

[Haw. Rev. Stat. § 346-53.63.]

§ 346-53.63. Federally qualified health center or rural health clinic; adjustment for changes to scope of services: Specific Provisions Covering Public Assistance and Child Welfare 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 attributable 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.

Note

Section effective upon approval of the Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services. L Sp 2008, c 8, §9.

L Sp 2008, c 8, §4 provides:

"SECTION 4. A federally qualified health center or rural health clinic shall submit a prospective payment system rate adjustment request under section [346-53.63], 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 [346-53.63], 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 [346-53.63], Hawaii Revised Statutes."