

STATE OF HAWAII
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for inpatient facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Balanced Budget Act of 1997, which requires that reimbursements be in conformity with the applicable State and Federal laws, regulations; quality and safety standards; and provide for cost reimbursement for inpatient acute care services in Critical Access Hospitals (CAH).

C. REIMBURSEMENT PRINCIPLES

1. For dates of admission on or after July 1, 2022, the Hawaii Medicaid Program shall reimburse in-state general acute hospitals and children's hospitals for inpatient hospital services, excluding transplant services, based on prospective payment rates under an All Patient Refined Diagnosis Related Group (APR DRG) reimbursement methodology.

The Prospective payment rate shall include all services provided in an acute inpatient setting except:

- a. Professional component, including physician services or any other professional fees excluded under Part A Medicare.
- b. Ambulance; and
- c. Durable medical equipment (except for implanted devices) that the patient takes home after he or she is discharged.

Each claim for an inpatient hospital admission will be assigned a DRG code and a corresponding DRG relative weight based on the APR DRG classification system established. The APR DRG assignment will reflect adjustments for Health Care Acquired Conditions (HCACs) in the APR DRG software. The APR DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and the applicable policy adjuster, with the applicable transfer adjustment, plus the applicable outlier payment.

A hospital will not be reimbursed separately for outpatient diagnostic services and admission-related outpatient non-diagnostic services provided to a patient within a three day window of an inpatient admission ("preadmission services"). A hospital will also not be reimbursed separately for changes to lower levels of care prior to patient discharge from the hospital ("waitlisted days"). Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes (described in Section I.C.1.f).

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a. DRG Relative Weights

The APR DRG methodology classifies inpatient admissions into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using APR DRGs and Severity of Illness (SOI) levels, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG primarily based on the patient's diagnoses, surgical procedures performed, age, sex, birth weight, and discharge status. A claim for an inpatient hospital admission will be assigned the DRG code derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1, using the APR DRG grouper software logic.

The DRG relative weights will be based on the APR DRG national "hospital specific relative value" (HSRV) weights published for the associated APR DRG grouper version. MQD will use the version 37.1 APR DRG grouper and national HSRV weights for payments effective July 1, 2022.

MQD will update its APR DRG grouper version and associated national HSRV weights no less than every five years, concurrently with rebasing DRG base rates (described in the next section). When updating its APR DRG grouper version and relative weights, MQD will apply a prospective scaling adjustment to the published national HSRV weights. This scaling adjustment factor will be determined by MQD to result in the same aggregate case mix as the prior APR DRG grouper version used by MQD for payment. Any update to the APR DRG Grouper version and relative weights will be submitted in a future state plan amendment for CMS approval.

The version 37.1 APR DRGs and relative weights effective July 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

b. DRG Base Rates

Hospital DRG base rates are based on statewide standardized amounts, adjusted by applying the hospital's indirect medical education (IME) factor.

The statewide standardized amounts are prospective and differ by hospital class, as follows:

1. Privately owned in-state general acute hospitals and children's hospitals will have a statewide standardized amount modeled to be budget neutral to base period payments in aggregate. Base period payments are based on the reported paid amounts in the SFY 2018 Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine budget neutral standardized amounts will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

2. Publicly-owned in-state general acute hospitals will have a statewide standardized amount equal to 55% of the private hospital standardized amount.

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MQD will rebase its DRG base rates, including the standardized amounts and IME factors, no less than every five years, concurrently with updating the APR DRG grouper version. When rebasing, MQD will model new DRG standardized amounts modeled to be budget neutral to new base period payments in aggregate using the most recently available mature state fiscal year or calendar year of Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine rebased DRG base rates will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments. Any rebasing to the APR DRG base rates, including the standardized amounts and the IME factors, will be submitted in a future state plan amendment for CMS approval.

Hospital IME factors effective July 1, 2022 are based on the operating IME factors published by CMS in the federal fiscal year (FFY) 2021 Medicare inpatient prospective payment system (IPPS) Final Rule Impact File effective October 1, 2020. IME factors for hospitals that are not included in the Medicare IPPS Final Rule Impact File are based on data from the fiscal year ending 2019 Medicare Cost Report. MQD will rebase the IME factors, no less than every five years, concurrently with updating the statewide standardized amounts, based on the operating IME factors published by CMS in the Medicare IPPS Final Rule Impact File effective October 1st in the federal fiscal year ending prior to the start of the effective calendar year, and the most recently available Medicare cost report data for Medicare IPPS-exempt hospitals.

New hospitals reimbursed under the APR DRG methodology will be assigned a DRG base rate with the applicable standardized amount and a hospital IME factor based on the most recently available Medicare IPPS operating IME factor published by CMS as of the hospital Medicaid provider enrollment date.

The statewide standardized amounts, IME factors, and DRG base rates for each hospital effective July 1, 2022 are posted on the MQD website at: <https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

c. Policy Adjusters

MQD will apply policy adjusters to payment amounts when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services. The criteria established for application of these policy adjusters include the following:

1. Neonatal DRGs
2. Well newborn DRGs
3. Maternity DRGs (normal delivery and cesarean section delivery)
4. Psychiatric and alcohol and drug abuse DRGs
5. Trauma DRGs
6. All other pediatric services (patients aged 20 and under)

All other adult services will not be subject to a policy adjuster. Policy adjusters are mutually exclusive, and there will be only a single applicable policy adjuster applied for each inpatient admission.

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MQD will rebase its policy adjusters no less than every five years, concurrently with updating the APR DRG grouper version and rebasing APR DRG base rates. When rebasing, MQD will model updated policy adjuster factors for the services described in this section, as needed, to ensure access to quality care to these services. The MQD modeling process to determine rebased policy adjuster factors will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base rates, transfer adjustments, and outlier payments. Any rebasing to the APR DRG policy adjusters will be submitted in a future state plan amendment for CMS approval.

The policy adjuster factors effective July 1, 2022, by APR DRG, are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

d. DRG Base Payment

For each hospital admission, the DRG base payment equals the hospital's DRG base rate multiplied by the DRG relative weight and the service's applicable policy adjuster.

e. Transfer Adjustment

The DRG base payment may be subject to transfer adjustments as described in the following paragraphs.

A transfer adjustment to the DRG base payment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital. The transferring hospital will be reimbursed the lesser of the full DRG base payment and the DRG transfer adjusted payment. The transfer adjusted payment is equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day. The receiving hospital (for the same patient) will not be impacted by the transfer adjustment unless it transfers the patient to another general acute hospital or Critical Access Hospital.

The DRG geometric mean lengths of stay will be based on the APR DRG HSRV national trimmed geometric mean lengths of stay published for the associated APR DRG grouper version. MQD will use APR DRG grouper version 37.1 and associated national geometric mean lengths of stay for transfer adjustments effective July 1, 2022.

The actual length of stay at the transferring hospital is based on discharge date less admission date, not to be less than 1.

MQD will update its APR DRG national geometric mean lengths of stay no less than every five years, concurrently with updating the APR DRG grouper version. Any update to the APR DRG geometric mean lengths of stay, in determining the transfer adjusted payments, will be submitted in a future state plan amendment for CMS approval.

The DRG national geometric mean lengths of stay effective July 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

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f. Outlier Payment

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier payment in addition to the DRG base payment. A claim will qualify for an outlier payment if the claim cost exceeds the outlier threshold. The claim cost is determined by multiplying the claim covered charges by the hospital's outlier cost-to-charge ratio (CCR). The outlier threshold is equal to the DRG base payment (including transfer adjustments described previously) plus the fixed loss amount.

The outlier CCRs for all hospitals will be determined as follows:

1. For children's hospitals in Hawai`i, the outlier CCR is based on sum of the Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year. Hawai`i children's hospitals outlier CCRs effective July 1, 2022 will be based on the sum of Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the FFY 2022 Federal Register Final Rule tables effective October 1, 2021.
2. For in-state general acute hospitals in Hawai`i, the outlier CCR is based on sum of hospital-specific Medicare IPPS operating and capital outlier CCRs published in the Final Rule Impact File effective October 1st in the year preceding the start of the effective calendar year. Hawai`i general acute hospital outlier CCRs effective July 1, 2022 will be based on the sum of Medicare IPPS hospital-specific operating and capital outlier CCRs published in the FFY 2022 Final Rule Impact File effective October 1, 2021.

New hospitals reimbursed under the APR DRG methodology will be assigned an outlier CCR based on the sum of the most recently available hospital-specific Medicare IPPS operating and capital outlier CCRs published by CMS as of the hospital Medicaid provider enrollment date. If hospital-specific Medicare IPPS outlier CCRs are not available, the new hospital outlier CCR will be based on the sum of the Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year.

MQD will update the outlier CCRs annually on January 1st each year, and will not adopt any Medicare IPPS outlier CCR updates for the rest of the calendar year.

MQD outlier payment parameters, including the fixed loss amount and marginal cost factors, is modeled to result in outlier payments equal to 10% of total inpatient APR DRG payments. The outlier fixed loss amount effective July 1, 2022 is \$58,000. The MQD modeling process to determine the outlier fixed loss amount will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc.

Where a claim qualifies for an outlier payment, the outlier payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the marginal cost factor. The marginal cost factor will be based on the APR DRG severity of illness level. The marginal cost factors effective July 1, 2022 will be 75% for claims assigned Severity of Illness levels 1 and 2, and 85% claims assigned Severity of Illness levels 3 and 4.

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MQD will prospectively update the outlier fixed loss amount on July 1st, 2023 if it determines that annual outlier payments were above 11.0% of total APR DRG payments, to result in modeled outlier payments equal to 10.0% of total statewide modeled inpatient APR DRG payments. For the outlier fixed loss amount effective July 1, 2023, MQD will measure outlier payments using Medicaid inpatient managed care encounter data and fee-for-service claims data paid under APR DRGs from the period July 1, 2022 through December 31, 2022.

MQD will subsequently make prospective updates to the outlier fixed loss amount on January 1st each year starting in 2024 through the next rebasing period if it determines that annual outlier payments were above 11.0% of total APR DRG payments, to result in modeled outlier payments equal to 10.0% of total statewide modeled inpatient APR DRG payments. Each year MQD will measure annual outlier payments using Medicaid inpatient managed care encounter data and fee-for-service paid claims data paid under APR DRGs for the 12 month state fiscal year ending 6 months prior to the fixed loss update effective date (for example, for the outlier fixed loss amount effective January 1, 2024, MQD will measure outlier payments using Medicaid inpatient managed care encounter data and fee-for-service claims data from the period July 1, 2022 through June 30, 2023).

Updates to the outlier fixed loss amount will be modeled using the same Medicaid inpatient managed care encounter data and fee-for-service claims data paid under APR DRGs used to measure the outlier payments, and will be posted on the MQD website: <https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

MQD will rebase its outlier payment parameters, including the fixed loss amount and marginal cost factors when updating the APR DRG grouper version and rebasing APR DRG base rates, to result in outlier payments equal to a targeted percentage of total inpatient APR DRG payments. The MQD modeling process will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc. Any update to the outlier payment parameters as part of this APR-DRG rebasing will be submitted in a future state plan amendment for CMS approval.

Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes. Claim covered charges can be subject to retrospective utilization review, and may be adjusted for items such as non-covered services (such as personal care and convenience items), medical necessity of length of stay (for non-waitlisted days), and appropriate level of care among others.

g. DRG Final Payment

The DRG final payment amount is equal to the DRG base payment amount (with applicable transfer adjustment) plus the DRG outlier payment amount.

h. Readmissions

a) An inpatient readmission to the same facility within twenty four (24) hours of discharge for the same spell of illness and for a similar primary diagnosis as the index admission is considered to be the same admission and must be billed as a single stay. When the inpatient readmission occurs at a different hospital from the index admission, both the index admission hospital and the readmission hospital should bill separately, and denial or partial payment adjustments may be made for the index admission at the original hospital based on nationally recognized admission and discharge review criteria. This policy does not apply to patients who leave the original facility against medical advice.

b) Readmission to the same facility within thirty (30) days of a discharge for a similar diagnosis is subject to review by the Department based on nationally recognized admission and discharge review criteria. Based on this review, the DRG payment for a readmission within 30 days may be consolidated with the index admission DRG payment. This policy does not apply to patients who leave the facility during the original admission against medical advice, or for planned readmissions.

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i The following definitions shall apply for the purpose of APR-DRG payment methodology.

1. All Patient Refined Diagnosis Related Groups (APR DRGs): Base APR-DRG classifications assigned to inpatient claims based on a variety of factors (including patient diagnosis and surgical procedures, among others) using the APR-DRG Health Information Systems software.
2. DRG geometric mean lengths of stay (GMLOS): factor that represents the GMLOS for each combination of APR DRG and SOI level used for transfer adjustments, based on APR DRG national HSRV trimmed GMLOS amounts published for the APR DRG grouper version used for payment.
3. DRG Relative Weights: factor that represents the average resource requirements and level of acuity for each combination of APR DRG and SOI level used for base DRG payments, based on APR DRG national HSRV weights published for the APR DRG grouper version used for payment.
4. DRG Base Rates: Based on statewide standardized amounts adjusted by applying the hospital's IME factor, used for base DRG payments.
5. DRG Base Payments: For each hospital admission, the DRG base payment equals the hospital's DRG base rate multiplied by the HAC-adjusted DRG relative weight and the service's applicable policy adjuster.
6. Health Care Acquired Condition (HCAC)-Adjusted DRG: APR DRG and SOI assignment derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1.
7. Indirect Medical Education (IME) factors: based on hospital-specific operating IME factors in the Medicare inpatient prospective payment system (IPPS) published by CMS, used to adjust DRG base rates.
8. Outlier cost: Estimated claim cost for outlier payment purposes, based on claim covered charges multiplied by the hospital outlier CCR.
9. Outlier cost-to-charge ratio (CCR): Based on the Medicare IPPS combined operating and capital outlier CCRs for outlier payment purposes.
10. Outlier threshold: Based on the base DRG payment plus the fixed loss amount, for purposes of determining if a claim qualifies for an outlier payment.
11. Outlier marginal cost factor: Factor based on SOI level that is applied to the claim outlier cost exceeding the outlier threshold, for outlier payment purposes.
12. Outlier Payment: Claim payment add-on, in addition to the base DRG payment, for extraordinarily high cost cases where the claim outlier cost exceeds the claim outlier threshold.
13. Policy Adjusters: Adjusters to base DRG payments when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services.
14. Severity of Illness (SOI) level: SOI level 1 through 4 assigned to inpatient claims based on comorbid conditions and the severity of the underlying illness, using the APR-DRG Health Information Systems software.
15. Transfer Adjustment: Adjustment to the DRG base payment when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital, equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day (not to exceed the full DRG base payment).

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2. The Hawaii Medicaid Program shall reimburse all in-state freestanding psychiatric and rehabilitation providers for inpatient hospital services based primarily on the prospective per diem payment rates developed for each facility as determined in accordance with this Plan, except for CAH. In addition, certain costs (Such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay not more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.
3. A hospital -specific retrospective settlement adjustment shall be made for those providers whose Medicaid charges are less than Medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.
4. Prospective rates shall be derived from historical facility costs, and facilities shall be classified based on discharge volume and participation in an approved Medical Education program.
5. Providers that average fewer than 250 Medicaid discharges per year shall be classified as Classification I facilities and shall receive All-Inclusive Rates plus all appropriate Adjustments (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the All-Inclusive Rates.
6. Providers which average 250 Medicaid discharges or more per year shall be separated into two facility classifications (Classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid an All-Inclusive Rate, plus all appropriate Adjustments (Section I.D.3.). Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.
7. The freestanding rehabilitation hospital shall be excluded from Classifications I, II, and III, shall be designated as Classification IV, and will be paid an All-Inclusive Rate, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.

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8. Claims for payment shall be submitted following discharge of a patient, except as follows:
 - a. Claims for nonpsychiatric inpatient stays which exceed the Outlier Threshold (Section I.D.34.), shall be submitted in accordance with Section IV.D.
 - b. If a patient is hospitalized in the freestanding rehabilitation hospital for more than 30 days, the facility may submit an interim claim for payment every 30 days until discharge. The final claim for payment shall cover services rendered on all days not previously included in an interim claim.
9. The prospective payment rates shall be paid in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in Section I.E. below.
10. At the point that a patient reaches the Outlier Threshold (Section I.D.34.), the facility is eligible for interim payments computed pursuant to Section IV. D.
11. Reimbursement for inpatient services provided by CAH facilities will be on a reasonable cost basis under Medicare principles of reimbursement without application of any Medicaid Tax Equity and Fiscal Responsibility Act (TEFRA) target amounts. Outpatient, waitlisted and acute swing to continue to be reimbursed under the current method.
12. Reimbursement for services related to organ transplants will be made by a contractor selected by the State. The contractor will also be responsible to coordinate and manage transplant services. Reimbursement of services related to organ transplants will be approved by the State. The negotiated care rate will not exceed Medicare or prevailing regional market rates.

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Citation: 42 CFR 434, 438 and 447; and Social Security Act 1902(a)(4), 1901(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions.

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Hospital-Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below of the plan:

Adjustment of inpatient hospital reimbursement to account for non-payment of HCACs and OPPCs.

In accordance with 42 CFR 447.26(c), no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment that patient by that provider. Reductions in provider payment are limited to the extent that the State can reasonably isolate for non-payment, the portion of the payment directly related to treatment for, and related to, the PPC that would otherwise result in an increase in payment.

Hospitals will use the Present on Admission indicator to identify whether an identified HCAC or OPPC was present on admission or hospital acquired. For hospitals reimburse on a per diem basis, such claims will be reviewed to determine whether the HCAC or OPPC resulted in a longer length of stay or increased acuity that can be directly and independently attributable to the HCAC or OPPC. For hospitals reimbursed on an APR DRG[~~+~~] basis, the APR DRG and SOI level assignment will be based on the Medicare HCAC adjusted classifications under the APR DRG software logic, and payment will not include additional payment for the HCAC or OPPC that was not present on admission.

Lastly, in accordance with 42 CFR 447.26(c)(5), non-payment for OPPCs shall not prevent access to medically necessary covered services for Medicaid recipients.

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D. DEFINITIONS APPLICABLE TO THE PROSPECTIVE RATE SYSTEM

The following definitions shall apply for purpose of calculating prospective payment rates and adjustments for acute inpatient services:

1. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.
2. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.
3. "Adjustments" mean all adjustments to the Basic Per Diem, Basic Per Discharge and All-Inclusive Rates and/or the Capital Payments that are defined in this Plan and that are appropriate for a particular Provider. Those adjustments may include the ROE/GET Adjustment, the Medical Education Adjustment, and/or the Severity and Case Mix Adjustment.
4. "All-Inclusive Rates" means the separate per diem rates that are paid to Classification I and IV facilities for psychiatric and nonpsychiatric cases, and the per diem rates that are paid to Classification II and III facilities for psychiatric cases only. The All-Inclusive Rates are calculated to include reimbursement for both routine and ancillary costs.
5. "Ancillary Services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.
6. "Base Year" means the State fiscal year used for initial calculation and recalculation of prospective payment rates. The Base Year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base Year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report.

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7. "Breakeven Point" means the point at which a hypothetical Special Care Percentage in the Base Year would not have resulted in the elimination of any costs due to the application of the ceiling factors in calculating the PPS rates.
8. "Basic Per Diem Rate" means the applicable per diem amount for each Provider for each category of care, as calculated pursuant to the methodology defined in this Plan. It does not include the various adjustments to that basic per diem rate defined in this Plan.
9. "Basic Per Discharge Rate" means the applicable per discharge amount for each Provider in Classifications II and III for each category of care, as calculated pursuant to the methodology defined in this Plan. It does not include the various adjustments to that basic per diem rate defined in this Plan.
10. "Capital Payment" means the payment in addition to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to compensate a Provider for Medicaid's fair share of the Provider's Capital Related Costs.
11. "Capital Related Costs" means costs associated with the capital costs of the provider's facilities and equipment under Medicare principles of reimbursement. For purposes of the prospective payment methodology, Capital Related Costs shall include depreciation, interest, property taxes, property insurance, capital leases and rentals, and costs and fees related to obtaining or maintaining capital related financing.
12. "Claim Charge Data" means charges and other information obtained from billing claim forms processed by the Medicaid fiscal agent.
13. "Costs" means total finally-settled allowable costs of acute inpatient services, unless otherwise specified.
14. "Critical Access Hospital" means a hospital designated and certified as such under the Medicare Rural Hospital Flexibility Program.
15. "Discharge" means the release of a patient from an acute care facility. The following events are considered discharges under these rules:

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- a. The patient is formally released from the hospital.
 - b. The patient is transferred to an out-of-state hospital.
 - c. The patient is transferred to a long-term care level or facility.
 - d. The patient dies while hospitalized.
 - e. The patient signs out against medical advice.
 - f. In the case of a delivery where the mother and baby are discharged at the same time, the mother and her baby shall be considered two discharges for payment purposes. In cases of multiple births, each baby will be considered a separate discharge.
 - g. A transfer shall be considered discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in Section IV.B.6.a.
16. "Federal PPS" means the prospective payment system based upon diagnostic related groups ("DRGs") used by the Medicare program under Title XVIII of the Social Security Act to pay some hospitals for services delivered to Medicare beneficiaries.
17. "Inflation Factor" means the estimate of inflation in the costs of providing hospital inpatient services for a particular period as estimated in the DRI McGraw-Hill Health Care Costs: National Forecast Tables, PPS-Type Hospital Market Basket, or its successor.
18. "Inpatient" means a patient who is admitted to an acute care facility on the recommendation of a physician or dentist and who is receiving room, board, and other inpatient services in the hospital at least overnight, and requires services that are determined by the State to be medically necessary. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission

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regardless of whether the stay was overnight. Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

19. "Medical Education" means direct costs associated with an approved intern and resident teaching program as defined in, the Medicare Provider Reimbursement Manual, HCFA Publication 15-I, Section 404.1
20. "Medical Education Adjustment" (Section III.D.5.), means the adjustment to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to compensate a Provider for Medicaid's fair share of the expenses of participating in medical education.
21. "New Provider" means a Provider that began operations before January 1, 1993, but does not have a cost report in the Base Year that reflects at least a full twelve months of operations.
22. "Nonprofit Provider" means a Provider that is organized as a nonprofit corporation and is generally exempt from state general excise and federal income taxes.
23. "Operating Year" means the twelve consecutive month period beginning on the latest of the following dates:
 - a. July 1, 1990; or
 - b. The date that a hospital becomes a Provider.
24. "Outlier Claim" means any claim which has total charges in excess of the Outlier Threshold, provided, however, that an Outlier Claim does not cease to have that status by reason of a subsequent increase in the Outlier Threshold.
25. "Outlier Threshold" means \$35,000 increased by the cumulative Inflation Adjustment since the state fiscal year ending June 30, 1987; provided, however, that the Department may round the figure to the nearest thousand dollars. For the state

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fiscal year beginning July 1, 1994, the Outlier Threshold is \$53,000. Effective with the State fiscal years beginning July 1, 2000 and July 1, 2001, the Outlier Thresholds are increased by the inflation factor resulting in an Outlier Threshold of \$64,000 for the State fiscal year beginning July 1, 2000.

26. "Outpatient" means a patient who receives outpatient services at a hospital which is not providing the patient with room and board and other inpatient services at least overnight. Outpatient includes a patient admitted as an inpatient whose inpatient stay is not overnight, except in cases where the patient expires in the facility.
27. "PPS" means the prospective payment system that is established by this Plan.
28. "Plan" means this document.
29. "Proprietary Provider" means a Provider that is organized as a for-profit entity and is subject to state general excise and federal income taxes.
30. "Provider" means a qualified and eligible facility that contracts with the Department to provide institutional acute care services to eligible individuals.
31. "Rebasing" means calculating the Basic PPS Rates by reference to a new Base Year and new Base Year Cost Reports.
32. "ROE/GET Adjustment" means the adjustment to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to provide Medicaid's fair share of a return on the investment that a Proprietary Provider has made in its facility and for Medicaid's fair share of the general excise taxes that it pays the State of Hawaii, as calculated under this Plan.
33. "Routine services" means daily bedside care, such as room and board, serving and feeding patients, monitoring life signs, cleaning wounds, bathing, etc.
34. "Severity and Case Mix Adjustment" means an increase of 2% to the All-Inclusive Rate of the Classification IV facility.

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35. "Special Care Percentage" means the result of dividing the Medicaid special care days for a given cost reporting period by the total Medicaid days for the same period. The days reported in the nursery cost center on the cost report shall be excluded from the calculation.

36. "Total All-Inclusive Rate" means the All-Inclusive Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total All-Inclusive Rate is the result of multiplying the following components of the total rate for each Provider or category of payments that has an All-Inclusive Rate:

- (All-Inclusive Rate)
- (ROE/GET Adjustment [if applicable])
- (Medical Education Adjustment Factor [if applicable])
- (Severity and Case Mix Adjustment
[if applicable])
- (cumulative Inflation Factor)

37. "Total Per Diem Rate" means the Basic Per Diem Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total Per Diem Rate is the result of the multiplying the following components of the total rate in each category for which the Provider has a Basic Per Diem Rate:

- (Basic Per Diem Rate)
- (ROE/GET Adjustment [if applicable])
- (Medical Education Adjustment Factor [if applicable])
- (cumulative Inflation Factor)

38. "Total Per Discharge Rate" means the Basic Per Discharge Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total Per Diem Rate is the result of multiplying the following components of the total rate in each category for which the Provider has a Basic Per Diem Rate:

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(Basic Per Discharge Rate)
(ROE/GET Adjustment [if applicable])
(Medical Education Adjustment Factor [if applicable])
(cumulative Inflation Factor)

- 39. "Waitlisted patient" means a patient who no longer requires acute care and is awaiting placement to a long-term care facility.

E. SERVICES INCLUDED IN THE PROSPECTIVE PAYMENT RATE

The prospective payment rate shall include all services provided in an acute inpatient setting except:

- 1. Professional component, including physician services or any other professional fees excluded under Part A Medicare;
- 2. Ambulance; and
- 3. Durable medical equipment (except for implanted devices) that the patient takes home after he or she is discharged.

II. PREPARATION OF DATA FOR PROSPECTIVE PAYMENT RATE CALCULATION

A. SOURCE

- 1. The calculation of prospective payment rates shall be based on facility-specific claims and cost data, as follows:
 - a. Cost data shall be abstracted at the time the rate calculation begins from finally-settled uniform cost reports submitted to the Department by each Provider in accordance with federal Medicaid requirements.
 - b. The cost report used for each facility shall be the facility's report which ended during the state fiscal year selected as the Base Year.
 - c. Supplemental costs reporting forms submitted by providers shall be used as necessary. Claims data shall be derived from claims

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submitted by Providers for Medicaid reimbursement.

- d. For Rebasing, the latest available claims data for a two fiscal year period shall be used. Claims that are paid by December 31 of the year following the year in which the last fiscal year included in the data collection effort ends shall be considered as a paid in the fiscal year when the service was rendered.
- 2. Additional cost data supplied by Providers shall be utilized to update cost data only as specified in this plan. For Rebasing, Providers will be given an opportunity to submit cost data similar in nature to that included in the TAC cost reports, excluding Capital Related Costs.
- 3. Inflation in the costs of delivering Inpatient hospital services shall be recognized by using the Inflation Factor (Section I.D. 17) provided that no inflation adjustment shall be applied in determining the rates for the 4th quarter of FFY 2013, FFY 2014 and the 1st, 2nd, and 3rd quarters of FFY 2015.

B. CLASSIFICATION OF ACUTE INPATIENT FACILITIES

- 1. For purposes of establishing the PPS rates, acute Inpatient facilities shall be classified into the following four mutually exclusive groups:
 - a. Classification I - Facilities averaging less than 250 Medicaid discharges per year;
 - b. Classification II - Facilities averaging 250 Medicaid discharges per year or more, which do not participate in approved intern and resident teaching programs;
 - c. Classification III - Facilities averaging 250 Medicaid discharges per year or more which participate in approved intern and resident teaching programs; and
 - d. Classification IV - The freestanding rehabilitation hospital.

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2. Facility classification changes shall only be recognized at the time of a Rebasing. If a facility changes classification in accordance with the definitions above, then rates established under this Plan shall continue to apply until the Rebasing. A facility that adds an approved intern and resident teaching program, however, may seek rate reconsideration under Section V.C.1.c.

C. SERVICE CATEGORY DESIGNATIONS

1. Services provided by acute inpatient facilities shall be classified into four mutually exclusive categories:
 - a. Maternity - An inpatient stay which results in a delivery with a maternity principal or secondary diagnosis code;
 - b. Surgical - An inpatient stay with the following characteristics:
 - (1) the claim has not been classified as a maternity claim;
 - (2) the claim includes a surgical code that is considered to be an operating room procedure in the latest and most current version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and
 - (3) the claim includes either:
 - (a) a surgical date; or
 - (b) an operating room charge.
 - c. Psychiatric - An inpatient stay with a primary psychiatric principal diagnosis code and with no operating room charge; or
 - d. Medical - An inpatient stay not classified into one of the above three service categories.

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D. PREPARATION OF DATA FOR CALCULATION OF BASE YEAR

PROSPECTIVE PAYMENT RATES

1. Base Year Claim Charge Data shall be prepared in order to establish charge ratios used in the payment calculation.
 - a. Claim Charge Data for all Medicaid claims shall be considered based on dates of discharge which correspond to each facility's fiscal year end. Medicare cross-over claims shall be excluded from the calculation.
 - b. If more than one year of Claim Charge Data is used, the charges reflected on the earlier year's claims data shall be inflated to the period covered by the most recent year's claims data in accordance with Section II.A.3.
 - c. Claims shall be edited and properly classified.
 - d. Claim Charge Data, including charge amounts, days of care, and number of discharges, shall be classified into the four service categories identified in Section II.C.1. Combined claims for the delivery of a normal newborn shall be counted as one discharge in the calculation process. Claims for newborns described in Section III.E.1.e shall be classified into the appropriate service category.
 - e. Claim charge data for surgical, maternity, and medical claims in Classification II and III facilities shall be segregated into routine, special care, and ancillary service charges. Nursery charges shall be included in the routine charges.
 - f. Claim Charge Data shall be adjusted in the case of Classification II and III facilities to delete nonpsychiatric ancillary claim charges associated with claims in excess of

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the Outlier Threshold in effect for the Base Year.

- g. Claim Charge Data shall be adjusted to delete ancillary charges for wait listed patients.
2. Cost report data, including costs, days, and discharges, shall be extracted from Base Year cost reports and shall be prepared in order to determine Medicaid allowable inpatient facility costs.
- a. Cost of services excluded under Section I.E. shall be deleted from costs for purposes of the prospective rate calculation. This process shall involve identifying items pertaining to the excluded services and subtracting these costs from the cost report data.
 - b. Costs in excess of federal Medicare cost reimbursement limitations shall be deleted from costs for purposes of the prospective rate calculation. Costs which are not otherwise specifically addressed in this plan shall be included in a Base Year if they comply with HCFA Publication 15 standards. Capital costs associated with the revaluation of assets for any reason or due to a change in ownership, operator, or leaseholder where such revaluation occurred after July 18, 1984 shall be identified and excluded. Costs in excess of charges shall not be deleted from costs for the purpose of the prospective rate calculation.
 - c. Allowable Medicaid inpatient facility costs shall be determined separately for routine and ancillary costs. Nursery costs shall be combined with other routine costs and reclassified into the routine service component.
 - d. The Medicaid inpatient portion of malpractice costs shall be determined by multiplying the ratio of Medicaid inpatient costs to total costs by the facility's total malpractice

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costs. This amount shall be added to allowable Medicaid inpatient facility costs.

- e. To recognize costs differences due to varying fiscal year ends and annual inflationary increases, allowable Medicaid inpatient facility costs shall be standardized and inflated as described in Section III.G.
- f. Capital, medical education, and for Proprietary Providers, return on equity and gross excise tax amounts, shall be deleted from allowable Medicaid inpatient facility costs and shall be reimbursed in accordance with Section III.D.
- g. Except as stated in Section I.E., services provided to patients during an inpatient stay but billed by a provider other than the inpatient facility shall be added to allowable Medicaid inpatient facility costs. To obtain the estimated amount, the Department shall survey facilities and accept reasonable estimates of such services.
- h. In computing the nonpsychiatric ancillary per discharge rates, the total ancillary costs and discharges associated with nonpsychiatric outlier claims and the ancillary costs associated with wait listed patients shall be deleted from allowable Medicaid inpatient facility costs and discharges based on the claim charge ratios identified in Section II.D.1. above. Routine costs and days related to the outlier claims shall be included in inpatient costs and days extracted from the costs reports and used in computation in the prospective payment rates. Routine costs and days related to wait listed patients shall not be extracted from the cost reports and shall be excluded from the computation of the inpatient rates.

III. CALCULATION OF BASE YEAR PROSPECTIVE PAYMENT RATES

A. PSYCHIATRIC SERVICES

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1. A base per diem rate for acute psychiatric inpatient services shall be established for all inpatient facilities using the following general methodology:
 - a. Deduct the Capital Related Costs allocated to psychiatric services on the Base Year cost report.
 - b. Establish facility-specific ratios from Claim Charge Data for psychiatric routine, special care, and ancillary charges and days to total routine, special care, and ancillary charges and days.
 - c. Multiply the ratios in paragraph (b), by total Medicaid inpatient costs, excluding Capital Related Costs and days for routine, special care, and ancillary to achieve total psychiatric routine, special care, and ancillary Medicaid inpatient costs and days as derived from the cost report.
 - d. Sum the resulting psychiatric costs and days for routine, special care, and ancillary and achieve a facility-specific average Medicaid psychiatric cost per day by dividing total psychiatric Medicaid inpatient cost by total psychiatric inpatient Medicaid days.

2. A psychiatric per diem rate ceiling which applies to all facilities statewide shall be calculated in the following manner:
 - a. Total the costs, excluding Capital Related Costs, and days for all psychiatric services for all facilities, as identified in (1). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
 - b. Divide the total psychiatric inpatient costs calculated in paragraph (a) by total psychiatric inpatient days; and

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- c. Multiply the result of paragraph (b) by the statewide psychiatric ceiling factor of 1.15. This result shall be the statewide Base Year per diem rate ceiling for psychiatric services.
3. The prospective payment rate for psychiatric services for all facilities shall equal the lesser of either the facility-specific per diem rate or the per diem rate ceiling for inpatient psychiatric services.

B. CLASSIFICATION I - NONPSYCHIATRIC SERVICES

- 1. A base per diem rate for nonpsychiatric services for Classification I facilities shall be established using the following general methodology:
 - a. Deduct the Capital Related Costs allocated to nonpsychiatric services on the Base Year cost report.
 - b. Calculate nonpsychiatric inpatient Medicaid facility costs and days for all facilities in Classification I by subtracting the facility's psychiatric costs and days for routine, special care, and ancillary services as specified in Section III.A. from the facility's total allowable Medicaid inpatient costs and days for routine, special care, and ancillary services as derived from the cost report and as calculated in Section II.D.
 - c. Sum the resulting costs, excluding Capital Related Costs, and days for routine, special care, and ancillary services and achieve a facility-specific Medicaid inpatient nonpsychiatric cost per day by dividing total nonpsychiatric Medicaid costs by total nonpsychiatric inpatient Medicaid days. Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;

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2. The Classification I per diem rate ceiling for nonpsychiatric services shall be calculated as follows:
 - a. Total the costs, excluding Capital Related Costs, and days for all nonpsychiatric services for all facilities in Classification I, as identified in (1). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
 - b. Divide total nonpsychiatric inpatient costs calculated in paragraph (a) by total nonpsychiatric inpatient days for all facilities in Classification I; and
 - c. Multiply the result of paragraph (b) by the nonpsychiatric Classification I ceiling factor of 1.20. This result shall be the Classification I per diem rate ceiling for nonpsychiatric facilities.
3. The prospective payment rate for Classification I facilities shall equal the lesser of either the facility-specific per diem rates or the Classification I per diem rate ceiling for nonpsychiatric inpatient services.

C. CLASSIFICATIONS II AND III - NONPSYCHIATRIC SERVICES

1. The facility-specific prospective payment base rates for nonpsychiatric services rendered in facilities in Classifications II and III shall be comprised of two separately established rate components, one per diem rate for routine services and one per discharge rate for ancillary services.
2. The facility-specific base routine per diem and per discharge ancillary rate for nonpsychiatric services for each service category (maternity, surgical and medical) shall be established using the following general methodology:

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- a. Deduct the Capital Related Costs allocated to nonpsychiatric services and ancillaries on the Base Year cost report.
 - b. Determine separately for each service category the ratio of nonpsychiatric claim charges, days, and discharges to total claim charges, days, and discharges associated with routine, special care, and ancillary components.
 - c. Multiply the ratios determine in (b) by total Medicaid inpatient days, discharges and costs, excluding Capital Related Costs.
 - d. Determine the routine per diem costs for each service category by dividing the sum of routine and special care costs, excluding Capital Related Costs, by the sum of routine and special care days as derived from the cost report.
 - e. Determine the facility ancillary cost per discharge for each service category by dividing the ancillary service costs, excluding Capital Related Costs, by the discharges as derived from the cost report.
3. The Base Year per diem rate component ceiling shall be calculated for each nonpsychiatric service category for all facilities in Classifications II and III as follows:
- a. For all facilities within a classification, total for each service category the routine costs, excluding Capital Related Costs, and days identified in (2). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
 - b. Divide the total costs calculated in paragraph (a) above for each service category by the total patient days;

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- c. Multiply the result for each facility classification by the nonpsychiatric Classification II and III ceiling factor of 1.20; and
 - d. The result shall be the per diem rate component ceiling for nonpsychiatric services for each service category within each facility classification.
4. A facility's prospective payment rate component for routine services for each nonpsychiatric service category shall equal the lesser of either the facility-specific base rate component or the per diem rate ceiling for the appropriate facility classification.
5. The ancillary services per discharge rate component ceiling shall be established separately for each service category in the following manner:
- a. For all facilities within a classification, total the ancillary costs, excluding Capital Related Costs, and discharges within each nonpsychiatric service category. Any average per discharge amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
 - b. Divide the total costs calculated in paragraph (a) above by total discharges for each service category;
 - c. Multiply the result of paragraph (b) for each facility classification by the nonpsychiatric Classification II and III ceiling factor of 1.20; and
 - d. The result shall be the ancillary rate component ceiling for nonpsychiatric services for each nonpsychiatric service category within each facility classification.
6. A facility's prospective per discharge base payment rate component for ancillary services for each nonpsychiatric service category shall equal

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the lesser of either the facility-specific per discharge base rate or the per discharge rate ceiling for the appropriate facility classification.

D. ADDITION OF FACILITY-SPECIFIC FACTORS

1. A facility's Basic Per Diem and Per Discharge Rates, as determined above, shall be adjusted to recognize factors that are specific to that Provider. Those adjustments may include the Medical Education Adjustment and/or the ROE/GET Adjustment. Eligible Providers shall also receive payments in addition to the Basic Per Diem and Per Discharge Rates (e.g., Capital Payments).

2. The Capital Payments shall be determined and paid as follows:
 - a. The interim Capital Payments shall be determined according to the general procedures that are used to reimburse hospitals that are exempt from the Federal PPS for capital costs under Medicare (and prior to the implementation of the Medicare capital PPS), except that Capital Related Costs shall be reduced by 10%. At the option of the Department, the following procedure may be utilized:
 - (1) Each facility shall identify its Capital Related Costs associated with providing acute care services. If a facility provides both acute and distinct part long term care services, only the Capital Related Costs associated with acute care shall be identified.
 - (2) Each facility shall submit an estimate of its allowable Capital Related Costs and projected Medicaid utilization for each PPS rate year. The projected Medicaid utilization shall be based upon the ratio of Medicaid patient days to total patient days.

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- (3) The Department shall review the estimates for reasonableness and determine an amount of projected allowable Capital Related Costs for each facility.
- (4) The projected allowable Capital Related Costs (less 10%) shall be divided by 12.
- (5) The product of the foregoing computation shall, at the Department's option, be multiplied either by the facility's projected Medicaid utilization rate or by the facility's actual Medicaid utilization (based upon the ratio of Medicaid patient days to total patient days) reflected in the most recently filed cost report.
- (6) The net result shall constitute the interim Capital Payment, which shall be paid on a monthly basis throughout the fiscal year.

b. The final Capital Payment shall be determined as follows:

- (1) After the end of the fiscal year, the Department shall adjust and settle the Capital Related Costs of each facility based upon information reflected in the finally settled cost reports that cover the fiscal year under review.
- (2) Capital Related Costs shall follow the Medicare PPS capital pass through methodology in 42 C.F.R. Part 413, Subpart G, as of 10/1/87.
- (3) A provider may appeal the Department's final settlement of Capital Related Costs in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules (see appendix to state plan). The Department

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may settle tentatively on the Capital Related Costs.

- 3. For Proprietary Providers, the ROE Adjustment, which represents a hospital's percentage of return on equity received in the Base Year under Medicare cost reimbursement principles, shall be determined as follows:
 - a. Divide the total allowed Medicaid inpatient return on equity amounts by allowed Medicaid inpatient total costs; and
 - b. The results shall be added to 1.00 to obtain the return on equity adjustment factor.
- 4. All Providers that participate in an approved teaching program shall receive the Medical Education Adjustment, calculated as follows:
 - a. Divide allowed Medicaid inpatient medical education costs by total allowed Medicaid inpatient total costs; and
 - b. The result shall be added to 1.00 to obtain the medical education adjustment factor.
 - c. For New Providers, the medical education factor shall be determined as part of the rate reconsideration process as authorized in Section V.C.1.c.

E. FINAL PROSPECTIVE PAYMENT CALCULATIONS

- 1. Based on the PPS rates as adjusted in Section III.D. above and inflated in Section III.G. below, a facility's payment for each inpatient stay in each classification shall be calculated as follows:
 - a. For psychiatric discharges, multiply the Total All-Inclusive Rate for a psychiatric discharge by the number of days of the psychiatric inpatient stay. The result shall be the payment for a psychiatric discharge;

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- b. For nonpsychiatric service discharges in Classification I facilities, multiply the Total All-Inclusive Rate for the discharge by the number of days of the inpatient stay. The result shall be the payment for a nonpsychiatric service discharge.
- c. For surgical, maternity, and medical service discharges in Classification II and III facilities, calculate the prospective payment for each facility as follows:
 - (1) Multiply the Total Per Diem Rate component for the appropriate nonpsychiatric inpatient service category by the number of days of care for each service category for the inpatient discharge;
 - (2) Add the Total Per Discharge Rate for the appropriate service category; and
 - (3) The result shall be the payment for each nonpsychiatric service discharge.
- d. If a woman delivers a child, then payment for the mother and baby shall be made separately. A per diem payment shall be made separately for care delivered to a normal newborn based on the costs and days associated with nursery care.
- e. The following situations shall not be considered as constituting care that is delivered to a normal newborn, and shall be reimbursed as indicated:
 - (1) If it is medically necessary for the baby to remain in the hospital more than six days following birth (including the birthday), then the payment shall be determined separately based on the same criteria as any other discharge;
 - (2) If the claim form for services delivered to the newborn indicates an intensive

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care unit revenue code, then the payment for a medical case shall be made; or

(3) If both of the following requirements are met:

(a) the claim form reflects information that would result in the claim being characterized as a surgical case under Section II.C.1.b; and

(b) the newborn remains in the hospital for more than three days; then the payment for a surgical case shall be made.

2. Payment shall be made under the prospective payment rate based on the date of discharge, except as provided in Sections I.C.6., I.C.9. and IV.D.

3. In addition, each Provider shall receive the Capital Payments defined in Section III.D.2.F

F. ADJUSTMENT TO PROSPECTIVE PAYMENT RATE FOR PUBLIC HOSPITALS

1. All publicly owned and operated hospitals shall receive an adjustment to their rate to cover otherwise uncompensated costs of serving Medicaid-eligible patients. The adjustment shall be equal to the difference between the final prospective payment rate as determined in accordance with section III.E and the allowable cost of serving a Medicaid-eligible patient.

2. Publicly owned and operated hospitals shall certify their otherwise uncompensated costs of serving Medicaid-eligible patients, which shall be the basis for claiming federal

G. FACILITIES WITH SPECIAL PROSPECTIVE PAYMENT RATE CONSIDERATIONS

1. For a facility with insufficient observations (less than five claims) in a given service category, the PPS rate shall be calculated using the weighted average for the applicable service category for the facility's classification.

2. PPS rates for Classification IV, the freestanding rehabilitation hospital, shall be calculated in the following manner:

a. Facility-specific claims and charge data shall be prepared in accordance with Section II.D.

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- b. A facility-specific per diem base rate for psychiatric services shall be calculated in accordance with Section III.A.
- c. A facility-specific per diem base rate for nonpsychiatric services shall be calculated by dividing total nonpsychiatric costs, excluding Capital Related Costs, for the hospital by nonpsychiatric Medicaid patient days.
- d. The facility specific factors shall be computed or reimbursed as defined in Section III. D.

H. ADJUSTMENT TO BASE YEAR COSTS FOR INFLATION

Cost increases due to varying fiscal year ends and inflation shall be recognized for purposes of establishing prospective payment rates in accordance with the following general methodology.

- 1. Base year facility-specific costs shall be standardized to remove the effects caused by varying fiscal year ends of the facility. This shall be accomplished by dividing the Inflation Factor for the Base Year, as determined in accordance with Section II.A.3. by 12 and multiplying this result by the number of months between the hospital's Base Year fiscal year end and June 30 of each year. This result shall be added to 1.00 to yield an inflation adjustment factor which shall then be multiplied by the facility-specific costs.
- 2. Cost increases due to inflation which occurred from the Base Year shall utilize the inflation factor specified in Section II.A.3.
- 3. For years in which the Department does not Rebase the PPS rates, cost increases due to inflation shall be recognized by multiplying the Total All-Inclusive, Total Per Diem and Total Per Discharge Rates in effect for the fiscal year by one plus the Inflation Factor for the following fiscal year. To insure the prospective nature of the PPS, the inflation factor shall not be retroactively adjusted nor modified, except as noted below.
- 4. For years in which the Department does not Rebase and in which the Inflation Factor for the prior year was reduced pursuant to Section III.G.6.,

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then the average rates for the prior fiscal year shall be deemed to be the rates in effect on June 30.

5. For each year in which the Department does Rebase, cost increases due to inflation shall be recognized by multiplying the Base Year rates by one plus the Inflation Factor for each subsequent year, using the most current and accurate Inflation Factor data then available. To insure the prospective of the PPS, that data shall not be retroactively adjusted nor modified.

6. Absent circumstances beyond the control of the Department before the expiration of six months in each fiscal year the Department shall determine whether the aggregate amount of reimbursement for the state fiscal year is projected to exceed the amount that would be paid for the same services under Medicare principles of reimbursement. In making the determination, the Department shall exclude sums paid pursuant to Section III.D.1. or any exception to or exemption from the ceilings on rate of hospital cost increases as defined pursuant to 42 C.F.R. Part 413. In making its determination, the Department shall use the most current information available, including the most recent cost reports filed by the facilities. If the projected aggregate amount of reimbursement is reasonably anticipated to exceed the amount that would be paid under Medicare principles of reimbursement, then the Department shall reduce the Inflation Factor used to calculate the rates for the remainder of the fiscal year so that the aggregate payments for the entire fiscal year are reasonably projected to be no more than that which would be paid under Medicare principles of reimbursement.

IV. SPECIAL PAYMENT PROVISIONS

A. TREATMENT OF NEW FACILITIES

1. Rates for new Providers shall be calculated by a separate method. A New Provider shall receive a statewide weighted average payment rates for

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its classification times the following New provider adjustment factor:

- a. First Operating Year 150%;
 - b. Second Operating Year 140%;
 - c. Third Operating Year 130%; and
 - d. Fourth Operating Year and thereafter 125%.
 - e. If a facility's Operating Year does not coincide with the PPS fiscal year, then the New Provider's rates shall be prorated based on the PPS fiscal year. For example, a New Provider that begins its First Operating Year on January 1 would receive 145% of the statewide weighted average payment rates for its classification for the entire PPS fiscal year that begins on the immediately following July 1.
2. Capital Related Costs shall be reimbursed as defined in Section III.D.2 and 3.
 3. For New Providers that are also Proprietary Providers, the PPS rates shall also be adjusted by ROE and GET Adjustments, (Section III.D.3.). Those factors shall be based on projected costs and receipts and calculated as defined in the Plan.
 4. A New Provider may seek rate reconsideration under Section V.C.1.c if it adds an approved intern and resident teaching program.
 5. Notwithstanding the foregoing, a Provider that begins operations after January 1, 1993, shall receive the statewide weighted average per diem and per discharge rates for its classification.
 6. A New Provider shall have its PPS rates determined under this section until a Rebasing occurs that identifies a Base Year in which the New Provider has a cost report that reflects a full twelve months of operations. Thereafter, its PPS rates

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shall be based on its Base Year cost report like all other Providers.

B. PAYMENT FOR TRANSFERS

1. A hospital inpatient shall be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility.
2. A hospital which receives a transfer and subsequently discharges that individual shall be considered the discharging hospital. All other hospitals which admitted and subsequently transferred the patient during a single spell of illness shall be considered transferring hospitals.
3. The service category into which the patient falls at the time of transfer or discharge shall be considered the appropriate service category for purposes of payment to that facility.
4. If a Classification I or IV facility transfers an inpatient to another Classification I or IV facility, then both facilities shall receive their All-Inclusive Rates.
5. If a Classification I or IV facility transfers an inpatient to a Classification II or III facility, the Classification I or IV facility shall receive its All-Inclusive Rate, and the Classification II or III facility shall receive the full per diem and ancillary reimbursement rates defined in Section III.E.
6. If a Classification II or III facility transfers an inpatient to another acute inpatient facility:
 - a. In the nonpsychiatric cases, where medical necessity requires that the patient remain in the transferring hospital three or more days or that the patient be cared for in the intensive care or coronary care units, the transferring Classification II or III facility shall receive the full per diem rate for routine care and the full ancillary

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discharge rate for the appropriate service category, as calculated in accordance with Section III.E.

- b. For nonpsychiatric cases of less than three days and not involving intensive care, payment to a transferring Classification II or III facility shall be the facility-specific per diem rate for routine care and 30 percent of the ancillary discharge rate for the appropriate service category, as calculated in accordance with Section III.E.
 - c. For nonpsychiatric services, payment to a discharging Classification II or III facility shall be the full prospective payment rates calculated in Section III.E. of these rules.
 - d. For nonpsychiatric services, payment to a discharging Classification I facility or, Classification IV facility, shall be determined by multiplying the number of days of stay in the discharging facility by the per diem calculated in Section III.E or F.2, respectively.
 - e. For psychiatric services, payment to any transferring or discharging facility shall be determined by multiplying the number of days of stay by the per diem calculated in Section III.E.
7. Transfers shall be subject to utilization review, and the Department may deny full or partial payment to either the transferring or discharging facility if it is determined that the transferring facility was able to provide all required care or that a patient was held three days or more or placed in intensive care when it was not medically necessary.
8. For the purposes of determining Capital Related Costs associated with transfers, all days and charges associated with services rendered by each facility to the transferred patient shall be included in that facility's computation.

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C. PAYMENT FOR READMISSION

1. Readmissions to the same facility within 24 hours of discharge for the same spell of illness and for the same general diagnosis as the original admission shall be considered to be the same admission and shall be billed as a single stay. The Department may deny full or partial payment for the original inpatient stay or the subsequent readmission if it is determined that the facility should have provided all required services during the original inpatient stay. This section shall not apply in cases where a patient leaves the hospital against medical advice.
2. Readmission to the same facility within 30 days of a previous discharge for similar diagnosis shall be subject to utilization review. The Department may deny full or partial payment for the original stay or the subsequent readmission if it is determined that the facility should have provided all required services during the original inpatient stay. This section shall not apply in cases where a patient leaves the hospital against medical advice.

D. PAYMENT FOR NONPSYCHIATRIC CASES WHICH EXCEED THE OUTLIER THRESHOLD

1. If charges for nonpsychiatric services rendered to a patient during an inpatient stay are in excess of the Outlier Threshold, then billing and payment for this stay shall be as follows:
 - a. For Classification I facilities, and Classification IV facilities, payment will be made at applicable per diem rates for the full inpatient stay.
 - b. For Classifications II and III facilities:
 - (1) An initial interim bill shall be submitted covering the period from the admission date through the date that the charge for the case reaches the Outlier Threshold. Payment for this interim bill shall be the classification per

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diem rate for the service category multiplied by the number of days covered by the bill plus the full appropriate ancillary rate as calculated in Section III.E.

- (2) Sixty days after a patient reaches outlier status, monthly thereafter, and upon discharge, a facility shall bill the Department for charges in excess of the outlier threshold. The facility shall also document to the Department's reasonable satisfaction the medical necessity for the days of care and services rendered. The Department shall pay such bills that are appropriately documented and properly within the scope of the acute care Medicaid program no less than quarterly. The Department shall pay for the full per diem and 80% of the ancillary charges, excluding amounts included in computing the Outlier Threshold. At the next Rebasing, the Department shall calculate a new percentage of ancillary charges that it will pay for Outlier Claims based upon the statewide weighted average ancillary cost to charge ratio.

- 2. For the purpose of determining Capital Related Costs associated with outlier cases, the full amount of charges shall be included in the facility's computation.

E. PAYMENT FOR SERVICES RENDERED TO PATIENTS WITH OTHER HEALTH INSURANCE

Medicaid is a secondary payor. In no case will Medicaid pay a sum, when considered in conjunction with payments from all other sources (including the patients cost share and Medicare), that exceeds the amount that would have been paid if no other source of reimbursement existed.

F. LIMITATIONS ON ACUTE CARE FACILITY PAYMENT

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1. Calculation of the prospective payment rate shall not be affected by a public provider's imposition of nominal charges in accordance with federal regulations. However, for providers whose charges are less than costs on the most recently filed cost report and who do not qualify as a nominal charge provider, the prospective rate shall be reduced during the interim until the applicable cost report is filed and a settlement adjustment made in accordance with Section I.C.2. The interim reduction shall be in proportion to the ratio of costs to charges on the most recent filed cost report. Updated data and charge structures may be provided to the state's fiscal intermediary if the provider believes its rate structure has changed significantly since the most recent filed cost report. But the state will be responsible for approving the final interim rate reduction necessary to approximate final settlement as closely as possible.
2. Payment for out-of-state acute care facility services shall be the lesser of the facility's charge the other state's Medicaid rate, or the weighted average Hawaii Medicaid rate applicable to services provided in comparable Hawaii facilities.
3. The Department or its utilization review agent may deny full or partial payment if it is determined that the admission or transfer was not medically necessary or the diagnosis or procedure code was not correctly assigned, or the patient was retained in the facility longer than necessary. The Department shall recovery amounts due using the most expedient methods possible, which shall include but not be limited to off setting amounts against current payments due providers.

V. CHANGES TO PROSPECTIVE PAYMENT RATES

A. ADJUSTMENTS TO BASE YEAR COST DUE TO AUDIT OR APPEAL OF AUDIT ADJUSTMENT

1. Changes subsequent to the initial determination of Base Year rates due to an audit of contracted services data reported on the provider's survey,

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or due to appeals of audit and adjustment made to costs reported on the based year cost report, shall not result in changes to the rate ceiling or classification group.

2. Base Year costs shall be adjusted to reflect the audit and appeal decisions, and the facility's specific prospective rates (including the impact of all adjustment factors) and reimbursement for Capital Related Costs rate shall be recalculated, effective the first day of the initial rate year in which those costs were used to compute the PPS rate, based on the adjusted Base Year cost, as long as the rate ceilings are not exceeded.

B. REBASING THE PROSPECTIVE PAYMENT RATES

The Department shall perform a Rebasing periodically so that a Provider shall not have its Basic per Diem and Per Discharge Rates calculated by reference to the same Base Year for more than eight state fiscal years; provided, however, that the duty to Rebase shall be suspended during the period that the 1115 research and demonstration waiver is in existence and for one state fiscal year thereafter.

C. REQUESTS FOR RATE RECONSIDERATION

1. Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the Base Year:
 - a. Extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, changes in Licensure law, rules or regulations, significant changes in case mix or the nature of service, or addition or new services occurring subsequent to the Base Year. Mere inflation of costs, absent extraordinary circumstances, shall not be grounds for rate reconsideration.
 - b. Reduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration.

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relief provided under this section shall be the lesser of actual growth in the cost per day since the Base Year or 75 percent of the reduction in the average cost per discharge (inflated) since the Base Year divided by the current average length of stay. In no case shall the add on exceed the actual ancillary and room and board costs of the facility.

- c. The addition of an approved intern and resident teaching program. This is the only circumstance that is eligible for a rate reconsideration request by a New Provider.

2. A Provider may also obtain a rate reconsideration if it provides an atypically high percentage of special care, determined as follows. In order to obtain the relief, the Provider must meet each of the tests and follow each of the procedures defined below:

- a. One or more of the facility's per diem rates is affected by the ceiling in its classification for that type of service;
- b. The percentage of the facility's Base Year Medicaid special care days over total Base Year Medicaid days (excluding days that are reported in the nursery cost center on the cost report) is greater than 150% of the same average for all other facilities in its classification. The data to perform the comparison shall be obtained from the Base Year Medicaid cost reports;
- c. The facility's average per diem costs for both general inpatient routine service and special care, excluding Capital Related Costs and medical education costs, are no greater than 120% of the weighted average for all other facilities in the same classification. The data to perform the comparison shall be obtained from the Base Year Medicaid cost reports;
- d. The Provider must analyze its Base Year costs and vary its Special Care Percentage to determine its Breakeven Point. This analysis

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shall be performed for each PPS rate that was affected by a component ceiling;

- e. The Provider must compute its Special Care Percentage based upon the most recent information available;
 - f. The Provider must certify to the Department in conjunction with its rate reconsideration request that, based upon its most recently filed cost report, the percentage defined in subsection b. continues to exceed 150% of the average for all other facilities in its classification during the Base Year. The certification shall be based upon a cost report classification method that is consistent with the method that the facility used in the Base Year Medicaid cost report;
 - g. The Provider must submit the results of all of the foregoing analyses and calculations, along with its certification, to the Department as part of its rate reconsideration request. For each rate category in which the most recent Special Care Percentage exceeds the Breakeven Point, the Provider shall have the applicable PPS rate increased by the amount that was it was reduced due to the application of the component ceilings. For each rate category in which the most recent Special Care Percentage is equal to or less than the Breakeven Point, the Provider shall receive no increase in its PPS rates.
3. Requests for reconsideration 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:

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- a. A presentation of data to demonstrate reasons for the hospital's request for rate reconsideration.
 - b. If the reconsideration request is based on changes in patient mix, then the facility must document the change using diagnosis related group case-mix index or other well-established case-mix measures, accompanied by a showing of cost implications.
4. A request for reconsideration shall be submitted within 60 days after the prospective rate is provided to the facility by the Department or at other times throughout the year if the Department determines that extraordinary circumstances occurred. The addition of an approved intern and resident teaching program shall be one example of that type of extraordinary circumstance that justifies a mid-year rate reconsideration request.
 5. The provider shall be notified of the Department's discretionary decision in writing within a reasonable time after receipt of the written request.
 6. Pending the Department's decision on a request for rate reconsideration, the facility shall be paid the prospective payment rate initially determined by the Department. If the reconsideration request is granted, the resultant new prospective payment rate will be effective no earlier than the first date of the prospective rate year.
 7. A provider may appeal the Department's decision on the rate reconsideration. The appeal shall be filed in accordance with the procedural requirements of Chapter 17-1736, administrative rules (see appendix to state plan).
 8. Rate reconsiderations granted under this section shall be effective for the remainder of the prospective rate year. If the facility believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection 2 within 60 days of

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the notice of the facility's rate for each subsequent rate year. The Department shall review the documentation and notify the facility of its determination as described in subsection 4 above.

- 9. The Department may, at its discretion, grant a rate adjustment which is automatically renewable until the Base Year is recalculated.
- 10. Rate increases will be paid as a lump-sum amount.

VI. REPORTING REQUIREMENTS
A. COST REPORTING REQUIREMENTS

- 1. All participating acute care facilities shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.
- 2. Participating facilities shall submit the following on an annual basis no later than five months after the close of each facility's fiscal year:
 - a. Uniform Cost Report;
 - b. Working Trial Balance;
 - c. Provider Cost Report Questionnaire;
 - d. Audited Financial Statements if available; and
 - e. Disclosure of Appeal Items Included in the Cost Report.
 - f. A listing of all Medicaid credit balances showing information deemed necessary by the State, and copies of provider policies and procedures to review Medicaid credit balances and refund overpayments to the State.
- 3. Claims payment for services will be suspended 100 percent until an acceptable cost report submission is received. A 30 day maximum extension will be granted upon written request only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.
- 4. Each provider shall keep financial and statistical records of the cost reporting year for at least

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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.

B. AUDIT REQUIREMENTS

1. The Department or its fiscal agent shall conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating Providers in each Provider classification.
2. Reports of the on-site or desk audit findings shall be retained by the Department for a period of not less than three years following the date of submission of the report.
3. Each Provider shall have the right to appeal audit findings in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules (see appendix to state plan).

VII. WAITLISTED PATIENTS

A. Payments for waitlisted patients shall reflect the level of care required by the patient. The facility shall receive a routine per diem for each day that a waitlisted patient remains in the acute care part of the facility. Room and board waitlisted rates are to be determined based upon the statewide weighted average costs of providing either Acuity Level A or C services by distinct part facilities per the Medicaid long term care prospective payment rate calculations with the following exceptions:

1. The waitlisted rates cannot exceed the facility's own distinct part Acuity Level A or C prospective payment rates.
2. A facility with a distinct part SNF, but no ICF, would have an Acuity Level A waitlisted rate based on the statewide weighted average (but not to exceed the facility's distinct Acuity Level C PPS rate).
3. In no case will any relief granted under rate reconsideration be used to adjust the waitlisted rates.

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- B. Waitlisted rates shall be annually adjusted by the same inflation factors as the long term care PPS rates.
- C. In all cases, the payment rate under this Plan for Waitlisted long term care patients in acute care beds does not include ancillary services except for medical supplies and maintenance therapy. These excluded ancillary services must therefore be billed separately. Payments will be consistent with the ancillary rates paid to long-term care facilities.

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VIII. DISPROPORTIONATE SHARE PAYMENTS

A. DEFINITIONS

In this Section VIII, the following definitions apply:

1. "DSH" means disproportionate share hospital.
2. "DSH provider" means a hospital that meets the following tests:
 - a. Either --
 - (i) Has at least two obstetricians with staff privileges at the facility who have agreed to provide obstetric services to individuals who are eligible for assistance under the Medicaid program; or
 - (ii) Did not offer non-emergency obstetric services as of December 21, 1987;
 - b. Has a Medicaid utilization rate equal to or greater than one (1) percent.
 - c. The above qualifying DSH providers will include those hospitals meeting 42 USC 1396r-4(b)(1).
3. "Medicaid utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period or under the Med-QUEST 1115 waiver (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. For this purpose, the term 'inpatient day' includes each inpatient in the hospital, whether or not the individual is in a

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specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4. "Uncompensated care costs" means the costs of providing care to the uninsured, shortfall in reimbursement of the cost of providing inpatient and outpatient services under the QUEST managed care program, and any shortfall in reimbursement of the cost of providing inpatient or outpatient services on a fee-for-service basis to Medicaid eligible patients. The State will adhere to the OBRA'93 hospital specific DSH limits (42 USC 1396r-4(g)) and is net of any profit earned on fee-for-service or managed care reimbursement. "Shortfall" means the cost of providing service less the payment received for the service, either pursuant to the state plan or pursuant to the section 1115 waiver and is net of any profit earned on fee-for-service or managed care reimbursement.
5. "Governmental DSH Provider" means a hospital meeting the tests in Paragraph 2 (above) that is owned and operated by the Hawaii Health Systems Corporation.

B. PAYMENT ADJUSTMENT

1. With respect to DSH State plan rate year ending September 30, 2012, DSH providers (which do not include Governmental DSH providers) shall receive payments from a pool of funds in the amount of one million, seven hundred and fifty thousand dollars (\$1,750,000.00) (total computable).
 - a. The distribution of funds from the pool shall be the basis of each qualifying hospital's proportionate share of uncompensated cost (as defined in paragraph A-4 above), as reported on the most recent available hospital cost reports.
 - b. In no event shall the total payments to a DSH provider for DSH State plan rate year ending September 30, 2012 exceed the uncompensated care costs of the provider for DSH State plan rate year ending September 30, 2012. If the provider has uncompensated care costs attributable to DSH State plan rate year ending September 30, 2012 that are less than the amount of the payments that would be made to that provider pursuant to subparagraph (a) above (or to the payments redistribution described in this sentence), the payments to that provider shall be reduced to the amount of its uncompensated care costs attributable to DSH State plan rate year ending September 30, 2012 and the difference shall be distributed to the remaining DSH providers in accordance with subparagraph (a) above.
 - c. Any overpayment to a DSH hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other DSH hospitals in accordance with paragraph (a) above.
2. With respect to DSH State plan rate year ending September 30, 2012, Governmental DSH providers will receive DSH payments based on each qualifying governmental DSH hospital's uncompensated care cost (as defined in paragraph A-4 above) attributable to DSH State plan rate year ending September 30, 2012.
 - a. The federal share of the DSH payments to government hospitals under this paragraph 2., when combined with the federal share of the DSH payment made to DSH hospitals under paragraph 1., shall not exceed ten million (\$10,000,000.00).
 - b. No payment shall be made to any governmental hospital in excess of its total inpatient and outpatient hospital uncompensated care costs.

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c. In the event that the aggregate uncompensated care costs of the governmental DSH hospitals exceed the maximum allotment available for the governmental DSH hospitals, each governmental DSH hospital's uncompensated costs shall be reduced pro rata so that the aggregate of uncompensated costs is equal to the maximum allotment available for the governmental DSH hospitals. Any overpayment to a governmental hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other governmental DSH hospitals based on the proportion of each remaining hospital's uncompensated care cost to the aggregate of the remaining hospitals' uncompensated care costs.

3. With respect to DSH state plan rate year ending September 30, 2013 and after:

a. DSH providers (which do not include governmental DSH providers) shall receive payments from a pool of funds which equal to the total computable amount of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act, reduced by the twenty-five dollars (\$25.00) total computable amount for governmental DSH providers specified in paragraph 3.b below.

1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's proportionate share of uncompensated costs (as defined in paragraph A-4 above), as reported on the most recent available hospital cost reports.

Effective 10/01/2021, only for purposes of distribution of funds, each hospital's uncompensated costs will be adjusted as follows:

- a. Medicaid uncompensated costs will be limited to lower of Medicaid shortfall or all payments received for Medicaid hospital inpatient and outpatient claims.
- b. The uninsured uncompensated costs will be limited to lower of uninsured shortfall or Net Hospital Inpatient and Outpatient revenue less Medicaid Net Hospital Inpatient and Outpatient revenue.

2. In no event shall the total payments to a DSH provider for any DSH state plan rate year exceed the uncompensated care costs, as defined in paragraph A.4, of the provider for the same DSH state plan rate year. If the provider has uncompensated care costs attributable to DSH state plan rate year that are less than the amount of the payments that would be made to that provider pursuant to subparagraph (1) above (or to the redistribution described in this sentence), the payments to that provider shall be reduced to the amount of its uncompensated care costs attributable to DSH state plan rate

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year, and the difference shall be distributed to the remaining DSH providers in accordance with subparagraph (1) above.

3. Any overpayment to a DSH hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other DSH hospitals in accordance with subparagraph (1) above.
- b. Governmental DSH providers shall receive payments from a pool of funds in the total computable amount of twenty-five dollars (\$25.00).
1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's uncompensated care cost (as defined in paragraph A-4 above).
 2. The federal share of the DSH payments to governmental hospitals under this paragraph b., when combined with the federal share of the DSH payment made to DSH hospitals under paragraph 3.a., shall not exceed the federal share of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act.
4. No payment will be made to any hospital in excess of its total inpatient and outpatient hospital uncompensated care costs.

C. PAYMENT METHOD

Payments will be made in up to four installments for each DSH state plan rate year.

DSH payments for governmental DSH providers will be reconciled in accordance with the methodology set forth in the Protocol referred to in Section E.

D. SOURCE OF DATA

The calculations to be made in determining the payment amounts in accordance with section B.1. above shall be based on cost reports for each hospital's most current fiscal year concluded by June 30, 2011 for DSH state plan rate year ending September 30, 2012. For all subsequent state plan rate years, the payment amount calculations in section B.3.a shall also follow the same timing (e.g., cost reports for each hospital's most current fiscal year concluded by June 30, 2012 for DSH state plan rate year ending September 30, 2013). The calculations to be made in determining the payment amounts in accordance with sections B.2. and B.3.b. above shall be based on sources as specified in the cost protocol in section E below.

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E. COST PROTOCOL

Uncompensated cost of government DSH providers will be determined in accordance with the following Cost Protocol:

Government-Owned Hospital Uncompensated Care Cost (UCC) Protocol

Introduction

This protocol directs the method that will be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by this Section VIII (Disproportionate Share Payments).

Summary of Medicare Cost Report Worksheets

Expenditures will be determined according to costs reported on the hospitals' 2552 Medicare cost reports as follows:

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

- (i) overhead;
- (ii) routine;
- (iii) ancillary;
- (iv) outpatient;
- (v) other reimbursable; and
- (vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B

Allocates overhead (originally identified as General Services Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C

Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B. after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The governmentally operated hospitals (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost-to-charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any DSH payments to hospitals by the

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State related to this DSH computation will not be reflected in the payment received to determine hospitals' uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g. state-only, local-only, or state-local health programs).

Notes:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due five months after the end of the hospital's fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services cost from the Medicaid Fee For Service (Medicaid FFS), QUEST Integration (QI), and Uninsured population, less payments received from Medicaid FFS, (QI), and uninsured patients. Uncompensated care costs is defined consistently with 42 USC1396r-4(g).

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals reopening, or reconsideration shall be incorporated into the final determination.

Determination of Allowable Payment to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospital's (hospital) allowable UCC, the following steps must be taken to ensure Federal financial participation (FFP):

Annual Payment

Each hospital's annual DSH payments will be based on its filed Medicare cost reports for the spending year to which the payments apply or, if not available, for the most recent year for which a report is available. If a prior year cost report is used for the interim payment purposes, the annual payment will be determined as described below but using the data from that prior period, and such interim payment will then be first reconciled to the annual payment computed from the spending cost reporting period, as described below, once that spending year Medicare cost report is filed by the hospital.

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The annual payment is based on the calculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges, and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total cost of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS 2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private from differential cost from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center's per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets.

For outpatient UCC cost computation, each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the cost are included in the program costs described above, including payments from managed care entities, for serving QUEST Integration (QI) enrollees, will be included in the total program payments under this annual initial reconciliation process. Non-Medicaid payments, funding and subsidies made by a state or unit of local government will not be included in the total program payment offset.

Final Reconciliation Payment

Each hospital's annual DHS payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported under the final reconciliation payment.

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If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center's per diem and cost-to-charge ratios from the finalized Medicare cost report for the services period. The hospital will update the program charges to include only paid claims from Medicaid FFS and QUEST Integration (QI) in computing program cost for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured. Days, charges, and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payment will originate from the providers auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for Federal financial participation for the uncompensated care costs under this DSH process.

The inpatient and outpatient costs computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim DSH payments.

Payment that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, findings, and subsidies made by a state or unit of local government shall not be offset. Federal matching funds may be claimed for UCCs up to the hospitals' eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within six months after the issuance of all of the finalized government-owned hospital Medicare cost reports from each respective fiscal year. The State is responsible to ensure the accuracy of DSH amounts used for federal claiming.

If a hospital financial and cost reporting period does not coincide with the Medicaid State plan period for which the DSH UCC cost is being computed, the hospital's cost will be the computed based on its full cost reporting period, as prescribed above, and then allocated pro rata to a State plan period based on the number of months covered by the financial or cost reporting period that are included in the Medicaid State plan period.

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ATTACHMENT 4.19-A

IX. PUBLIC PROCESS

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN No. 07-005
Supersedes
TN No. 98-005

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