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

- 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



1 and underinsured residents by creating a process whereby  
2 community health centers and rural health clinics will receive  
3 supplemental medicaid payments and seek modifications to their  
4 scope of services. This Act also provides an appropriation to  
5 adequately pay federally qualified community health centers for  
6 services for the uninsured.

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

10 **"§346-A Centers for Medicare and Medicaid Services**

11 **approval.** The department shall implement sections 346-B, 346-C,  
12 and 346-D, subject to approval of the Hawaii medicaid state plan  
13 by the Centers for Medicare and Medicaid Services.

14 **§346-B Federally qualified health centers and rural health**  
15 **clinics; reconciliation of managed care supplemental payments.**

16 (a) Federally qualified health centers or rural health clinics  
17 that provide services under a contract with a medicaid managed  
18 care organization shall receive estimated quarterly state  
19 supplemental payments for the cost of furnishing such services  
20 that are an estimate of the difference between the payments the  
21 federally qualified health center or rural health clinic  
22 receives from medicaid managed care organizations and payments



1 the federally qualified health center or rural health clinic  
2 would have received under the Benefits Improvement and  
3 Protection Act of 2000 prospective payment system methodology.  
4 Not more than one month following the beginning of each calendar  
5 quarter and based on the receipt of federally qualified health  
6 center or rural health clinic submitted claims during the prior  
7 calendar quarter, federally qualified health centers or rural  
8 health clinics shall receive the difference between the  
9 combination of payments the federally qualified health center or  
10 rural health clinic receives from estimated supplemental  
11 quarterly payments and payments received from medicaid managed  
12 care organizations and payments the federally qualified health  
13 center or rural health clinic would have received under the  
14 Benefits Improvement and Protection Act of 2000 prospective  
15 payment system methodology. Balances due from the federally  
16 qualified health center shall be recouped from the next  
17 quarter's estimated supplemental payment.

18 (b) The federally qualified health center or rural health  
19 clinic shall file an annual settlement report summarizing  
20 patient encounters within one hundred fifty days following the  
21 end of a calendar year in which supplemental payments are  
22 received from the department. The total amount of supplemental



1 and medicaid managed care organization payments received by the  
2 federally qualified health center or rural health clinic shall  
3 be reviewed against the amount that the actual number of visits  
4 provided under the federally qualified health centers' or rural  
5 health clinics' contract with the medicaid managed care  
6 organization would have yielded under the prospective payment  
7 system. The department shall also receive financial records  
8 from the medicaid managed care organization. As part of this  
9 review, the department may request additional documentation from  
10 the federally qualified health center or rural health clinic and  
11 the medicaid managed care organization to resolve differences  
12 between medicaid managed care organization and provider records.  
13 Upon conclusion of the review, the department shall calculate a  
14 final payment that is due to or from the participating federally  
15 qualified health center or rural health clinic. The department  
16 shall notify the participating federally qualified health center  
17 or rural health clinic of the balance due to or from the  
18 federally qualified health center or rural health clinic. The  
19 notice of program reimbursement shall include the department's  
20 calculation of the balance due to or from the federally  
21 qualified health center or rural health clinic.



1        (c) For the purposes of this section, the payments  
2 received from medicaid managed care organizations exclude  
3 managed care risk pool accruals, distributions, or losses, or  
4 any pay-for-performance bonuses or other forms of incentive  
5 payments such as quality improvement recognition grants and  
6 awards.

7        (d) An alternative supplemental managed care payment  
8 methodology other than the one set forth herein may be  
9 implemented as long as the alternative payment methodology is  
10 consented to in writing by the federally qualified health center  
11 or rural health clinic to which the methodology applies.

12        **§346-C Federally qualified health center or rural health**  
13 **clinic; adjustment for changes to scope of services.** (a)

14 Prospective payment system rates may be adjusted for any  
15 increases or decreases in the scope of services furnished by a  
16 participating federally qualified health center or rural health  
17 clinic, provided that:

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



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

6       (3) The federally qualified health center or rural health  
7       clinic proposes a projected adjusted rate within one  
8       hundred and fifty days of the changes to the scope of  
9       services.

10       (b) This proposed projected adjusted rate is subject to  
11       departmental approval. The proposed projected adjusted rate  
12       shall be calculated based upon a consolidated basis where the  
13       federally qualified health center or rural health clinic takes  
14       all costs for the center that would include both the costs  
15       included in the base rate, as well as the additional costs, as  
16       long as the federally qualified health center or rural health  
17       clinic had filed its baseline costs report based on total  
18       consolidated costs. A net change in the federally qualified  
19       health center's or rural health clinic's rate shall be calculated  
20       by subtracting the federally qualified health center's or rural  
21       health clinic's previously assigned prospective payment system  
22       rate from its projected adjusted rate.



1        (c) Within one hundred twenty days of its receipt of the  
2 projected adjusted rate and all additional documentation  
3 requested by the department, the department shall notify the  
4 federally qualified health center or rural health clinic of its  
5 acceptance or rejection of the projected adjusted rate. Upon  
6 approval by the department, the federally qualified health center  
7 or rural health clinic shall be paid the projected rate, which  
8 shall be effective from the date of the change in scope of  
9 services through the date that a rate is calculated based upon  
10 the first full fiscal year that includes the change in scope of  
11 services.

12        (d) The department shall review the calculated rate of the  
13 first full fiscal year cost report if the change of scope of  
14 service is reflected in more than six months of the report. For  
15 those federally qualified health centers or rural health clinics  
16 in which the change of scope of services is in effect for six  
17 months or less of the cost report fiscal year, review of the next  
18 full fiscal year cost report also is required. The department  
19 shall review the calculated inflated weighted average rate of  
20 these two cost reports. The total costs of the first year report  
21 shall be adjusted to the Medical Economic Index of the second



1 year report. Each report shall be weighted based upon number of  
2 patient encounters.

3 (e) Upon receipt of the cost reports, the prospective  
4 payment system rate shall be adjusted following a review by the  
5 fiscal agent of the cost reports and documentation. Adjustments  
6 shall be made for payments for the period from the effective  
7 date of the change in scope of services through the date of the  
8 final adjustment of the prospective payment system rate.

9 (f) For the purposes of prospective payment system rate  
10 adjustment, a change in scope of services provided by a  
11 federally qualified health center or rural health clinic means  
12 the following:

13 (1) The addition of a new service, such as adding dental  
14 services or any other medicaid covered service, that is  
15 not incorporated in the baseline prospective payment  
16 system rate or a deletion of a service that is  
17 incorporated in the baseline prospective payment system  
18 rate;

19 (2) A change in service resulting from amended regulatory  
20 requirements or rules;

21 (3) A change in service resulting from either remodeling  
22 or relocation;





- 1        (4) A change in type, intensity, duration, or amount of  
2        service resulting from a change in applicable  
3        technology and medical practice used;
- 4        (5) An increase in service intensity, duration, or amount  
5        of service resulting from changes in the types of  
6        patients served, including but not limited to  
7        populations with human immunodeficiency virus,  
8        acquired immunodeficiency syndrome, or other chronic  
9        diseases, or homeless, elderly, migrant, or other  
10       special populations;
- 11       (6) A change in service resulting from a change in the  
12       provider mix of a federally qualified health center or  
13       a rural health clinic or one of its sites;
- 14       (7) Any changes in the scope of a project approved by the  
15       federal Health Resources and Services Administration  
16       where the change affects a covered service; or
- 17       (8) Changes in operating costs due to capital expenditures  
18       associated with a modification of the scope of any of  
19       the services, including new or expanded service  
20       facilities, regulatory compliance, or changes in  
21       technology or medical practices at the federally  
22       qualified health center or rural health clinic.



1       (g) No change in costs, in and of itself, shall be  
2 considered a scope of service change unless the cost is allowable  
3 under medicaid principles of reimbursement and the net change in  
4 the federally qualified health center's or rural health clinic's  
5 per visit rate equals or exceeds three per cent for the affected  
6 federally qualified health center or rural health clinic site.  
7 For federally qualified health centers or rural health clinics  
8 that filed consolidated cost reports for multiple sites to  
9 establish their baseline prospective payment system rates, the  
10 net change of three per cent shall be applied to the average per  
11 visit rate of all the sites of the federally qualified health  
12 center or rural health clinic for purposes of calculating the  
13 costs associated with a scope of service change. For the  
14 purposes of this section, "net change" means the per visit change  
15 attributable to the cumulative effect of all increases or  
16 decreases for a particular fiscal year.

17       (h) All references in this section to "fiscal year" shall  
18 be construed to be references to the fiscal year of the  
19 individual federally qualified health center or rural health  
20 clinic, as the case may be.

21       §346-D Federally qualified health center or rural health  
22 clinic visit. (a) Services eligible for prospective payment



1 system reimbursement are those services that are furnished by a  
2 federally qualified health center or rural health clinic that  
3 are:

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

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

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

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

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

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



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

3 (7) Within the scope of services provided by the State  
4 under its fee-for-service medicaid program and its  
5 QUEST program, on and after August 1994, and as  
6 amended from time to time.

7 (b) Contacts with one or more health professionals and  
8 multiple contacts with the same health professional that take  
9 place on the same day and at a single location constitute a  
10 single encounter, except when one of the following conditions  
11 exists:

12 (1) After the first encounter, the patient suffers illness  
13 or injury requiring additional diagnosis or treatment;  
14 or

15 (2) The patient makes one or more visits for other  
16 services such as dental or behavioral health.

17 Medicaid may pay for a maximum of one visit per day  
18 for each of these services in addition to one medical  
19 visit.

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



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

9 SECTION 3. (a) Notwithstanding any law to the contrary,  
10 reports for final payment under section 346-B, Hawaii Revised  
11 Statutes, for each calendar year shall be filed within one  
12 hundred fifty days from the date the department of human  
13 services adopts forms and issues written instructions for  
14 requesting a final payment under that section.

15 (b) All payments owed by the department of human services  
16 shall be made on a timely basis.

17 SECTION 4. A federally qualified health center or rural  
18 health clinic shall submit a prospective payment system rate  
19 adjustment request under section 346-C, Hawaii Revised Statutes,  
20 within one hundred fifty days of the beginning of the calendar  
21 year occurring after the department of human services first  
22 adopts forms and issues written instructions for applying for a



1 prospective payment system rate adjustment under section 346-C,  
2 Hawaii Revised Statutes, if, during the prior fiscal year, the  
3 federally qualified health center or rural health clinic  
4 experienced a decrease in the scope of services; provided that  
5 the federally qualified health center or rural health clinic  
6 either knew or should have known the rate adjustment would  
7 result in a significantly lower per-visit rate. As used in this  
8 paragraph, "significantly lower" means an average rate decrease  
9 in excess of three per cent.

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

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

- 20 (1) Primary medical;  
21 (2) Dental;  
22 (3) Behavioral health care; and



- 1           (4) Ancillary services, including:
- 2                 (A) Education;
- 3                 (B) Follow-up;
- 4                 (C) Outreach; and
- 5                 (D) Pharmacy services.

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

8           SECTION 6. There is appropriated out of the general  
9 revenues of the State of Hawaii the sum of \$                    or so  
10 much thereof as may be necessary for fiscal year 2008-2009 to  
11 the department of health for direct medical care to the  
12 uninsured.

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

15           SECTION 7. In codifying the new sections added by section  
16 2 of this Act, the revisor of statutes shall substitute  
17 appropriate section numbers for the letters used in designating  
18 the new sections in this Act.

19           SECTION 8. New statutory material is underscored.

20           SECTION 9. This Act shall take effect on July 1, 2008;  
21 provided that section 2 of this Act shall take effect upon



- 1 approval of the Hawaii medicaid state plan by the Centers for
- 2 Medicare and Medicaid Services.





**Report Title:**

Public Health; Federally Qualified Health Centers

**Description:**

Ensures continued community-based primary care for the uninsured, underinsured, or medicaid recipients by helping the community health center system to remain financially viable and stable in the face of the increasing needs of these populations.  
(SB2542 SD2)

