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LATE

January 30, 2008

MEMORANDUM

TO: Honorable David Y. Ige, Chair
Senate Committee on Health

Honorable Suzanne Chun Oakland, Chair
Senate Committee on Human Services and Public Housing

FROM: Lillian B. Koller, Director

SUBJECT: S.B. 2542 – RELATING TO PUBLIC HEALTH

Hearing: Wednesday, January 30, 2008 1:15 p.m.
Conference Room 016, State Capitol

PURPOSE: To ensure 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.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) 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 S.B. 2542.

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.

Sections 2 to 4 of this bill propose to establish a timeline by which DHS 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.

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

Section 2 establishes three new sections on FQHC and RHC reimbursements.

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

§346-A (a) 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-A (5) The bill establishes that the Department shall repay the Federal share of any overpayment 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-B Federally qualified health center or rural health clinic; adjustment for changes to scope of services.

§346-B (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.

This bill does not indicate the timeframe that the FQHC or RHC must meet to submit a proposal for a projected adjusted rate. A typical timeframe would be one hundred and fifty days from the effective date of the change in scope of service. This bill also

does not indicate the timeline that the FQHC or RHC must meet to resubmit a rejected proposal for a projected adjusted rate and does not indicate whether the timeline is to be reset to ninety days following the rejection and subsequent resubmission of a proposed projected adjusted rate.

§346-B (6) This bill provides a number of examples that indicate a change of scope of services. Federal CMS approval in a State Plan Amendment for provisions that define a change in scope of service as remodeling or relocation, changes in applicable technology and medical practice, changes in operating costs due to capital expenditures, or indirect medical education adjustments and any direct graduate medical education payment will be difficult.

§346-B (7) This section contradicts the timeline of submission of a proposal for a projected adjusted rate. §346-B (1) establishes the timeline for notification to the Department within sixty days of the effective date of the change in scope of service. §346-B (7) establishes the timeline for requesting a rate adjustment to be once per calendar year. This annual timeline, if used to submit rate adjustments for a previously submitted change of scope of service, would result in an annual rebasing of the previously established adjusted rate. CMS approval for a State Plan Amendment that establishes annual rebasing will be difficult.

§346-C Federally qualified health center or rural health center visit.

This section identifies services that are required to be reimbursed under the prospective payment system and does not appear to overtly extend the definition of services and visits beyond that already established in the State Plan and the Medicaid Provider Manual.

Section 4 establishes a contradictory timeframe to submit a prospective payment system adjustment request for a decrease in change of scope of service. This section changes the timeframe to one hundred fifty days after the beginning of the calendar year following the effective date of the change in scope of service. §346-B (1) establishes a timeframe of sixty days to notify the Department of a change of scope and to submit a projected adjusted rate thereafter, whether it is an increase or a decrease in scope.

Sections 6 and 7 provide appropriations for the Department of Human Services and the Department of Health, for the implementation of the prospective payment system and for direct medical care to the uninsured, respectively. In as much as these sections will require additional State appropriations, DHS respectfully requests that such funding not adversely impact nor replace the priorities in the Executive Supplemental Budget.

Section 10. The Department must first submit a State Plan Amendment and receive approval from the Centers for Medicare & Medicaid Services (CMS) prior to any changes to Administrative Rules. Without this approval, Federal financial participation will not be received.

The DHS defers to the Department of Health regarding sections 5 to 7 of this bill.

Thank you for the opportunity to comment on this bill.