Green, M.D., Chair
House Committee on Health

Honorable Maile S.L. Shimabukuro, Chair
House Committee on Human Services and Housing

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 2795 – RELATING TO MEDICAID**

Hearing: Wednesday, January 30, 2008 9:30 a.m.
Conference Room 329, State Capitol

PURPOSE: The purpose of this bill is to establish a timeline by which the Department of Health shall reconcile managed care supplemental payments; provide a clear definition of what conditions constitute a "change of scope" for purposes of increasing or decreasing prospective rates paid to a federally qualified health center (FQHC) or rural health clinic (RHC); specify a process through which these providers may file for a new rate due to "change of scope;" and to identify services that are required to be reimbursed under the prospective payment system.

DEPARTMENT'S POSITION: The Department of Human Services appreciates the intent of the bill and is willing to work with the community health center system in adopting and implementing the processes identified in H.B. 2795.

First, we would like to recommend that DHS is the appropriate agency for this proposed bill because this is a Medicaid reimbursement issue and this bill proposes to amend chapter 346.

The Department agrees that the federally qualified health centers are the best system of community-based primary care for uninsured, underinsured, and Medicaid clients, and would like to improve the existing collaborative partnership. As the objectives of the Department are congruent with those of the community health centers, it would be in the best interest of the Department and its clients to ensure that these centers remain financially viable.

We would like to provide the following comments on Section 2 of this bill.

§346-A Centers for Medicare & Medicaid Services approval.

As indicated in the bill, the Department must first submit a State Plan Amendment and receive approval from the Federal Centers for Medicare & Medicaid Services (CMS) prior to any changes to the Administrative Rules. Without this approval, Federal financial participation will not be received.

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

The Department appreciates the delineation of deadlines for both the Department and FQHCs. This section was unclear as to how many review days the Department had after it had rejected a FQHC financial report submission and the FQHC had 90 days for resubmission. The timeline proposed is as follows:

FQHC submission	150 days
Departmental review	120 days

FQHC resubmission	90 days
Department cannot exceed	210 days from date of receipt.

This would indicate the Department would have 0 days to review the resubmission. This bill also does not establish a timeframe for health plans to submit annual financial reports, a critical element in the Department's performance of a final settlement review. The Department recommends a timeframe of one hundred and fifty days following the end of the calendar year be implemented.

§346-B (5)

Establishes that the Department shall repay the Federal share of any over-payment to a FQHC or RHC within sixty days of the date of the discovery of the overpayment. Repayment of the Federal share of an overpayment typically occurs after overpaid funds are recouped not discovered.

§346-C Federally qualified health center or rural health clinic; adjustment for changes to scope of services.

§346-C (3)

Establishes a method of calculation of the proposed projected adjusted rate due to a change in scope of services. The calculation has the potential to rebase all of a FQHC's or RHC's cost to current cost. The intent of an adjustment to the prospective rate for a change of scope of service is to reimburse only the additional cost of the new services not covered by the existing rate. It is unlikely that CMS will approve a State Plan Amendment that has the potential to rebase the existing prospective rate. Under the Federal Benefits Improvement and Protection Act of 2000 (BIPA), section 702, rebasing the FQHC PPS rate must be initiated by CMS at the direction of Congress.

The prospective rates were established beginning January 1, 2001 and are updated annually for the Medicare Economic Index (MEI). This index has averaged 2.6% per annum since inception.

Thank you for this opportunity to testify.