ACT 8

S.B. NO. 2542

A Bill for an Act Relating to Public Health.

Be It Enacted by the Legislature of the State of Hawaii:

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

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

The purpose of this Act is to ensure that the community health center system remains financially viable and stable in the face of the increasing needs of the population of uninsured and underinsured residents by creating a process whereby community health centers and rural health clinics will receive supplemental medicaid payments and seek modifications to their scope of services.

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

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

§346-B Federally qualified health centers and rural health clinics; reconciliation of managed care supplemental payments. (a) Federally qualified health centers or rural health clinics that provide services under a contract with a medicaid managed care organization shall receive estimated quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the federally qualified health center or rural health clinic receives from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of federally qualified health center or rural health clinic submitted claims during the prior calendar quarter, federally qualified health centers or rural health clinics shall receive the difference between the combination of payments the federally qualified health center or rural health clinic receives from estimated supplemental quarterly payments and payments received from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Balances due from the federally qualified health center shall be recouped from the next quarter's estimated supplemental payment.

(b) The federally qualified health center or rural health clinic shall file an annual settlement report summarizing patient encounters within one hundred fifty days following the end of a calendar year in which supplemental payments are received from the department. The total amount of supplemental and medicaid managed care organization payments received by the federally qualified health center or rural health clinic shall be reviewed against the amount that the actual number of visits provided under the federally qualified health centers' or rural health clinics' contract with the

medicaid managed care organization would have yielded under the prospective payment system. The department shall also receive financial records from the medicaid managed care organization. As part of this review, the department may request additional documentation from the federally qualified health center or rural health clinic and the medicaid managed care organization to resolve differences between medicaid managed care organization and provider records. Upon conclusion of the review, the department shall calculate a final payment that is due to or from the participating federally qualified health center or rural health clinic. The department shall notify the participating federally qualified health center or rural health clinic of the balance due to or from the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's calculation of the balance due to or from the federally qualified health center or rural health clinic.

(c) For the purposes of this section, the payments received from medicaid managed care organizations exclude payments for non-prospective payment system services, managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards.

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

§346-C Federally qualified health center or rural health clinic; adjustment for changes to scope of services. (a) Prospective payment system rates may be adjusted for any increases or decreases in the scope of services furnished by a participating federally qualified health center or rural health clinic, provided that:

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

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

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

(b) This proposed projected adjusted rate is subject to departmental approval. The proposed projected adjusted rate shall be calculated based on a consolidated basis where the federally qualified health center or rural health clinic takes all costs for the center that would include both the costs included in the base rate, as well as the additional costs, provided that the federally qualified health center or rural health clinic calculated the baseline prospective payment system rate based on total consolidated costs. A net change in the federally qualified health center's or rural health clinic's rate shall be calculated by subtracting the federally qualified health center's or rural health clinic's previously assigned prospective payment system rate from its projected adjusted rate.

(c) Within one hundred twenty days of its receipt of the projected adjusted rate and all additional documentation requested by the department, the department shall notify the federally qualified health center or rural health clinic of its acceptance or rejection of the projected adjusted rate. Upon approval by the department, the federally qualified health center or rural health clinic shall be paid the projected rate, which shall be effective from the date of the change in scope of services through

the date that a rate is calculated based upon the first full fiscal year that includes the change in scope of services.

(d) The department shall review the calculated rate of the first full fiscal year cost report if the change of scope of service is reflected in more than six months of the report. For those federally qualified health centers or rural health clinics in which the change of scope of services is in effect for six months or less of the cost report fiscal year, review of the next full fiscal year cost report also is required. The department shall review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report shall be adjusted to the Medical Economic Index of the second year report. Each report shall be weighted based upon number of patient encounters.

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

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

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

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

(3) A change in service resulting from relocation;

(4) A change in type, intensity, duration, or amount of service resulting from a change in applicable technology and medical practice used;

(5) An increase in service intensity, duration, or amount of service resulting from changes in the types of patients served, including but not limited to populations with human immunodeficiency virus, acquired immunodeficiency syndrome, or other chronic diseases, or homeless, elderly, migrant, or other special populations;

(6) A change in service resulting from a change in the provider mix of a federally qualified health center or a rural health clinic or one of its sites;

(7) Any changes in the scope of a project approved by the federal Health Resources and Services Administration where the change affects a covered service; or

(8) Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the federally qualified health center or rural health clinic.

(g) No change in costs, in and of itself, shall be considered a scope of service change unless the cost is allowable under medicaid principles of reimbursement and the net change in the federally qualified health center's or rural health clinic's per visit rate equals or exceeds three per cent for the affected federally qualified health center or rural health clinic site. For federally qualified health centers or rural health clinics that filed consolidated cost reports for multiple sites to establish their baseline prospective payment system rates, the net change of three per cent shall be applied to the average per visit rate of all the sites of the federally qualified health center or rural health clinic for purposes of calculating the costs associated with a scope of service change. For the purposes of this section, "net change" means the per visit change at-

tributable to the cumulative effect of all increases or decreases for a particular fiscal year.

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

§346-D Federally qualified health center or rural health clinic visit. (a) Services eligible for prospective payment system reimbursement are those services that are furnished by a federally qualified health center or rural health clinic that are:

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

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

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

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

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

(6) Provided at the federally qualified health center's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of residence, including long term care facilities, or at another medical facility; and

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

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

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

(2) The patient makes one or more visits for other services such as dental or behavioral health. Medicaid may pay for a maximum of one visit per day for each of these services in addition to one medical visit.

(c) A federally qualified health center or rural health clinic that provides prenatal services, delivery services, and post natal services may elect to bill the managed care organization for all such services on a global payment basis. Alternatively, it may bill for prenatal and post natal services separately from delivery services and be paid the per visit prospective payment system reimbursement for prenatal and post natal visits. In this case, it may bill the managed care organization separately for inpatient delivery services that are not eligible for prospective payment system reimbursement.

§346-E Appeal. A federally qualified health center or rural health clinic may appeal a decision made by the department if the medicaid impact is $10,000 or more, whereupon the opportunity for an administrative hearing under chapter 91 shall be afforded. Any federally qualified health center or rural health clinic aggrieved by the final decision and order shall be entitled to judicial review in accordance with chapter 92 or may submit the matter to binding arbitration pursuant to chapter 658A."

SECTION 3. (a) Notwithstanding any law to the contrary, reports for final payment under section 346-B, Hawaii Revised Statutes, for each calendar year shall

be filed within one hundred fifty days from the date the department of human services adopts forms and issues written instructions for requesting a final payment under that section.

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

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

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

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

(1) Primary medical;
(2) Dental;
(3) Behavioral health care; and
(4) Ancillary services, including:
    (A) Education;
    (B) Follow-up;
    (C) Outreach; and
    (D) Pharmacy services.

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

SECTION 6. There is appropriated out of the general revenues of the State of Hawaii the sum of $1,000,000, or so much thereof as may be necessary for fiscal year 2008-2009, to the department of health for direct medical care to the uninsured.

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

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

SECTION 8. New statutory material is underscored.[1]

SECTION 9. This Act shall take effect on July 1, 2008; provided that section 2 of this Act shall take effect upon approval of the Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services.

(Vetoed by Governor and veto overridden by Legislature on July 8, 2008.)

Note

1. Edited pursuant to HRS §23G-16.5.