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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 08-007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

JUN 2 5 2010

Lillian B. Koller, Esq.
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Ms. Koller:

Enclosed is an approved copy of Hawaii State Plan Amendment (SPA) No. 08-007, which clarifies the reimbursement methodology for Federally Qualified Health Centers (FQHCs) in Attachment 4.19-B; delineates the providers covered under the FQHC benefit under Attachment 3.1-A and 3.1-B; and outlines the State's liability for cost-sharing for full-benefit dual eligibles and Qualified Medicare Beneficiary (QMB) Plus individuals who receive Medicaid-covered services outside the FQHC setting under Supplement 1 to Attachment 4.19-B. This SPA is effective May 14, 2008.

If you have any questions, please contact Don Novo at (415) 744-3568.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Kenneth Fink, Med-QUEST Administrator
Michele Bowser, CMS Center for Medicaid and State Operations (two copies)
Mary Rydell, Pacific Area Representative

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 08-007

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: MAY 14, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: ~~BIPA of 2000~~ 1902(bb) of the Social Security Act + see Box 23

7. FEDERAL BUDGET IMPACT:
a. FFY 08 $359,000
b. FFY 09 ~~$702,000~~ $857,025

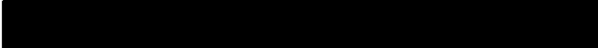
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-B, Pages 14, 14.1, 14.2, 14.3, 14.4, 14.5, 14.6, and 14.7
Supplement 1 to Attch. 4.19-B, p.3
Supplement 1 to Attch. 3.1-A + 3.1-B, p.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-B, Pages 14, 14.1, 14.2, 14.3, 14.4, and 14.5
Supplement 1 to Attch. 4.19-B, p.3
Supplement 1 to Attch. 3.1-A + 3.1-B, p.1

10. SUBJECT OF AMENDMENT:
FQHCs AND RHCs

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
LILLIAN B. KOLLER

14. TITLE:
DIRECTOR OF HUMAN SERVICES

15. DATE SUBMITTED:
5/7/08

16. RETURN TO:
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
POLICY AND PROGRAM DEVELOPMENT OFFICE
P.O. BOX 700190
KAPOLEI, HI 96709-0190

FORM HCFA-179 (07-92)

1. The utilization control committee of an acute hospital facility shall determine the medical necessity for admission and continued stay for all recipients. Extension of hospital stay shall be requested when a patient is awaiting placement in a long-term facility. Psychiatric inpatient care is limited to 40 days per calendar days. Substance Abuse Treatment (SAT) services must be equal to services rendered for physical diseases and illnesses, which are not limited by service days, but determined by medical necessity. SAT services are also based on medical necessity and not limited by service days.

2a. Outpatient psychiatric services are limited to one-hour individual and two-hour group therapy sessions. The number of visits are limited to 24 individual or 24 group therapy visits within 12-month period or a combination of 6 individual and 24 group therapy visits or 6 group therapy and 24 individual visits within 12 months. Approval of a second and subsequent request shall be based on the severity of the patient's illness. Outpatient psychiatric services for SAT services that are medically necessary shall be provided with no limits on the number of visits. The providers for SAT services are psychiatrists, psychologist, licensed social workers in behavioral health, and advance practice registered nurses (APRN) in behavioral health. Setting where services will be delivered are in outpatient hospital/clinic including methadone clinics, and physician/provider offices. Only professional fees are paid when services are provided in an outpatient clinic setting and are paid at or below the Medicare fee schedule rate. SAT services that are medically necessary shall be reimbursed with the existing approved Medicaid Fee Schedule located in Attachment 4.19-B, Section 1. Hawaii Medicaid Fee Schedule, item (a) and (d) and Section 2. Medicaid Payment for Other Non-Institutional Items and Services are Determined as Follows, item (i).

2c. FQHC services are congruent with the general scope and limitation to services of Hawaii's Medicaid program.

FQHC services shall be delivered exclusively by the following health care professionals who are licensed and a resident of the State of Hawaii:

i. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry);
ii. Physician Assistant;
iii. Nurse Practitioner;
iv. Nurse Midwife;
v. Visiting Nurse;
vi. Clinical Social Worker;
vii. Clinical Psychologist; or
viii. Licensed dieticians

3. Payment for laboratory services made only for tests performed by standard procedures and techniques commonly accepted by the medical community.

4a. Authorization by the Department's medical consultant is required for level of care and admission to a NF.

4b. All services listed under 1905(a) of the Social Security Act are available to EPSDT eligible individuals if the services are medical necessary, even though the services are not covered in this plan. The services are not covered in this plan but which are available to EPSDT eligible individuals are as follows.

10. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINIC (RHCs) PAYMENT SYSTEMS:

10.0 Introduction

This section describes the payment methodology for services performed on or after January 1, 2001 by federally qualified health centers (FQHCs), including FQHC look-a-likes as designated by the Public Health Service and Rural Health Clinics (RHCs) and as required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act ("BIPA") of 2000. The payment methodology is as follows:

(a) Effective January 1, 2001, federally qualified health center ("FQHC") and rural health clinic ("RHC") services shall be reimbursed on a prospective payment system ("PPS") that conforms to the requirements of section 702 of the Benefits Improvement and Protection Act of 2000 ("BIPA").

(b) In the period before the PPS is fully implemented, payment to FQHCs and RHCs will continue at the fee-for-service rates in effect on December 30, 2000. Following full implementation of the PPS, adjustments will be made for the period from January 1, 2001 through the date on which the PPS is fully implemented.

10.1 Prospective Payment System

(a) The baseline PPS rate for FQHCs and RHCs that have filed at least two annual cost reports as of January 1, 2001 will be calculated from the respective cost reports for the fiscal years ending in 1999 and 2000. Total visits will be obtained from "as filed" cost reports. For FQHCs and RHCs 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 in the medical cost per visit baseline PPS rates. A separate PPS rate will be computed for dental visits. Total costs of all Medicaid covered ambulatory services provided by the FQHCs/RHCs for each year will be divided by the total number of visits in that year to determine average cost per visit for each year. The average cost per visit for each year will be added and then divided by two to determine the baseline PPS rate.

(b) For FQHCs and RHCs which could have filed two annual cost reports as of May 31, 2001 but only filed one cost report, the baseline rate will be calculated from the cost report submitted. Total visits and costs will be obtained from the "as filed" cost report. Vision visit and costs will be included in the medical cost per visit baseline PPS rate. A separate PPS rate will be computed for dental visits.

Each year's costs will be divided by total visits. Total costs should include the cost of all Medicaid covered services provided by the FQHC or RHC, including all ambulatory services previously paid on a fee-for-service basis.

(c) Service provided at a satellite service site or a mobile satellite facility that is affiliated with an FQHC or RHC shall be reimbursed at the same PPS rate as that of the affiliated FQHC or RHC, subject to the FQHC's or RHC's right to request a scope-of-service adjustment to the rate. A satellite facility or mobile unit is affiliated with an FQHC or RHC when it is owned and operated by the same entity and has been approved or certified by the Health Resources and Services Administration ("HRSA") as part of the official scope of the project on a Notice of Grant Award.

(d) Baseline rates for FQHCs and RHCs that did not file annual cost reports as of May 31, 2001 will be set at 100% of the costs of furnishing such services at the cost per visit rate established by the method described in the preceding paragraphs for the FQHC or RHC, respectively, that is most similar in scope of service and case load.

(e) For FQHCs and RHCs that submitted cost reports for their respective fiscal years ending 1999 and 2000 but, as of December 31, 2000, were not certified as FQHCs or RHCs long enough to produce two annual cost reports based on their respective fiscal years, baseline PPS rates will be set at the higher of the cost per visit rate for the FQHC or RHC that is most similar in scope of service and case load or the actual cost per visit rate calculated using the FQHC's and RHC's most recent "as filed" cost report.

(f) The FQHC/RHC PPS rates will be effective for services rendered from January 1 through December 31 of each year.

(g) Starting January 1, 2002, PPS rates will be adjusted annually using 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 calendar year as published in the Federal Register.

(h) To be eligible for PPS reimbursement, services must be delivered exclusively by the following licensed health care professionals: physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, and licensed dieticians

10.2 Supplemental Managed Care Payments

(a) FQHCs and RHCs that provide services under a contract with a Medicaid managed care organization ("MCO") will receive quarterly supplemental payments that represent the estimated difference between payments received from the MCO and payments that the FQHC or RHC would receive under the PPS methodology. Not more than one month following the end of each calendar quarter, and based on the receipt of FQHC and RHC submitted claims during the prior calendar quarter, FQHCs and RHCs shall be paid the difference between the amount received from estimated supplemental quarterly payments and from MCOs (excluding payment for non-PPS services, managed care risk pool accruals, distributions or losses and pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) and the payment that each FQHC or RHC would have received under the PPS methodology. Any balance due from an FQHC or RHC shall be recouped from the next quarter's estimated supplemental payment.

(b) Within 150 days of the end of each calendar year, FQHCs and RHCs will file annual settlement reports, stating the amounts of MCO and supplemental payments received and the actual number of visits provided during the applicable calendar year. The Department shall also request financial data from the MCOs. The reports shall be reviewed and the total amounts received by the FQHCs and RHCs as supplemental payments and from MCOs (excluding payment for non-PPS services, managed care risk pool accruals, distributions or losses and pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) shall be compared with the amount that would have been paid under the PPS system for the actual number of visits provided under the FQHC's or RHC's contract with the MCO. Any discrepancies between the MCO and provider submitted claims data will be resolved on a case-by-case basis. After reviewing the reports, the Department will notify participating FQHCs and RHCs of any balance due to or from the FQHC or RHC.

10.3 Adjustments for Changes in Scope of Service

(a) PPS rates may be adjusted for changes in the scope of services provided by an FQHC or RHC upon submission of a written notice to the Department specifying the changes in scope of service and the reasons for those changes within 60 days of the effective date of the changes. If the written notice is greater than 60 days after the effective date of changes the Department will consider the effective date of change of scope of services to be the notification date.

(b) An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit data/documentation/schedules that substantiate any changes in services and the related adjustment of reasonable costs following Medicare principles of reimbursement.

(c) An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit a projected adjusted rate within 150 days of the changes. The projected adjusted rate is subject to approval by the Department and shall be calculated based on a consolidated basis, including both costs included in the base rate and additional costs, provided that the FQHC's or RHC's baseline PPS rate was calculated based on consolidated costs.

(d) Within one hundred twenty days of receipt of the projected adjusted rate and all additional documentation requested by the Department, the Department shall notify the FQHC or RHC of its acceptance or rejection of the projected adjusted rate. The Department will reduce the projected adjusted rate by twenty percent of the difference between the FQHC's or RHC's previously assigned PPS rate and the projected adjusted rate to eliminate the reporting of cost increases not related to a qualifying scope change. Upon approval by the Department, the FQHC or RHC will be paid the reduced projected adjusted rate effective from the date of the change in scope of services through the date that a rate is calculated based on the submission of cost reports for the first full fiscal year which include the change in scope of service.

(e) The Department will review the calculated rate of the first full fiscal year cost report if the change of scope in service is reflected in more than six months of the report. For those FQHCs or RHCs in which the change of scope of services is in effect for less than six months, the next full year cost report is also required. The Department will review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report will be adjusted to the MEI of the second year report. Each report will be weighted based on the number of patient encounters.

(f) The PPS rate will be adjusted following review of the cost reports and supporting documentation by the Department or its designated agent.

(g) Payment adjustments will be made 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.

(h) To qualify for rate adjustment, a change of scope must be a change in type, intensity, duration or amount of service, or any combination therein. A change in cost alone, in and of itself will not be considered a change in scope of service.

(i) Change in scope includes any of the following only if these changes result in a change in type intensity, duration or amount of service, or any combination therein:

i. Addition of new services not incorporated in the baseline rate or deletion of services incorporated in the baseline rate;

ii. Changes necessary to maintain compliance with amended state or federal requirements or;
iii. Changes resulting from relocation;
iv. Changes resulting from the opening of a new service location;
v. Changes in the type, intensity, duration or amount of service caused by changes in technology and medical practice used;
vi. Increase in service intensity, duration, or amount of service resulting from the changes in the types of patients served, including, but not limited to, populations with HIV/AIDS, or other chronic diseases, or homeless, elderly, migrant or other special populations;
vii. Changes resulting from a change in the provider mix of a FQHC, RHC or an affiliated site;
viii. Changes in the scope of a project approved by the HRSA, where the change affects a covered service, as described below;
ix. Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, described below, including new or expanded service facilities, regulatory compliance measures, or change in technology or medical practices at the FQHC or RHC.

(j) In addition to the criteria as stated under (h), the cost must be allowable under Medicare principles of reimbursement and the net change in the FQHC's or RHC's per visit rates equals or exceeds 3 per cent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish baseline PPS rates, the net change of 3 percent shall be applied to the average per visit rate of all the sites of the FQHC or RHC for purposes of calculating the costs associated with a scope of service change. "Net change" shall mean the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year. "Fiscal year" shall be construed to reference the fiscal year of the specific FQHC or RHC under consideration.

10.4 Other Payment Adjustments

(a) FQHCs and RHCs may request other payment adjustments in the event of extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, and changes in licensure laws. Inflationary cost changes, absent extraordinary circumstances, shall not be grounds for other payment adjustments. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs including those associated with extraordinary circumstances, other payment adjustments is not warranted.

(b) The Department will accept requests for other payment adjustments at any time throughout the prospective payment year or within thirty days following the end of a prospective payment year. Such requests must be made in writing, shall set forth the reasons for the request, and be accompanied by data satisfactory to

establish the existence of extraordinary circumstances warranting other payment adjustments. Documentation shall include:

i. Presentation of data to demonstrate reasons for the FQHC's or RHC's request for other payment adjustments;

ii. Documentation showing the cost impact, which must be material and significant ($200,000 or 1% of the FQHC's or RHC's total costs, whichever is less). The documentation submitted must be sufficient to compute an adjustment amount to the PPS payment for the purpose of determining a QUEST and QExA managed care supplemental payment amount.

(c) Each other payment adjustment request will be applicable for only the remainder of the PPS rate year. If the other payment adjustment request is granted, it will be effective no earlier than the first day of the PPS rate year during which the other payment adjustment request is received. If an FQHC or RHC believes that its experience justifies continuation of the other payment adjustment in subsequent years, then it shall submit information to update the documentation provided in the prior request for each affected year.

(d) An FQHC or RHC requesting other payment adjustments will be notified of the Department's decision on the request in writing within ninety days from the date of receipt of all necessary verification and documentation.

(e) Amounts granted for other payment adjustments requests will be paid as part of the on-going payment and not as revised PPS rates.

10.5 Cost Reporting, Record Keeping and Audit Requirements

(a) All participating FQHCs and RHCs shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation sufficient to support all data.

(b) Annual cost reports will be required only under the following circumstances:

i. FQHCs and RHCs that request rate changes due to changes in scope of service shall submit cost reports for the first one or two full fiscal years reflecting the change in scope of services along with significant related data. Consolidated cost reports, which combines the costs from all the FQHC or RHC sites and services, shall be prepared. Exceptions to the requirement for consolidated cost reports may be made only if the FQHC or RHC originally filed site specific cost reports during two baseline years and subsequently established site-specific PPS baseline rates using such "as filed" cost reports.

ii. FQHCs and RHCs that request other payment adjustments shall submit cost reports for the fiscal years for which the other payment adjustments were authorized.

iii. In either of the circumstances described above, the following documentation must be submitted no later than five months after the close of the FQHC's or RHC's fiscal year:
- Uniform cost report;
- Working trial balance;
- Provider cost report questionnaire;
- Audited financial statements, if available;
- Disclosure of appeal items included in the cost report;
- Disclosure of increases or decreases in scope of services; and
- Other schedules as identified by the Department.

(c) Each FQHC or RHC that submits an annual cost report shall keep financial and statistical records of the cost reporting consistent with 45 CFR 74.53(b) after submitting the cost report to the Department and shall make such records available to authorized state or federal representatives upon request.

(d) The Department or its fiscal agent may conduct periodic on-site or desk audits of cost reports, including financial and statistical records of a sample of FQHCs or RHCs.

(e) FQHCs and RHCs must submit other information (statistics, cost and financial data) as deemed necessary by the Department.

10.6 Rebasing

Baseline PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress.

10.7 Eligible Services

(a) To be eligible for PPS reimbursement services must be:

i. Within the legal authority of an FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended;

ii. Actually provided by the FQHC or RHC, either directly or under arrangements;

iii. Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan;

iv. Provided to a recipient eligible for Medicaid benefits;

v. Delivered exclusively by licensed health care professionals (physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, or licensed dieticians);

vi. Provided in an outpatient settings during business or after hours on the FQHC's or RHC's site. For full-benefit dual eligibles only, services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's

home, within the limitation noted in Supplement 1 to Attachment 4.19-B, page 3 and;

vii. 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.

(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 shall constitute a single encounter unless:

i. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

ii. The patient makes one or more covered encounters for dental or behavioral health. Medicaid shall pay for a maximum of one visit per day for each of these services in addition to one medical visit.

10.8 Non-FQHC Services

It is permissible for an FQHC to bill the Department or the designated fiscal agent for the non-FQHC professional services provided by an employed or contracted practitioner. In such instances, the services provided by the practitioner are not considered FQHC services and are not to be considered in calculations pertaining to PPS-based payments to FQHCs for FQHC services. In such instances, the Department or the designated fiscal agent will reimburse the FQHC on behalf of the practitioner at the rate specified for that practitioner under the State Plan in Attachment 4.19B for the professional services provided to the Medicaid beneficiary.

10.9 Appeal

An FQHC or RHC may appeal a decision made by the Department and shall be afforded an opportunity for administrative hearing under HRS Chapter 91. An FQHC or RHC aggrieved by the final decision and order of such an administrative hearing shall be entitled to judicial review in accordance with HRS Chapter 91, or may submit the matter to binding arbitration pursuant to HRS Chapter 658A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES – OTHER TYPE OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

For all inpatient and outpatient hospital services payments are limited to State plan rates and payment methodologies.

For all other services, payments are up to the full amount of the Medicare rate.

For FQHC services that are covered under Medicare and Medicaid, payments will be paid first by Medicare and the difference by Medicaid, up to the States payment limit.

Reimbursement for outpatient services provided outside the FQHC or RHC facility site shall be limited to Qualified Medicare Beneficiary Plus (QMB Plus) and Full Benefit Dual Eligibles (FBDEs) up to the State Plan limit.