

99. Section 17-1739-53, Hawaii Administrative Rules, is repealed as follows:

["§17-1739-53 Definitions. As used in this subchapter:

"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.

"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. The 1983 state fiscal year shall be the base year for purposes of initial calculation of prospective payment rates.

"Break-even 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.

"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.

"Cash subsidies for patient services" means, without limitation, amounts appropriated by the state legislature or a local governmental entity, either as direct subsidies or general fund allotments, and paid to the provider.

"Charity care" means, without limitation, care for which the provider never expected or sought payment. Charity care includes care provided pursuant

to the Hill-Burton program, but excludes cash subsidies for patient services as defined above.

"Claim charge data" means charges and other information obtained from billing claim forms processed by the medicaid fiscal agent.

"Costs" means total finally-settled allowable costs of acute inpatient services, unless otherwise specified.

"Discharge" means the release of a patient from an acute care facility. The following events are considered discharges:

- (1) The patient is formally released from the hospital;
- (2) The patient is transferred to an out-of-state hospital;
- (3) The patient is transferred to a long-term care level or facility;
- (4) The patient dies while hospitalized;
- (5) The patient signs out against medical advice; or
- (6) In the case of a delivery where the mother and baby are discharged at the same time, release of 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.
- (7) A transfer shall be considered a discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in section 17-1739-70(f)(1).

"Disproportionate share adjustment" means the largest of the following adjustments:

- (1) Divide indigent acute inpatient days by total acute inpatient days. Each percentage point or fraction thereof in excess of fifteen per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment;
- (2) Calculate the facility's medicaid utilization rate and subtract one standard deviation above the statewide mean medicaid utilization rate. Each percentage point in excess of this standard deviation shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment. A calculation resulting in a fraction of a percentage point shall be

rounded up to the next percentage point. When the medicaid utilization rate equals the rate at one standard deviation point, it will be considered a fraction of a percentage point and rounded up; or

(3) Calculate the facility's low income utilization rate and subtract twenty-five per cent. Each percentage point or fraction thereof in excess of twenty-five per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment.

"Disproportionate share provider" means a facility that meets the following tests:

- (1) Either --
 - (A) 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
 - (B) Did not offer nonemergency obstetric services as of December 21, 1987; and
- (2) Either --
 - (A) Has indigent inpatient days equal to or greater than fifteen per cent of total acute inpatient days;
 - (B) Has a medicaid utilization rate equal to or greater than one standard deviation above the statewide mean medicaid utilization rate; or
 - (C) Has a low income utilization rate equal to or greater than twenty-five per cent.

In applying the foregoing, the medicaid and total days and revenues shall be obtained from the facility's most recently filed cost report or related financial information for the period covered by that cost report. The Supplemental Security Income days shall be determined by the department based on the most recent information obtained from the Health Care Financing Administration. All other information shall be obtained from the most recent and reliable data available at the time the computation is made.

"Distinct part" means that portion of an acute care facility that is licensed to and provides long-term care services under subchapter 2.

"Indigent" means an individual who is considered eligible for Supplemental Security Income (SSI) or medicaid, or both.

"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 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.

"Low income" means medicaid eligible and indigent patients.

"Low income utilization rate" means the sum of the following:

- (1) A fraction (expressed as a percentage)--
 - (A) The numerator of which is the sum (for a period) of (I) the total revenue paid the hospital for patient services under a state plan under Title XIX of the Social Security Act and (II) the amount of the cash subsidies for patient services received directly from state and local governments; and
 - (B) The denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies for patient services) in the period; and
- (2) A fraction (expressed as a percentage)--
 - (A) The numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period; and
 - (B) The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph 2(A) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a state plan approved under Title XIX of the Social Security Act).

"Medicaid utilization rate" means 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 the state plan approved under Title XIX of the Social Security Act in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

"Medical education" means direct costs associated with an approved intern and resident teaching program as defined in the Medicare provider reimbursement manual, publication HIM-15.

"New provider" means a provider that does not have a cost report in the base year that reflects at least a full twelve months of operations.

"Operating year" means the twelve consecutive month period beginning on the latest of the following dates:

- (1) The effective date of the plan amendment that adds this definition to the plan; or
- (2) The date that a hospital becomes a provider.

"Outlier claims" means any claim which has total charges in excess of the outlier threshold, as defined in the State Plan.

"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 in which the patient expires.

"Provider" means a qualified and eligible facility that contracts with the department to provide institutional acute care services to eligible individuals.

"Routine services" means daily bedside care, such as room and board, serving and feeding patients, monitoring life signs, cleaning wounds, bathing, etc.

"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.

"State plan" means the Hawaii medicaid State Plan for methods and standards for establishing payment rates - prospective reimbursement system for inpatient services.

"Wait listed patient" means a patient who no longer requires acute care and is awaiting placement to a long-term care facility." [Eff 11/13/95; am 01/29/96; R] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

100. Section 17-1739.1-2, Hawaii Administrative Rules, is repealed.

[“§17-1739.1-2 Definitions. As used in this chapter:

“Automated tests” means laboratory tests automatically conducted through a mechanical testing aid.

“Clean claim” means one that can be processed without obtaining additional information from the provider of the service from a third party.

“Controlled procedure” means a procedure that is rendered often enough by a provider or group of providers that specific usual or customary charge data for the procedure can be established based on the usual and customary methodology.

“Conversion factor” means the element that is used in calculating reimbursement for non-controlled procedures. The conversion factor is multiplied by the number of units assigned to each procedure. Conversion factors are determined by adding all submitted charges for all procedures within a specialty (with the exception of laboratory services) and dividing by the total number of units for all the submitted procedures. This can be determined for specific providers or specialties.

“Cost-share” means the amount identified by the department as an applicant's or recipient's excess income available for meeting a portion of the individual's own health care cost.

“Coterminous” means the health care provider's contract with Medicaid shall be invalid upon termination of the state department of health's certification of the provider's compliance with state and federal requirements.

“Drug formulary” means a listing of prescribed drug items pursuant to 42 U.S.C. 1936r(8)(d)(4) for which payment may be made by the Hawaii Medicaid program.

“Employer” means one who employs another or who contracts with another for services in return for wages or payment.

"Enhanced prior authorization list" means a list of all other drugs in the therapeutic classes as those addressed by the preferred drug list but which require prior authorization.

"Established provider" means one who has been in the Medicaid program for twelve months or more.

"Estimated acquisition cost for a drug product" means one of the following which shall be designated by the department:

- (1) The average wholesale price minus 10.5 per cent; or
- (2) The manufacturer's direct price. Average wholesale price shall be derived from the most commonly used package size listed in the Blue Book or the department's best estimate of the price generally and currently paid by providers for a drug labeler in the package size most frequently purchased by providers.

"Federal upper limits (FUL)" for a drug product means the price established by the Center for Medicaid and State Operations.

"Hawaii Medicaid fee schedule" means the schedule of rate of payment for services provided by noninstitutional providers of medical care.

"Median charges" means the middle of all the actual charges made for a given service by a provider.

"Panel test" means a set of two or more laboratory tests done concurrently or in conjunction with the others.

"Part A" means Medicare hospital insurance benefits.

"Part B" means Medicare medical insurance benefits.

"PPS" means the prospective payment system of reimbursement.

"Practitioner" means a licensed doctor of medicine, dentistry, osteopathy, podiatry, and any other individual licensed practitioner of health care services the department chooses to include in its Medicaid program.

"Preferred drug list" means a list of medications, within specified therapeutic classes, that are designated as preferred for use as determined by a committee of physicians and pharmacists and approved by the department.

"Primary physician" means a practitioner selected by the recipient to manage the recipient's utilization of health care services.

"Program" means the state-administered medical assistance program as authorized under title XIX of the Social Security Act (42 U.S.C. §§1396-1396j) and chapter 346, HRS.

"Provider" means a provider of health care services, equipment, or supplies that is participating in the Medicaid program.

"QMB" means Qualified Medicare Beneficiaries.

"Routine nursing salary cost differential" means the amount reimbursed to a provider for the cost of inpatient routine nursing care for aged patients.

"Spend-down" means the monthly process by which an individual's or family's income in excess of the medically needy standard is applied toward incurred medical expenses until the net income no longer exceeds the medically needy standard resulting in eligibility for medical assistance.

"State maximum allowable cost (MAC)" for a multi-source drug product means the average of the estimated acquisition costs of the three least expensive generics available. At least one of the three generic products shall be provided by a manufacturer who participates in the Federal Drug Rebate Program.

"Visiting consultant" is a Medicaid provider who has expertise or knowledge in a specific area and generally recognized by the community as a specialist and this expertise or service is not readily available on a particular island. Included as a visiting consultant are specialists who are requested by other providers to render second opinions or to participate in the medical treatment of Medicaid recipients."]

[Eff 10/26/01; am 05/10/03; am 03/11/04;

R] (Auth: HRS §346-14; 42 C.F.R.
§431.10) (Imp: HRS §§346-14, 346-59; 42 C.F.R.
§431.10; 42 U.S.C. §1396r(8)(d)(4) and (5))

101. Section 17-1739.2-1, Hawaii Administrative Rules, is repealed as follows:

["§17-1739.2-1 Definitions. As used in this chapter, the following terms shall have the indicated meanings:

"Acuity based reimbursement system" means the Medicaid reimbursement system for nursing facility (NF) level of care described in Exhibit A, dated July 2003, which is located at the end of this chapter and made a part of this chapter. The acuity based reimbursement system applies to acuity level A and acuity level C services, excluding services in critical access hospitals.

"Acuity level A" means that the department has applied its standards of medical necessity and determined that a 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.

"Acuity level B" means that the department has applied its standards of medical necessity and determined that a resident requires the level of medical care and special services that are appropriately obtained from an ICF/MR.

"Acuity level C" means that the department has applied its standards of medical necessity and determined that a 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.

"Acuity level D" means that the department has applied its standards of medical necessity and determined that a resident requires a level of medical care that is relatively higher than acuity level C, but less than acute.

"Acuity ratio" means the estimated average acuity level A direct nursing costs divided by the estimated average acuity level C direct nursing costs, as determined by the department. For the FY 98 rebasing, the department has determined the ratio to be 1.00:0.8012.

"Adjusted PPS rate" means the basic PPS rate and any adjustments to that rate that are applicable to a particular provider. A formula to determine the adjusted PPS rate is defined in section 17-1739.2-19(f).

"Ancillaries payment" means a per diem payment outside of the basic PPS rate to reimburse certain providers for ancillary services that they provide to residents. The payment is available only to selected providers that are incapable of billing Medicaid on an itemized fee for services basis at this time. The payment is not an adjustment to the basic PPS rate.

"Audit adjustment factor" means a reduction to the costs reported in a cost report that has not been finally settled by the department to reflect the average amount of costs that the department has historically disallowed for facilities statewide as part of the final settlement process.

"Basic PPS rate" means the sum of the applicable per diem amounts for the direct nursing, capital, and general and administrative components for each provider and for each level of care that the provider is certified to provide, as calculated pursuant to the methodology defined in this chapter. It does not include the various adjustments or increases to the basic PPS rate defined in this chapter.

"Base year" means that state fiscal year chosen to identify the provider-specific cost reports that are used to calculate the basic PPS rate.

"Base year cost report" means the cost report of a provider that covers the reporting period that ends during the base year.

"Bed day(s)" means inpatient days on the Medicaid cost report.

"CAH" means critical access hospital.

"Capital component reduction factor" means a fraction with the capital cost per diem projected by a new provider to obtain its initial PPS rates as the numerator and the total projected capital, direct nursing and G&A per diem costs as the denominator.

"Capital incentive adjustment" means an increase to a provider's basic PPS rate that is calculated as

follows:

- (1) If the capital per diem cost component of the provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five percent of the difference between the median capital per diem cost for the peer group and the provider's capital per diem cost component;
- (2) If the capital per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five percent of the difference between the median capital per diem cost for the peer group and the provider's capital per diem cost component;
- (3) Notwithstanding the foregoing, the capital incentive adjustment shall not increase a provider's capital cost component above the capital component ceiling for the applicable acuity level in the provider's peer group.

"Critical access hospital" means a hospital designated and certified as such under the Medicare Rural Hospital Flexibility Program.

"Day-weighted median" means a numerical value determined by arraying the per diem costs and total patient days of each nursing facility and identifying the value at which half of the patient days are represented by providers with higher costs than this value.

"Dental allowance add-on" means a per diem amount added to the facility's basic PPS rate for dental services rendered to the facility's inpatients. The per diem amount will be the same for all facilities as determined by the department using historical paid dental claims data.

"Department" means the department of human services of the state of hawaii, which is the single state agency responsible for administering the medical assistance program.

"Distinct part" refers to a portion of an

institution or institutional complex (e.g. nursing home or a hospital) that is certified to provide SNF and NF services, or both.

"F/S NF" means freestanding nursing facility.

"FY 98 rebasing" means the rebasing that used the cost reports for fiscal years that ended during the state fiscal year ending June 30, 1995. The basic PPS rates that resulted from the FY 98 rebasing are effective July 1, 1997.

"G&A" means general and administrative.

"G&A incentive adjustment" means an increase to a provider's basic PPS rates that is calculated as follows:

- (1) If the G&A per diem cost component of the provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five percent of the difference between the median G&A per diem cost for the peer group and the provider's G&A per diem cost component;
- (2) If the G&A per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five percent of the difference between the median G&A per diem cost for the peer group and the provider's G&A per diem cost component;
- (3) Notwithstanding the foregoing, the G&A incentive adjustment shall not increase a provider's G&A cost component above the G&A component ceiling for the applicable acuity level in the provider's peer group.

"G&A small facility Adjustment" means an adjustment to small F/S NF's basic PPS rates. To qualify for this adjustment, the F/S NF must:

- (1) Have fifty beds or less; and
- (2) Have a base year facility specific G&A cost per day in excess of their facility specific G&A cost component ceiling.

To calculate the adjustment, the G&A cost component of the provider's basic PPS rate calculation is recomputed as follows:

- (1) A cost differential in the average base year G&A cost per day, inflated to the PPS rate year, is computed between:
 - (A) F/S NFs with fifty beds or less, and
 - (B) F/S NFs with more than fifty beds but less than one hundred twenty-five.
- (2) The provider's G&A cost component ceiling is increased by the computed cost differential described above.
- (3) The facility specific G&A cost per day is compared with the revised ceiling to determine the revised allowable G&A cost component of the provider's basic PPS rate.
- (4) The increase in the G&A portion of the provider's PPS rate as a result of the above calculations represents the adjustment.

"GET adjustment" means the adjustment to the basic PPS rate of a proprietary provider to reimburse it for gross excise taxes paid to the State of Hawaii. The GET adjustment shall be 1.04167; provided, however, that if the gross excise tax rate is increased or decreased, then the GET adjustment shall be revised accordingly.

"Grandfathered capital component" means the capital component of the basic PPS rates that a new provider or a provider with new beds was receiving immediately prior to the FY 98 rebasing.

"Grandfathered direct nursing and G&A adjustment" means an increase to an eligible provider's basic PPS rates calculated as follows: first, the department shall determine the provider's combined direct nursing and G&A components (including all incentives) as calculated in the FY 98 rebasing; second, the department shall determine the combined direct nursing and G&A component in the total PPS rates that the provider was receiving prior to the FY 98 rebasing for its old beds; third, the department shall increase that second amount by one-half of the inflation adjustment for FY 98; and finally, if the difference between the second amount and the first amount is a positive number, that number shall be multiplied by the ratio of the provider's old beds to its total

beds. The product shall be the per diem increase to the provider's basic PPS rates.

"Grandfathered PPS rate" means the total PPS rate that a provider was receiving prior to the FY 98 rebasing.

"Hawaii state plan" means the document that defines how Hawaii operates its Medicaid program. The provisions included in the state plan are approved by the Centers for Medicare and Medicaid Services (CMS). The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

"ICF" means intermediate care facility.

"ICF/MR" means intermediate care facility for the mentally retarded. The term also refers to a level of certification of a provider by Medicaid.

"Inflation adjustment" means the estimate of inflation in the costs of providing nursing facility services for a particular period as estimated in the CMS Nursing Home Without Capital Market Basket as reported in the Health Care Cost Review published quarterly by Global Insight, Inc., or its successor.

"Insufficient experience" means that a provider's base year cost report indicates that the provider delivered less than one hundred days of care at a particular acuity level in the base year.

"Level A rate" means the PPS rate for care delivered by a provider to an acuity level A resident in a nursing facility.

"Level B rate" means the PPS rate for care delivered by a provider to an acuity level B resident in ICF/MR.

"Level C rate" means the PPS rate for care delivered by a provider to an acuity level C resident in a nursing facility.

"Level D rate" means the PPS rate for care delivered by a provider to an acuity level D resident in a nursing or medical facility.

"LTC" means long term care facility.

"Maintenance therapy" means therapy provided by nursing staff or others whose purpose is not restorative or rehabilitative, but rather to prevent

the decline in the physical capabilities of patients. Maintenance therapy does not include physical therapy services that are reimbursed outside of the basic PPS rates.

"Medicaid" means the program to provide certain medical services to eligible individuals as defined generally in Title XIX of the Social Security Act, as amended from time to time.

"New beds" means beds of providers that were placed into service after the implementation of the Hawaii Medicaid program's initial prospective payment system.

"New provider" means a provider that began operations after the implementation of the Hawaii Medicaid program's initial prospective payment system.

"NF tax adjustment" means the adjustment to the basic PPS rate to a NF provider to reimburse it Medicaid's share of the taxes paid under Act 315, Session Laws of Hawaii, 1993. The NF tax adjustment was paid under a prior version of this provision during the period beginning June 1, 1993, and ending June 30, 1997.

"Nursing facility" or "NF" means a provider that is certified as a nursing facility under Medicaid.

"OBRA 87" means the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, and its interpretive guidelines and implementing regulations.

"OBRA 87 adjustment" means the adjustment to the basic PPS rate to reimburse a provider for the incremental costs of complying with OBRA 87. The OBRA 87 adjustment was paid under a prior version of this provision during the period beginning June 1, 1993, and ending June 30, 1997.

"Old beds" means the beds of a provider that were placed in service prior to the implementation of the Hawaii Medicaid program's initial prospective payment system.

"Patient" means an individual who receives medical care from a provider, and includes both residents and persons whose care is paid for by sources other than Medicaid.

"Plan" means this rule, which defines the methods

and standards whereby the Hawaii Medicaid program sets the rates that it pays to providers for services that they provide to residents.

"PPS" means the prospective payment system defined in this chapter.

"Proprietary provider" means a for profit provider.

"Provider" means a facility that is or becomes certified as qualified and contracts with the department to provide institutional long-term care services to residents.

"Rebasing" means calculating the basic PPS rates by reference to a new base year and new base year cost reports. Rebased basic PPS rates are the end product of a rebasing.

"Resident" means an individual who is eligible for benefits under Medicaid and receives long-term care benefits from or through a provider.

"ROE" means return on equity.

"ROE adjustment" means the adjustment to the basic PPS rate to a proprietary provider to reimburse it for return on equity, as computed and paid according to this chapter.

"Routine cost limit (RCL) " means the federal routine operating cost limits. Beginning with the effective date of these rules, the routine cost limit is calculated annually using the limit in effect on June 30th of the immediately preceding fiscal year multiplied by one plus the inflation adjustment.

"SNF" means skilled nursing facility.

"Substitute direct nursing component" means adjusting the direct nursing care component used to obtain a basic PPS rate for an acuity level as follows:

- (1) Increasing the facility-specific level A direct nursing component by dividing that component by the acuity ratio; or
- (2) Decreasing the facility-specific level C direct nursing component by multiplying it by the acuity ratio;
- (3) In calculating the substitute direct nursing component, the acuity ratio shall be applied

to the provider's direct nursing component prior to the application of the direct nursing component ceiling.

"Total PPS rate" means the basic PPS rate plus all applicable adjustments, additions or increases to that rate that are defined and authorized in this chapter.

"Upper limit" means the limit on aggregate payments to providers imposed by 42 C.F.R. §447.272."] (Auth: [Eff 09/01/03; am 05/05/05; R HRS §346-59; 42 U.S.C. §1396a) (Imp: 42 C.F.R. §447.252)