
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 centers have
6 experienced a tremendous increase in usage. Adding to the
7 strain placed on 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 underinsured residents by creating a process whereby



1 community health centers and rural health centers 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 managed care supplemental
11 payments. (a) Reconciliation of managed care supplemental
12 payments to a federally qualified health center or a rural
13 health center may be made by:

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

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



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



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



1 final settlement's receipt date, or within one year of
2 the resubmission date of a corrected report for final
3 settlement, whichever is later;

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

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

19 (5) Allowing the department to develop a repayment plan to
20 reconcile overpayment to a federally qualified health
21 center or rural health center. The department shall
22 repay the federal share of any overpayment within



1 sixty days of the date of the discovery of the
2 overpayment.

3 (b) An alternative supplemental managed care payment
4 methodology that will make any federally qualified health center
5 or rural health center whole as required under the Benefits
6 Improvement and Protection Act, other than the one set forth in
7 this section, may be implemented as long as the alternative
8 payment methodology is consented to in writing by the federally
9 qualified health center or rural health center to which the
10 methodology applies.

11 **§346-B Federally qualified health center or rural health**
12 **center; adjustment for changes to scope of services.**

13 Prospective payment system rates may be adjusted for any
14 adjustment in the scope of services furnished by a participating
15 federally qualified health center or rural health center;
16 provided that:

17 (1) The department is notified in writing of any changes
18 to the scope of services and the reasons for those
19 changes within sixty days of the effective date of
20 such changes;

21 (2) Data, documentation, and schedules are submitted to
22 the department that substantiate any changes in the



1 scope of services and the related adjustment of
2 reasonable costs following medicare principles of
3 reimbursement;

4 (3) A projected adjusted rate is proposed that is approved
5 by the department. The federally qualified health
6 center or rural health center shall propose a
7 projected adjusted rate to which the department may
8 agree. The proposed projected adjusted rate may be
9 calculated on a consolidated basis, where the
10 federally qualified health center or rural health
11 center takes all costs for the facility that would
12 include both the costs included in the base rate, as
13 well as the additional costs for the change, as long
14 as the federally qualified health center or rural
15 health center had filed its baseline cost report based
16 on total consolidated costs. A net change in the
17 federally qualified health center's or rural health
18 center's rate shall be calculated by subtracting the
19 federally qualified health center's or rural health
20 center's previously assigned prospective payment
21 system rate from its projected adjusted rate. The
22 department may disallow _____ per cent of the net



1 change to account for a combination that includes both
2 cost increases and decreases during the reporting
3 period. Within ninety days of its receipt of the
4 projected adjusted rate, the department shall notify
5 the federally qualified health center or rural health
6 center of its approval or rejection of the projected
7 adjusted rate. Upon approval by the department, the
8 federally qualified health center or rural health
9 center shall be paid the projected rate for the period
10 from the effective date of the change in scope of
11 services through the date that a rate is calculated
12 based on the submittal of cost reports. Cost reports
13 shall be prepared in the same manner and method as
14 those submitted to establish the proposed projected
15 adjusted rate and shall cover the first two full
16 fiscal years that include the change in scope of
17 services. The department's decision on the
18 prospective payment system rate adjustment may be
19 appealed if the medicaid impact is \$10,000 or more,
20 whereupon an opportunity shall be afforded for an
21 administrative hearing under chapter 91. Any person
22 aggrieved by the final decision and order shall be



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

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

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

18 (6) For the purposes of this section, a change in scope of
19 services provided by a federally qualified health
20 center or rural health center means any of the
21 following:



- 1 (A) The addition of a new service that is not
2 incorporated in the baseline prospective payment
3 system rate, or a deletion of a service that is
4 incorporated in the baseline prospective payment
5 system rate;
- 6 (B) A change in service resulting from amended
7 regulatory requirements or rules;
- 8 (C) A change in service resulting from either
9 remodeling or relocation;
- 10 (D) A change in types, intensity, duration, or amount
11 of service resulting from a change in applicable
12 technology and medical practice used;
- 13 (E) An increase in service intensity, duration, or
14 amount of service resulting from changes in the
15 types of patients served, including but not
16 limited to populations with HIV, AIDS, or other
17 chronic diseases, or homeless, elderly, migrant,
18 or other special populations;
- 19 (F) A change in service resulting from a change in
20 the provider mix of a federally qualified health
21 center or a rural health center or one of its
22 sites;



1 (G) Changes in operating costs due to capital
2 expenditures associated with any modification of
3 the scope of service described in this paragraph
4 that result in a change in the amount, duration,
5 or scope of services;

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.** (a) Services eligible for prospective payment
5 system 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, and as amended from time to time;

17 and

18 (2) A "visit", which for the purposes of this section,
19 shall mean any encounter between a federally qualified
20 health center or rural health center patient and a
21 health professional as identified in the state plan as
22 amended from time to time.



1 (b) Contacts with one or more health professionals and
2 multiple contacts with the same health professional that take
3 place on the same day and at a single location constitute a
4 single encounter, except when one of the following conditions
5 exists:

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

8 or

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

11 Medicaid may pay for a maximum of one visit per day
12 for each of these services in addition to one medical
13 visit.

14 (c) If a patient sees two health professionals on the same
15 day that result in additional diagnosis or treatment, this
16 situation constitutes two visits that may be billed on two
17 separate claims with remarks on both claims explaining the
18 reason for both visits."

19 SECTION 3. (a) Notwithstanding any laws to the contrary,
20 reports for final settlement under section 346-A, Hawaii Revised
21 Statutes, for each calendar year shall be filed within one
22 hundred fifty days from the date the department of human



1 services adopts forms and issues written instructions for
2 requesting a settlement under that section.

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

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

20 Notwithstanding any law to the contrary, the first two full
21 fiscal years' cost reports shall be deemed to have been
22 submitted in a timely manner if filed within one hundred fifty



1 days after the department of human services adopts forms and
2 issues written instructions for applying for a prospective
3 payment system rate adjustment for changes to scope of service
4 under section 346-B, Hawaii Revised Statutes.

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

8 (1) Primary medical;

9 (2) Dental;

10 (3) Behavioral health care; and

11 (4) Ancillary services, including:

12 (A) Education;

13 (B) Follow-up;

14 (C) Outreach; and

15 (D) Pharmacy services.

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

18 SECTION 6. There is appropriated out of the general
19 revenues of the State of Hawaii the sum of \$ or so much
20 thereof as may be necessary for fiscal year 2007-2008 for the
21 implementation of the prospective payment system.



1 The sum appropriated shall be expended by the department of
2 human services for the purposes of this Act.

3 SECTION 7. There is appropriated out of the general
4 revenues of the State of Hawaii the sum of \$, or so
5 much thereof as may be necessary for fiscal year 2007-2008, to
6 the department of health for direct medical care to the
7 uninsured.

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

10 SECTION 8. In codifying the new sections added by section
11 2 of this Act, the revisor of statutes shall substitute
12 appropriate section numbers for the letters used in designating
13 the new sections in this Act.

14 SECTION 9. New statutory material is underscored.

15 SECTION 10. This Act shall take effect on July 1, 2025;
16 provided that section 2 of this Act shall take effect upon
17 approval of the state plan by the Centers for Medicare and
18 Medicaid Services.



REPORT Title:

Public Health; Federally Qualified Health Centers

Description:

Ensures continued community-based primary care for people who are 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 this population. (SB973 HD2)

