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DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1740.1

REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

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§17-1740.1-1 Purpose and general principles. The purpose of this chapter is to establish the Medicaid prospective payment system (PPS) for federally qualified health centers (FQHCs) and rural health clinics (RHCs) as described under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. The FQHCs and RHCs prospective payment methodology shall apply to services provided by FQHCs and RHCs as described by sections 1905(a)(2)(C) and 1905(a)(2)(B) of the Social Security Act, respectively, on or after January 1, 2001. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-2 Definitions. As used in this chapter:

"Base year" means the first PPS year starting January 1, 2001 and ending December 31, 2001 or any subsequent year that rates are recalculated if a rebasing is determined to be necessary.

"Baseline PPS rate" means the rate calculated for the initial or first year under PPS.

"Cost reports" means the forms DHS 401 of a certified FQHC or RHC with all documentation and requirements which were necessary for acceptability.

"Federally qualified health center (FQHC)" means an entity that, based upon recommendation of the Health Resources and Services Administration within the Public Health Service, has been determined by the Secretary of the U. S. Department of Health and Human Services to

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meet the qualifications for a federally qualified health center, as defined in section 1861(aa)(4) of the Social Security Act.

"Fiscal agent" means an entity or organization contracted by the State of Hawaii who is responsible for the ongoing financial monitoring, and day to day maintenance and management of FQHC and RHC reimbursement systems.

"Medicare principles of reimbursement" means that body of accounting, cost finding, cost allocation, and cost limit principles that has developed over time in the administration of the Medicare program under Title XVIII of the Social Security Act. It includes, without limitation, the principles identified in the following authorities:

- (1) The Social Security Act, 42 U.S.C. §§1395 et seq.;
- (2) The regulations promulgated pursuant to that Act, including 42 C.F.R. Part 413;
- (3) Manuals published by the Health Care Financing Administration, including HCFA Pub. No. 15; and
- (4) Intermediary letters and bulletins disseminated by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS).

"PPS" means prospective payment system.

"Provider agreement" means the contract between the department and the FQHC or RHC for the delivery of covered items and services to eligible recipients.

"Rate reconsideration" means the formal process of submitting documentation and requesting a review of the PPS rates because of extraordinary circumstances beyond the control of the provider.

"Rebasing" means a determination by Congress that it is necessary to select another base year to recalculate the PPS rates or make necessary refinements to the PPS rates.

"Rural health clinic (RHC)" means an entity that meets the qualifications for a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act.

"Visit" means a face-to-face encounter between an eligible recipient who is a patient of the FQHC or RHC and either:

- (1) A health care professional; or
- (2) Another person who delivers health care services incident to the health care professional's practice; and

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- (3) The visit results in the eligible recipient receiving a covered item or service.

Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. [Eff 11/20/03; am 02/07/05] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-3 Calculations of the baseline PPS rates for FQHCs and RHCs who, as of May 31, 2001, have filed two annual cost reports for their respective fiscal years ending 1999 and 2000. For each FQHC and RHC, the baseline rate will be calculated using the cost reports for their respective fiscal years ending in 1999 and 2000. The baseline rate will be calculated as follows:

- (1) The total visits and costs shall be obtained from the "as filed" cost reports, submitted to the State for the respective FQHC or RHC fiscal years ending in 1999 and 2000. For those providers having more than one cost report ending in either of these years, a weighted average to the current year-end will be used to make both years consistent. Vision visits and costs will be included with the medical cost per visit baseline PPS rates.
- (2) Each year's total costs will be divided by the total visits. The total costs should include the costs of all Medicaid covered services provided by the FQHC or RHC. This includes all ambulatory services which were previously paid under a fee-for-service basis.
- (3) A two-year average of the calculated cost per visit rates for years 1999 and 2000 will be used for each facility. The average cost per visit rate will be calculated separately for each year, then added together and divided by two. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-4 Calculation of the baseline PPS rates for FQHCs and RHCs who, as of May 31, 2001, could

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have filed two annual cost reports for their respective fiscal years ending 1999 and 2000, but only filed one such annual cost report. For each FQHC and RHC, the baseline rate will be calculated using the cost report submitted. The baseline rate will be calculated as follows:

- (1) The total visits and costs shall be obtained from the "as filed" cost report. Vision visits and costs will be included with the medical cost per visit baseline PPS rates. A separate PPS rate will be computed for dental visits.
- (2) Each year's total costs will be divided by the total visits. The total costs should include the costs of all Medicaid covered services provided by the FQHC or RHC. This includes all ambulatory services which were previously paid under a fee-for service basis.
- (3) If the FQHC or RHC believes it provides more in scope of services or caseload, or both, than reflected in the base rate, it may seek an adjustment by submitting data and documentation that substantiates the difference in services or costs.
[Eff 11/20/03] (Auth: HRS §346-14, 42
C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-5 Calculations of the baseline PPS rates for FQHCs and RHCs who did not file cost reports as of May 31, 2001. (a) FQHCs and RHCs who did not file cost reports are:

- (1) Those who, prior to January 1, 2001, were certified as FQHCs or RHCs; or
 - (2) Those who are certified as FQHCs or RHCs on or after January 1, 2001.
- (b) Baseline rates will be calculated and assigned, as follows:
- (1) For a FQHC, one hundred per cent of the costs of furnishing such services based on a cost per visit rate established under this section for the FQHC in the state that is most similar in scope of service and caseload.

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- (2) For a RHC, one hundred per cent of the costs of furnishing such services based on a cost per visit rate established under this section for the RHC in the state that is most similar in scope of service and caseload.

(c) If the FQHC or RHC believes it provides more in scope of services or caseload, or both, than reflected in the base rate, it may seek an adjustment by submitting data and documentation that substantiates the difference in services or costs.

[Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10)
(Imp: Pub. L. No. 106-554)

§17-1740.1-6 Calculation of the baseline PPS rates for FQHCs and RHCs who submitted cost reports as of May 31, 2001 for their respective fiscal years ending in 1999 and 2000 but were not certified as FQHCs or RHCs as of December 31, 2000 for a length of time sufficient to produce two annual cost reports based on their respective fiscal years. (a) Baseline PPS rates for these FQHCs and RHCs will be the higher of the applicable assigned rate, as described in section 17-1740.1-4(b), or a cost per visit rate calculated using the most recent "as filed" cost report.

(b) If the FQHC or RHC believes it provides more in scope of services or caseload, or both, than reflected in the base rate, it may seek an adjustment by submitting data and documentation that substantiates the difference in services or costs.

[Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10)
(Imp: Pub. L. No. 106-554)

§17-1740.1-7 PPS rate year. The FQHC and RHC rates will be effective for services rendered from January 1 through December 31 of each year.

[Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10)
(Imp: Pub. L. No. 106-554)

§17-1740.1-8 PPS rates after baseline. The annual PPS rates starting January 1, 2002, will be the prior year's rate adjusted for the Medicare Economic Index (MEI, as defined in section 1842(i)(3) of the Social Security Act applicable to primary care services as defined in section 1842(i)(4) of the Social Security Act for that fiscal year). [Eff 11/20/03] (Auth: HRS

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§346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-9 Fee-for-service interim payments. Until the baseline PPS rates are calculated and implemented, interim payment to FQHCs and RHC will continue at rates established as of December 31, 2000. When the PPS rates are implemented, adjustments for the period from January 1, 2001 through the date of PPS implementation will be made. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-10 Supplemental managed care payments under PPS methodology. FQHCs or RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCE(s) (excluding managed care risk pool accruals, distributions or losses) and payments the FQHC or RHC would have received under the BIPA PPS methodology. At the end of each calendar year, the total amount of supplemental and MCE payments received, excluding managed care risk pool accruals or distributions, by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHCs or RHCs contract with the MCE(s) would have yielded under PPS. The FQHC or RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and total amount of supplemental and MCE payments received by the FQHC or RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC or RHC will refund the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC, if the PPS amount is less than the total amount of supplement and MCE payments. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-11 Adjustment for changes to scope of services. The PPS payment rates may be adjusted for any increases or decreases in the scope of services furnished by the FQHC or RHC.

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- (1) Providers must notify 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 such changes.
- (2) Providers must submit data, documentation, and schedules that substantiate any changes in services and the related increases or decreases of reasonable costs following Medicare principles of reimbursement.
- (3) Providers must propose a projected adjusted rate to which the department must agree. Upon agreement by the department, the provider will be paid the projected rate effective the date of change in scope of services through the date that a rate is calculated based on the submittal of cost reports for the first two full fiscal years which include change in scope of services as required by section 17-1740.1-13(b)(1).
- (4) Upon receipt of the costs reports required by section 17-1740.1-13(b)(1), the PPS rate will be adjusted following a review by the fiscal agent of the cost reports and documentation.
 1. (5) Adjustments will 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 PPS rate.
[Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

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§17-1740.1-12 Rate reconsideration. (a)
Providers shall have the right to request a rate reconsideration if extraordinary circumstances beyond the control of the provider occur after December 31, 2001 and PPS payments are insufficient due to these extraordinary circumstances. Extraordinary circumstances include, but are not limited to acts of God, changes in life and safety code requirements, and changes in licensure law, and rules or regulations. Mere inflation of cost, absent extraordinary circumstances, shall not be grounds for rate reconsideration. If a provider's PPS rate is sufficient to cover its overall costs including those associated with the extraordinary circumstances, then a rate reconsideration is not warranted.

(b) The department will accept a request for rate reconsideration for a prospective payment year at any

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time during that prospective payment year or within thirty days following the end of that prospective payment year.

(c) Requests for rate reconsiderations shall be submitted in writing to the department and shall set forth the reasons for the requests. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which reconsideration is requested meet the requirements noted above.

Documentation shall include the following:

- (1) A presentation of data to demonstrate reasons for the provider's request for a rate reconsideration.
- (2) The rate reconsideration request must be accompanied by documentation showing the cost implications. The cost impact must be material and significant (\$200,000 or one per cent of a facility's total costs, whichever is less). Documentation must be sufficient to compute an adjustment amount to the PPS rate for the purpose of determining a managed care supplemental payment amount if necessary.

(d) Each rate reconsideration request will be applicable only for the remainder of the PPS rate year. If the reconsideration request is granted, it will be effective no earlier than the first date of the PPS rate year during which the reconsideration request is received. If a provider believes that its experience justifies continuation of the reconsidered rate in subsequent years, then it shall submit information to update the documentation provided in the prior request. A request must be submitted for each affected year.

(e) Amounts granted for rate reconsideration requests will be paid as lump-sum amounts for those years and not as revised PPS rates.

(f) The provider shall be notified of the department's decision in writing within ninety calendar days from the date all necessary verification and documentation have been provided.

(g) A provider may appeal the department's decision on the rate reconsideration if the Medicaid impact is \$10,000 or more. The appeal shall be filed in accordance with the procedural requirements of chapter 17-1736. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

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§17-1740.1-13 Cost reporting, record keeping, and audit requirements. (a) All participating facilities shall maintain an accounting system that identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation to support all data.

(b) Annual cost reports will not generally be required, with the following exceptions:

- (1) For participating FQHCs and RHCs that request changes to their scope of services under section 17-1740.1-11, cost reports for the first two full fiscal years reflecting the change in scope of services and significant related data as identified in paragraph (3) must be submitted.
- (2) For participating FQHCs and RHCs that request rate reconsiderations under section 17-1740.1-12, cost reports for the provider's fiscal years covering the period for which the rate reconsideration was authorized and significant related data as identified in paragraph (3) must be submitted.
- (3) As related to provisions of paragraphs (1) and (2), the following shall be submitted no later than five months after the close of each facility's applicable fiscal year and shall be subject to all provisions in this section. Uniform cost report;
 - (A) Working trial balance;
 - (B) Provider cost report questionnaire;
 - (C) Audited financial statements, if available;
 - (D) Disclosure of appeal items included in the cost report;
 - (E) Disclosure of increases or decreases in scope of services; and
 - (F) Other schedules as identified by the department.

(c) Each provider who submits an annual cost report shall keep financial and statistical records of the cost reporting year for at least six years after submitting the cost report to the department and shall also make such records available upon request to authorized state or federal representatives.

(d) The department or its fiscal agent may conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating providers.

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(e) The providers must submit other information (statistics, cost and financial data) as deemed necessary by the department. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-14 Rebasing. There are no provisions for rebasing after the initial computation of the baseline PPS rates, unless authorized by Congress. [Eff 11/20/03] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§§17-1740.1-15 to 17-1740.1-17 (Reserved)

§17-1740.1-18 Billing. (a) Each FQHC or RHC shall complete and submit to the department's fiscal agent the appropriate claim form for any covered item or service, regardless of whether a claims-based interim payment will result.

(b) The claims shall either be on forms provided by the department or in a format that the department has indicated in advance is acceptable. [Eff 02/07/05] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

§17-1740.1-19 Provider agreement. Each FQHC or RHC shall execute a provider agreement with the department. [Eff 02/07/05] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)