
A BILL FOR AN ACT

RELATING TO PUBLIC HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that federally qualified
2 health centers are the best system of community-based primary
3 care for people who are uninsured, underinsured, or medicaid
4 recipients. However, over the years, the federally qualified
5 health centers and rural health clinics have experienced a
6 tremendous increase in usage. Adding to the strain placed on
7 these facilities are:

- 8 (1) The ever evolving nature and complexity of the
9 services provided;
- 10 (2) Inadequate procedures through which medicaid payment
11 and changes in the scope of services provided are
12 addressed; and
- 13 (3) The lack of adequate funding to pay for services for
14 the uninsured.

15 The purpose of this Act is to ensure that the community
16 health center system remains financially viable and stable in
17 the face of the increasing needs of the population of uninsured
18 and under-insured residents by creating a process whereby



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

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

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

13 (1) Reports for final settlement under this subsection
14 shall be filed within one hundred fifty days following
15 the end of a calendar year in which supplemental
16 managed care entity payments are received from the
17 department;

18 (2) All records that are necessary and appropriate to
19 document the settlement claims in reports under this
20 section shall be maintained and made available upon
21 request to the department;



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



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



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

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

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

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

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



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

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

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

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

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

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



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



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

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

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

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



1 center or rural health center means any of the

2 following:

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

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

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

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

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

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



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



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

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

6 (1) Services that are:

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

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

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

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



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

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

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

13 (iii) An optometrist licensed under chapter 459;

14 (iv) A chiropractor licensed under chapter 442;

15 or

16 (v) A dentist licensed under chapter 448;

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



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

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

14 and

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

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



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

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

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



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

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

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

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

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



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

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

5 SECTION 7. In codifying the new sections added by section
6 1 of this Act, the revisor of statutes shall substitute
7 appropriate section numbers for the letters used in designating
8 the new sections in this Act.

9 SECTION 8. New statutory material is underscored.

10 SECTION 9. This Act shall take effect on July 1, 2007.

11

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Report Title:

Public Health; Federally Qualified Health Centers

Description:

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

