State/Territory: HAWAII

## Free Choice of Providers

**Section 1: Recipient over-utilization or abuse**

(1) Freedom of choice in selecting health care providers shall not include the inexpedient utilization or over-utilization of the community's health care providers and supplies.

(2) When a recipient over-utilizes medical services, the department shall request the recipient's voluntary cooperation in curbing abusive utilization practices and shall monitor the recipient's case for no less than 6 months.

(3) When a recipient has been shown to be over-utilizing controlled drugs with multiple prescriptions filled at more than one pharmacy and written by multiple prescribers, the department shall require the recipient to choose one primary care physician and one pharmacy to be the only approved providers of usual care. The recipient shall select another provider if the initial provider selected is known to the department to be over-prescribing medications or medical services. Refer to section 2 for specific details regarding restrictions.

(4) When a recipient has been determined to be using excessive services provided by multiple physicians, the department may assist the recipient in receiving appropriate coordinated care. The department shall require the recipient to choose one primary care provider to coordinate all usual services for the recipient and make referrals to other providers, as needed. Refer to section 2 for specific details regarding restrictions.

State/Territory: HAWAII

**Free Choice of Providers**

**Section 2: Restriction:**

(1) If over-utilization or abuse continues, the recipient shall be administratively restricted for no less than 24 months to a primary care physician who is:

(A) Of the client's choice;

(B) Willing to provide and coordinate services to the client; and

(C) Certified by the department to participate in the medical assistance program

(2) A recipient who over-utilizes services which are provided by psychotherapists, pharmacies and dentists shall also be restricted to those providers if necessary to further curb recipient abuse.

(3) The individual who is restricted shall be afforded advance notice and appeals process.

(4) Emergency medical services shall not require the referral, assistance or approvals of the designated primary care physician.

(5) The restricted recipient shall receive a medical authorization card bearing the designated primary care physician until:

(A) Responsibility for care is transferred to another physician;

(B) The recipient requests a change in the primary care physician and the department and the affected physician concurs; or

(C) Control is no longer considered necessary by the designated primary care physician and the department's medical consultant concurs.

(6) If a recipient fails to select a primary care physician within 30 days following receipt of notice of medical service restrictions, the department shall select a physician who is in good standing with the medical program.

(7) When a physician who is willing to participate as the primary care physician cannot be found, the department's medical consultant shall provide prior approval for all health service required by restricted recipient with the exception of emergency care.

(8) The designated physician shall:

(A) Provide and coordinate all medical services to the client, except for emergency services; and

(B) Make referrals for other needed medical services; and

(C) Inform the department when the designated physician is no longer able to provide medical services to the recipient.

(9) A recipient shall continue to be restricted to a designated provider(s) until:

(A) There is documented evidence of that individual's compliance for at least one full year; and

(B) The primary care physician and the department's medical consultant concur.

(10) When the decision is made to continue restriction, the recipient shall be afforded advance notice and the appeals process.

(11) The recipient whose restriction has been terminated shall be monitored for no less than 24 months and placed back on restriction if there is evidence of recurrent over-utilization or abuse of Medicaid services during that period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.11-A

State of HAWAII

STANDARD-SETTING AUTHORITY FOR INSTITUTIONS

The following standards for private and public institutions are kept on file and made available to the Social and Rehabilitation Service on request:

(1) Public Health Regulations, Chapter 12, Hospitals

(2) Public Health Regulations, Chapter 12-A, Nursing Homes

(3) Public Health Regulations, Chapter 12-B, Care homes and Intermediate Care Facilities

TRANSMITTAL # 83-1 EFFECTIVE 1-1-83
REC'D RO 3-25-83 SUPERSEDED BY TRANSM # _____
APPROVED 5-13-83 EFFECTIVE _____

HAWAII

ATTACHMENT 4.14-B

Utilization review is provided by direct review by personnel of the medical assistance unit, by facility contract with county medical societies, by facility-based review, and by facility arrangements ~~contracts~~ with individuals.

For the majority of the ICF, SNF, and SNF/ICF facilities on Oahu, the Honolulu County Medical Society contracts with facilities to provide utilization review.

The Maui County Medical Society provides utilization review for certain ICF facilities in Maui county.

Certain other facilities have facility-based utilization review committees ~~that~~ provide review for their particular facility. or have arrangements with individuals to

Personnel of the medical assistance unit provide direct review in certain free-standing ICF's that are unable to obtain the necessary personnel to conduct utilization review.

All facilities have approved utilization review plans that are in conformity with this sub-part.

TRANSMITTAL # 85-17 EFFECTIVE 10-1-86
REC'D RO ____ SUPERSEDED BY TRANSM # ____
APPROVED 1-23-86 EFFECTIVE ____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.16-A

State of HAWAII

INTERRELATIONS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

The following is a description of the cooperative arrangements agreed upon with the State health and vocational rehabilitation agencies:

1. Identification of mutual objectives and the responsibilities of respective agencies;

2. Cooperative and collaborative relationships at the State level;

3. Arrangement for early identification of need for medical or remedial care and services for individuals under 21 years of age;

4. Arrangement for reciprocal referral service;

5. Arrangement for maintenance of medical case management;

6. Mutual exchange of information and reports for services provided under this agreement;

7. Delineation of responsibilities with respect to provision of services by both agencies at local levels;

8. Arrangement for provider reimbursement;

9. A periodic joint evaluation of provisions in the cooperative agreement and actions to effect desired changes;

10. Mutual reporting of changes in program policies of respective agencies which may affect the cooperative agreement;

11. Maintenance of continuous inter-agency liaison and designation of staff at State level to carry out the provisions of the agreement;

12. Reporting to each other any possible violation of the non-discrimination provisions of Civil Rights Act by the providers.

This Interagency Agreement shall take effect on the 1st day of April, 1984, by and between the STATE OF HAWAII, by its Department of Social Services and Housing, hereinafter referred to as "DEPARTMENT" and the Department of Health, hereinafter referred to as "PROVIDER".

I. INTRODUCTION

A. Purpose

Pursuant to 42 C.F.R. 431.615(c) which implements section 1902(a)(11) and (22) of the Social Security Act by setting forth State Plan requirements for arrangements and agreements between the Medicaid agency and State health agencies, this Agreement shall establish and maintain an interagency program coordination and a provider third party reimbursement arrangement in order to insure health care benefits for persons who are determined eligible for Medicaid and who, ipso facto, meet the standard of eligibility for DOH services under this Agreement.

This Agreement sets the policies which enables the DEPARTMENT and the respective PROVIDER programs to enter into individual agreements for specific medical services which is referred to as "Attachments".

B. Mutual Objectives

There is a mutual recognition that the programs of the PROVIDER and the DEPARTMENT have a similarity of purpose in providing optimal health care services to the maximum number of persons who are faced with selected medical needs. This mutual objective can be best achieved by the establishment of an interagency cooperative arrangement under which the fiscal

resources and services of the respective programs are coordinated both at the State and local levels.

C. Description Of Functions

1. The PROVIDER has general charge, oversight, and care of the health and lives of the people of the State. The PROVIDER administers the State's programs implemented under the Department of Health and which are included in the State Plan approved under this section of the Social Security Act.

2. The DEPARTMENT, through its Public Welfare Division, administers the Medical Assistance Program (Medicaid) under Title XIX of the Social Security Act, a program of comprehensive health care for the needy and the medically needy, on a statewide basis. Its chief responsibilities with respect to this program are determination of financial eligibility of persons for medical assistance, maintenance of utilization reviews and other methods of quality, quantity, and cost controls, making vendor payments for services which are within the scope and content of care provided under the program, identifying Medicaid recipients in need of preventive medical or remedial care and services, and encouraging comprehensive and continuous care to mutual recipients through early identification of Medicaid recipients.

II. SERVICES TO BE PROVIDED

A. Subject to the continuing availability of Federal and State funds, the PROVIDER, its designee or assignee (hereinafter referred to collectively as PROVIDER), shall provide on a continuing basis:

1. services for establishing and maintaining health and other standards for institutions participating in Medicaid, and

2. furnish Title V covered services to appropriate DSSH recipient including:

   (a) maternal and child health services,

   (b) crippled children's services,

   (c) maternal and infant care services, children and youth projects, and

   (d) projects for the dental health of children.

3. survey and certification of long-term care medical facilities, and

4. other services mutually agreed to by the DEPARTMENT and PROVIDER.

III. PAYMENT

A. The Medicaid agency shall reimburse the PROVIDER for the cost of services furnished eligible Medicaid recipients by or through the grantee in accordance with established Medicaid methods and rates as described in the State Plan.

B. The PROVIDER further agrees that no additional fees for services will be charged to Medicaid eligible recipients for services provided under the terms of this Agreement.

C. Payment by the DEPARTMENT shall be made to the PROVIDER through its fiscal agent where appropriate, upon receipt of a claim form from the PROVIDER, which shall contain the name and case number of eligible persons served by the PROVIDER, the type of service provided, and the cost of providing services to the eligible person. Claim form shall be the same form used by other Medicaid providers. Claim form shall be submitted within twelve (12) months of the date of service for which payment is requested. The failure of the PROVIDER to submit such claims within the specified time period shall result in non-payment of the entire reimbursement amount.

D. Payments by the DEPARTMENT to the PROVIDER for budgeted services shall be made upon receipt of a certified invoice from the PROVIDER which shall specify services rendered. Payment shall be made by a journal voucher or warrant to the PROVIDER.

E. The PROVIDER agrees that it shall not request payment for any services provided to any family or individual whose eligibility for services has not been determined by the DEPARTMENT or by the PROVIDER, or any service not specified. Further, payment for services not specifically allowed shall not be paid.

F. The PROVIDER agrees to refund all payments received from the DEPARTMENT for services which were not rendered or authorized by the DEPARTMENT for any family or individual.

## IV. GENERAL PROVISIONS AND CONDITIONS

### A. General Provisions

This Agreement is subject to all pertinent provisions of the Social Security Act as amended and Section 346-6, 346-7, and 346-8 Hawaii Revised Statutes as amended.

This system(s) of services and expenditures authorized under this Agreement shall conform to the requirements set forth in Title XIX of the Social Security Act as amended, the Code of Federal Regulations, Title 42, Chapter IV, Health and Human Services, Health Care Financing Administration, Subchapter C, "Medical Assistance Programs", and Hawaii Revised Statutes, and the Regulations of the DEPARTMENT.

### B. Other Provisions and Conditions

1. Binding Effect of Federal Regulations and State Plans

   This Agreement is subject to the provisions of any other relevant Federal regulations and any relevant provisions of the Hawaii State Plan of the DEPARTMENT submitted to and approved by the United States Department of Health and Human Services.

2. Licensing and Other Quality of Service Standards

   The PROVIDER agrees to comply with all State licensing standards, any applicable Federal service standards, and any other standards or criteria established by the DEPARTMENT to assure quality of services.

3. Statement of Compliance with Low Bid Requirements

The PROVIDER agrees to use its best efforts to obtain all supplies and equipment for use in the performance of this Agreement at the lowest practicable cost, and to purchase by means of a system of competitive bidding whenever required by law or whenever practical.

4. Prohibited Discrimination in Services.

The PROVIDER shall comply with all applicable Federal and State laws and regulations prohibiting the exclusion from participation, the denial of benefits, or the subjection to discrimination of any person from or under the services to be performed by the PROVIDER under this Agreement on prohibited grounds, such as on the ground of race, color, or national origin prohibited by Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, and 45 C.F.R. Part 80; on the basis of age as prohibited by Section 303 of the Age Discrimination Act of 1975, 42 U.S.C. §6102, and 45 C.F.R. Part 90; on the basis of sex in education programs and activities as prohibited by Section 901 of the Education Amendments of 1972, as amended, 20 U.S.C. §1681, and 45 C.F.R. Part 86; or on the basis of handicap as prohibited by Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, and 45 C.F.R. Part 84.

5. Prohibited Discriminatory Employment Practices.

The PROVIDER shall comply with all applicable Federal and State laws and regulations prohibiting

discriminatory employment practices, such as to fail or refuse to hire or to discharge any individual or otherwise to discriminate against any individual with respect to that individual's compensation, terms, conditions, or privileges of employment because of such individual's race, color, religion, sex, or national origin as prohibited by Section 703 of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. §2000e-2, and 29 C.F.R. Parts 1604, 1605, 1606, and 1607; to similarly discriminate against any individual because of such individual's age as prohibited by Section 4 of the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. §623, and 29 C.F.R. Part 860; to similarly discriminate against any individual in employment in education programs and activities because of such individual's sex as prohibited by Section 901 of the Education Amendments of 1972, as amended, 20 U.S.C. §1681, and 45 C.F.R. Part 86E; to similarly discriminate against any individual because of such individual's handicap as prohibited by Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, and 45 C.F.R. Part 84B; or to similarly discriminate against any individual because of such individual's race, sex, age, religion, color, ancestry, physical handicap, marital status, or arrest and court record that does not have a substantial relationship to the functions and

responsibilities of the prospective or continued employment as prohibited by Chapter 378, Hawaii Revised Statutes.

6. Fiscal Responsibility, Records, Control, Reports, and Monitoring Procedures

The PROVIDER agrees to maintain, in accordance with generally acceptable accounting practices, books, records, documents, and other evidence which sufficiently and properly reflect all direct and indirect current expenditures of any nature and those anticipated for the performance of this Agreement. The records shall be subject at all reasonable times to inspection, review, or audit by persons duly authorized by the DEPARTMENT, representatives of the Department of Attorney General, representatives of the Department of Accounting and General Services, and/or representatives of the Federal Department of Health and Human Services.

The PROVIDER agrees to collect statistical data of a fiscal nature and make statistical reports as required by the DEPARTMENT.

7. Program Records, Controls, Reports, and Monitoring Procedures

The PROVIDER agrees that a program and facilities review, may be conducted upon reasonable notice at any reasonable time by the State and Federal officials and other persons duly authorized by the DEPARTMENT. Program records, controls, reports

and monitoring procedures adopted jointly are described in the individual attachments.

The PROVIDER agrees to maintain records which include the names of eligible individuals as required by the DEPARTMENT, periodic program narrative, and statistical data.

The PROVIDER agrees to the exchange of reports as needed of services provided jointly to recipients, the exchange accorded the confidential treatment each agency prescribes. The procedures adopted jointly are described in the individual attachments.

8. Retention of Records

The PROVIDER agrees to retain all books, records, and other documents for a period of time determined by State and Federal statutes, State and Federal agreements entered into by the parties. Persons duly authorized by the DEPARTMENT shall have full access to and the right to examine any of said materials during said period.

9. Safeguarding Client Information

A provision to safeguard client information is agreed upon in order to insure confidential treatment each agency prescribes. The use of disclosure of any information concerning an applicant or recipient of services under this Agreement shall be subject to the limitations set

out in 42 Code of Federal Regulations Section 431.306, Hawaii Revised Statutes 346-10, and Chapter 601 of Title 17, Administrative Rules, et seq. Disclosures not authorized therein are prohibited except with the specific written consent of applicant, recipient, a minor's parent, or a legal guardian. Violation of this provision may constitute a misdemeanor under HRS 346-111. Disclosure procedures adopted jointly are described in the individual attachments.

10. Certification of Unavailability of Services Without Cost

The PROVIDER certifies that the services to be provided under this Agreement are not otherwise available without cost to eligible clients in the community.

11. Amendments

The provisions of this Agreement may be amended upon written request of either party subject to the agreement of the other. The party requesting an amendment will allow thirty (30) days for consideration and approval of the request.

All amendments shall be reduced to writing, duly signed and dated, and attached to the original of this Agreement. All provisions of all such amendments attached to the original shall be considered a modification of this Agreement.

12. Disputes Between the DEPARTMENT and the PROVIDER

In the event of any dispute between the DEPARTMENT and the PROVIDER, concerning any matter arising

under this Agreement, which cannot be resolved by mutual agreement between the parties within thirty (30) days, such dispute shall be submitted to the Attorney General of the State for resolution.

13. Termination or Reduction of Agreement

a. Termination at Will with Notice.

This Agreement may be terminated by either party at any time, with or without cause, upon sixty (60) days notice, in writing, and delivered by mail or in person to the other, provided, that any termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued.

b. Termination or Reduction Because of Lack of Funds.

Notwithstanding any other provisions of this Agreement, this Agreement may be terminated or amended by the DEPARTMENT without the consent of the PROVIDER upon written notice by the DEPARTMENT that the level of State or Federal funds available to support the DEPARTMENT's medical assistance programs are about to be or have been reduced, provided, however, that any such termination or amendment shall be without prejudice to any obligations or liabilities of either party already accrued.

Any termination shall be effective ten (10) days after the written notice is sent by certified mail.

Any amendments made pursuant to this subsection shall be reduced to writing, duly signed and dated, and attached to the original of this Agreement. A PROVIDER's refusal to sign such amendments shall constitute grounds for termination by default.

c. Termination for Default of PROVIDER.

Unless the PROVIDER's default is excused under the provisions of this Agreement, the DEPARTMENT may, by written notice of default to the PROVIDER, terminate this Agreement if the PROVIDER fails to perform any of the provisions of this Agreement.

Termination shall be effective ten (10) days after written notice of default is sent by certified mail. Any termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued.

d. Termination Arrangements.

The rights and remedies of the parties provided in this Agreement shall not be exclusive and are in addition to any other rights and remedies provided by law.

If this Agreement is terminated the PROVIDER shall:

(1) stop work under the Agreement on the date and to the extent specified by the DEPARTMENT or this Agreement;

(2) settle all obligations and claims arising out of the performance of this Agreement, including completion of any reports and refund of any payments required to be made under this Agreement. The DEPARTMENT may withhold all pending requests for payment until the final expenditure report is received.

14. Waivers

Waiver by any party of any default of the other shall not be deemed to be a waiver of any subsequent default. Waiver by any party of breach of any provision of the Agreement shall not be deemed to be a waiver of any other subsequent breach and shall not be construed to be an amendment of the terms of the Agreement unless made in compliance with the provisions of paragraph 20.

15. Continuous Liaison Between the Parties

It is recognized that a continuing interagency liaison is needed to carry out the provisions of this Agreement effectively. The PROVIDER and DEPARTMENT will designate representatives to serve as liaison both at State and local levels.

16. Indemnification

The PROVIDER shall indemnify and save harmless the DEPARTMENT, and their officers, employees, and agents from and against any and all actions, claims, suits, damages, and costs arising out of or resulting from the acts or omissions of the

PROVIDER or the PROVIDER's officers, employees, agents, or subcontractors occurring during or in connection with the performance of the PROVIDER's services under this Agreement.

17. Reciprocal Referrals

A provision for reciprocal referral services is agreed upon in order to insure optimal utilization of benefits available under the respective agency programs. Referral procedures adopted jointly are described in the individual attachments.

18. A provision to coordinate plans for health services relating to eligible recipients is agreed upon, the procedures adopted jointly are described in the individual attachments.

19. A provision for early identification of eligible individuals under 19 years of age in need of medical and remedial services is agreed upon. The method for providing this service adopted jointly is described in the individual attachments.

20. Periodic Review and Joint Planning for Changes

This Agreement will be jointly reviewed for evaluation of policies and for planning for changes annually or earlier when requested by either the DEPARTMENT or the PROVIDER.

Both parties hereby expressly acknowledge the potential for substantial changes in Federal regulations or State laws applicable to this Agreement and expressly agree to renegotiate this Agreement as necessary to comply with such changes.

21. Provision Terms and Conditions Included in the Agreement

This Agreement, together with any attachments and schedules, attached hereto and incorporated herein by reference, represent the complete, total, and final understanding of the parties and no other understandings or representations, oral or written, regarding the subject matter of this Agreement, shall be deemed to exist or to bind the parties hereto at the time of execution.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

| DEPARTMENT OF SOCIAL SERVICES AND HOUSING | DEPARTMENT OF HEALTH |
|---|---|
| Director | Director |

APPROVED AS TO FORM

Deputy Attorney General, State of Hawaii

ATTACHMENT A

CRIPPLED CHILDREN SERVICES

Medical Eligibility and Services

1. Provides diagnostic and treatment services for handicapped children based on definition and selection. Such services may include:
   a. Medical, surgical, dental, and hospital care.
   b. Care in convalescent or foster home.
   c. Prosthetics, appliances, transportation, and after-care to see that the child makes satisfactory personal adjustment and that treatment benefits are not lost by neglect.
2. Gives diagnostic and treatment services to children between 0-21 on all Islands for specific conditions listed below.
   a. Cleft lip and palate and serious cranial and facial anamolies;
   b. Cerebral palsy, epilepsy and other selected neurological problems;
   c. Rheumatic fever and rheumatic heart disease;
   d. Congenital heart disease;
   e. Orthopedic conditions, including arthritis;
   f. Selected surgical eye defects;
   g. Epilepsy;
   h. Selected external crippling conditions such as burns and severe disfigurements needing plastic procedure;
   i. Selected urogenital and other congenital defects;
   j. Selected hearing loss;
   k. Cystic fibrosis;
   l. Mental retardation;
   m. Conditions causing mental retardation;
   n. Hemophilia;
   o. Severe asthma;
   p. Learning disability.

ATTACHMENT B

MATERNITY AND INFANT CARE PROJECT

Medical Eligibility and Services Available

1. To any woman living in a Project area who requests family planning services including contraceptive supplies and medical counsel on infertility.
2. To any pregnant woman living in a Project area who needs:
   a. Pre-natal diagnosis and pre-natal care, except in a hospital.
   b. Post-natal care after return from the hospital;
   c. Public health nursing (for enrolled patients)*;
   d. Nutrition counselling (for enrolled patients)*;
   e. Social casework to supplement services available from other agencies (for enrolled patients)*;
   f. Drugs prescribed by the Project physician;
   g. Assistance with transportation to and from project authorized health services, when not otherwise available, and babysitting*;
   h. Any other ambulatory care needed for a pregnancy-related or pregnancy-threatening condition. Hospitalization is specifically excluded**.
   i. Dental examination and necessary treatments during pregnancy and six weeks after termination of pregnancy.
3. To every financially eligible Project maternity patient having a condition which is determined as high risk under Project guidelines, the following additional services:
   a. Complete medical and surgical care for pregnancy-related or pregnancy-threatening conditions, throughout the period of maternity up to six weeks following delivery;
   b. Hospital inpatient services for delivery of pre-natal or post-partum complications or for conditions which threaten to impair the outcome of the pregnancy;
   c. Complete newborn care for their infants; and
   d. Homemaker service*.

4. To financially eligible high-risk newborns of Project mothers during the first year of life (under Project guidelines for high-risk criteria for infants):

   a. Preventive health services, including immunizations, screening and periodic pediatric evaluations;

   b. Complete diagnostic study if needed;

   c. Complete medical and surgical treatment if needed;

   d. Hospital inpatient services;

   e. Drugs prescribed by Project physician;

   f. Nutrition counselling*;

   g. Social casework to supplement those services available from other agencies*;

   h. Public health nursing*;

   i. Transportation to and from medical facilities, when not otherwise available.

* Non-reimbursable services under Medicaid.

** To be reimbursed by DSSH if eligible for Medicaid.

ATTACHMENT C

CHILDREN AND YOUTH PROJECT

Services Available

1. To any child (birth to 16 years) living in Waimanalo:
   a. Preventive health services including screening, immunizations, routine examinations and evaluations, and parental education in child care and homemaking.
   b. Total health assessment, including medical, psychological*, speech-hearing, visual, dental, social*, nursing, nutritional, and homemaking components*.
   c. All diagnostic studies needed for assessment and diagnostic, whether done at the Project or through referral elsewhere.
2. To any financially eligible child (birth to 16 years) living in Waimanalo, in addition to the above:
   a. Medical, surgical and psychiatric treatment.
   b. Inpatient hospital care; blood and special nursing* if necessary.
   c. Psychological therapy and guidance*.
   d. Speech therapy.
   e. Dental care, excluding only orthodontia.
   f. Drugs, prosthetics, appliances, blood and the like.
   g. Public health nursing, nutrition service and social casework to complement the above, and to supplement services available from other agencies.
   h. Transportation for health care when not available otherwise (within budget limitations).
   i. Babysitting at the Project when necessary to achieve a visit for medical care*.

* Non-reimbursable services under Medicaid.

ATTACHMENT D

CHILD HEALTH CONFERENCE

Services Available

1. Physician services, including medical examinations;
2. Nursing assessments*;
3. Immunizations;
4. Diagnostic services;
5. Screening;
6. Health supervision*;
7. Nutrition counselling*;
8. Parental education in child care, guidance and safety*;
9. Transportation;
10. Outreach service*;
11. Referral and followup*.

* Non-reimbursable services under Medicaid.

ATTACHMENT E

Medicaid Reimbursement Rates

| Type of Service | Amount of Reimbursement Based On |
|---|---|
| 1. Inpatient hospital services | Medicare's principle of reasonable costs |
| 2. Physician's services (not applicable to clinics) | RVS 1970, as modified by DSSH |
| 3. Clinic services | $7.00 per visit |
| 4. X-ray and laboratory services | RVS 1970 |
| 5. Dental services (includes orthodontia in connection with cleft lip and palate treatment) | DSSH fee schedule |
| 6. Medical equipment and appliances | Reasonable charges (rental or purchase) |
| 7. Prosthetics | Reasonable charges |
| 8. Eye glasses | Manufacturer's price list plus 10 percent |
| 9. Eye exams, refractions and servicing | DSSH fee schedule |
| 10. Drugs | Usual and customary charges not exceeding 180% of Blue Book price list of smallest quantity |
| 11. Physical therapy | RVS 1970 |
| 12. Occupational therapy | Included in clinic fee of $7.00 when visit was made for other services also |
| 13. Speech therapy | $5.00 per 1/2 hour (individual)<br>$5.00 per 1 1/2 hour per patient (group) |
| 14. Speech evaluation | $12.00 - Oahu<br>$18.00 - Neighbor Islands |
| 15. Hearing evaluation, including audiogram | $12.00 - Oahu<br>$18.00 - Neighbor Islands |
| 16. Health screening (complete) | $15.00 |
| 17. Family planning services | |
| a. Initial visit, including: Breast and pelvic exams, Pap Smear, G. C. culture, other lab tests, contraceptive supplies, supportive counselling | $25.00 |

| Type of Service | | Amount of Reimbursement Based On |
|---|---|---|
| | b. Follow-up visits | $15.00 |
| 18. | Transportation | As charged |
| 19. | Immunizations and injections (If cost of injectible material exceeds $1.00, add $2.00 and identify material.) | $3.00 |
| | Oral Polio | $1.00 |

Attachment 4.16,

DEPARTMENT OF HUMAN SERVICES

INTRA-AGENCY AGREEMENT

Between

THE VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION

and

THE HEALTH CARE ADMINISTRATION DIVISION

## I. INTRODUCTION

1. Purpose

The purpose of this agreement is to mobilize personnel and financial resources of the Health Care Administration Division (HCAD) and the Vocational Rehabilitation and Services for the Blind Division (VRSBD) in order to provide vocational rehabilitation services to Department of Human Services (DHS) eligible recipients so that they may achieve economic self-sufficiency.

2. Mutual Objective

The programs of VRSBD and HCAD have a similarity of purpose in relation to rehabilitation of the physically and mentally handicapped. This mutual objective can be best achieved through an intra-agency cooperative arrangement in which the financial resources and service responsibilities of the respective divisions are coordinated both on the State and local levels.

3. Description of Functions

A. VRSBD

1. Vocational rehabilitation services shall focus upon the goal of employment. Such services may include:

a. Diagnostic and evaluation services to determine the individual's capacity for employment;

b. Training to prepare the individual for employment;

c. Placement and follow-up services to ensure satisfactory adjustment in a suitable employment;

d. Other services as needed.

(See Attachment A for description of services)

B. HCAD

1. Services from the HCAD may include payment for:

a. Outpatient;

b. Inpatient;

c. Long Term Care and;

d. Other Ancillary Health Care Services.

## II. COORDINATION OF SERVICES

1. Primary Resource

It is mutually agreed that VRSBD is the primary agency for arranging restorative services and providing counseling services for the vocational rehabilitation of persons who are handicapped due to a physical or mental disability.

2. Services

A. VRSBD Responsibility

VRSBD, having the basic responsibility under its program, will coordinate the activities necessary for the development of an individualized written rehabilitation program (IWRP) and together with the client identify the services needed, determine the cost of such services, and the responsibility of payment for needed services. VRSBD will follow through on the implementation of the IWRP.

B. HCAD Responsibility

HCAD will provide payment for covered Medicaid services to eligible recipients in accordance with Departmental rules.

C. Joint Responsibilities

Vocational Rehabilitation services will be considered in relation to the provision of goods and services that are not included in the Departmental rules governing HCAD.

3. Reciprocal Referral Services

HCAD supports the provision of referral services between VRSBD and the Public Welfare Division (PWD). Eligibility for medical assistance is determined by PWD upon policy issuance by HCAD. Thus, HCAD supports the referral procedures jointly adopted by VRSBD and PWD and attached to this Agreement as Attachment B.

## III. TERMS OF AGREEMENT

1. VRSBD will assume the full cost of vocational training and placement, as well as other incidental expenses necessary to vocationally rehabilitate eligible Medicaid recipients, and which are provided for in the IWRP.

2. HCAD will pay for, under its Medicaid program, the cost of medical, dental, psychological and psychiatric services to individuals who are eligible for this program. VRSBD will arrange and engage the services of Medicaid and Board-certified or eligible specialists for Medicaid eligible individuals for medical services provided for in the IWRP or for diagnostic purposes.

3. VRSBD will be responsible for case management and authorization of other services for eligible Medicaid recipients in the same manner as done for all VR clients.

4. VRSBD will provide services to eligible Medicaid recipients which are comparable in scope, quantity, quality and duration of services it provides to other clients.

5. VRSBD will provide HCAD any significant medical report as well as information on progress of case which it believes would be helpful in coordination of plans for recipients, especially as it relates to recipient's incapacity and waiver of work requirements and need for continuous services from VRSBD.

6. HCAD will provide VRSBD medical reports as well as information of the status of a case when requested by VRSBD, subject to the confidentiality rules of the HCAD Program.

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7. HCAD will make available their Dental Consultant's services to VRSBD for review and advice regarding dental treatment recommendations for any VR client.

## IV. OTHER CONDITIONS OF AGREEMENT

1. There will be a mutual sharing of information at the State level.

   VRSBD will provide statistical information to HCAD showing the number of registered referrals, the total number being serviced under its programs, the number of cases closed and reasons for termination of services. This report will be prepared and a copy transmitted to HCAD in July of each year. HCAD will provide technical health care information to assist VRSBD in the administration of its program.

2. Program policies and procedures planned by either Division will be jointly evaluated if, in the judgment of either Division, such changes might affect this cooperative agreement in any way.

3. It is recognized that a continuing inter-divisional liaison is needed to carry out the provisions of this Agreement effectively. VRSBD and HCAD will designate representatives to serve as liaison both at State and local levels, with designated HCAD personnel and VRSBD supervisors meeting as needed to discuss and resolve problems related to serving disabled Medicaid HCAD clients.

4. The staff of each agency will exercise due diligence in preserving the confidentiality of information exchanged and will not use it for purposes other than the reason for which it was given or received except on the written consent of the individual.

5. If any provision in this Agreement is found to be in conflict with provisions in the DHS Administrative Rule (Title 17), the Administrative Rule shall be the final authority. Further, any provision ruled invalid by the courts shall not invalidate the remaining provisions of this Agreement.

6. It is mutually understood that participating providers of medical and related services under both programs must comply with the non-discrimination provisions of Title VI, Civil Rights Act of 1964, as revised. VRSBD and HCAD agree to report to each other any provider violation.

7. This Agreement shall take effect July 1, 1986, and shall be in effect until cancelled with the approval of the Director.

| VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION | HEALTH CARE ADMINISTRATION DIVISION |
|---|---|
| VRSBD Administrator | Acting Health Care Administrator |

APPROVED:

Director of the Department of Human Services

Date

TN 88-1 Approval Date 10/22/87 Effective Date 7/1/87

# VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION, DSSH

## I. VOCATIONAL REHABILITATION SERVICES

The purpose of vocational rehabilitation is to assist disabled persons through a wide variety of services to prepare for, find, and maintain a suitable occupation. An individual rehabilitation plan is developed to enable the individual to pursue a gainful occupation, with services needed to develop the vocational capacity, incorporated with the plan.

### A. SERVICES

1. Evaluation of rehabilitation potential, including diagnostic and related services, incidental to the determination of eligibility for, and the nature and scope of, services to be provided.

2. Counseling, guidance and referral services -- to help the disabled person discover his vocational interests and aptitudes; to discuss his problems; and to work out a plan for rehabilitation that is most suitable for the individual. Referral to resources within the community which can best meet his needs.

3. Medical examination -- to learn the nature and extent of disability; to help determine eligibility for services; to determine need for additional medical services; to assess the disabled person's work capacity.

4. Medical services -- to restore or improve the disabled person's ability to do a job by providing medical, surgical or hospital services to remove or reduce the disability. This includes physical therapy, speech and hearing therapy, short-term psychiatric therapy.

5. Physical aids -- to include artificial limbs, braces, hearing devices, eye glasses and other aids.

6. Vocational and other training services -- books, tools and other materials to help the disabled person learn a new trade or regain lost skills through training in college or university, business school, vocational school, on-the-job, to prepare a person for the world of work through personal and vocational adjustment training, usually in a rehabilitation facility.

7. Maintenance and transportation -- to help the disabled person during preparation for work or while being helped to find a job.

8. Other goods and services in a wide range -- to assist in preparing for and obtaining the right job, including tools, equipment, licenses, reader services for the blind, orientation and mobility services for the blind, interpreter services for the deaf, etc.

9. Job placement -- to assist in finding the right job within the person's physical and mental abilities.

10. Post-employment services -- to assist the disabled person to maintain suitable employment.

B. COSTS

There is no cost for services which are necessary to evaluate the individual's problems, or for counseling and guidance, and job placement. The individual will be asked to share in the cost of other services if he is able to do so.

C. ELIGIBILITY

The requirements for eligibility are:

1. The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment and interferes with his ability to pursue a gainful occupation, or which threatens his or her continued employment.

2. The disabled person must have a reasonable chance of being able to engage in a suitable occupation after necessary rehabilitation services are provided.

3. Although there is no upper or lower age limits, the general guide is that the individual is at or near work age.

4. There is no residency requirement. However, the individual must be living in Hawaii and intends to make Hawaii his residence.

II. SERVICES FOR THE BLIND BRANCH (HO'OPONO)

A. SERVICES

1. Vocational rehabilitation services for the blind and visually handicapped, as enumerated in Section I-A, B, C, above.

2. Personal adjustment services at Ho'opono to assist individuals to adjust to their blindness through training in orientation and mobility, communications skills (braille, handwriting, typing, etc.), personal and home management, occupational therapy, manual arts, and group work.

3. Work evaluation and vocational adjustment training at Ho'opono -- to assess and determine the individual's abilities and skills, and to assist the individual to develop good work habits, attitudes, work tolerance, and confidence necessary for satisfactory job placement.

4. Evaluation and training of vending stand operators -- to license, place, and supervise such operators.

5. Extended employment for blind persons unable to work in the regular labor market.

6. Low Vision Clinic Services -- to individuals who are severely visually handicapped; to evaluate their ability to use optical aides to improve visual efficiency; and to provide such aides as prescribed.

7. Home teaching services -- to provide adjustment services to blind persons in their own homes.

8. Ho'opono Hale, a residential training program -- to give individuals being trained at Ho'opono an opportunity to upgrade their personal and home management skills through practical everyday experiences of cooking, housekeeping, budgeting, marketing, etc.

9. Case work services -- to assist parents of young blind children.

10. Services to elderly blind.

11. Aides and appliances for the blind to assist blind individuals in their various activities.

12. A statewide register of blind persons -- to determine causes of blindness, and to gather other data about blind persons in Hawaii.

13. Volunteer program -- to recruit, train, and use volunteers for a variety of services to blind persons in such areas as adjustment training, transportation, reader services, taping materials, etc.

14. Prevention of blindness services -- to educate the public about prevention of blindness.

15. Certify blindness.

B. ELIGIBILITY

Any blind or visually handicapped individual may be eligible for services of Ho'opono.

[illegible] Effective [illegible]

# RECIPROCAL REFERRAL PROCEDURES

1. Referral to VRSBD

   A. PWD Referring Units will refer GA recipients who:

      1) are physically or mentally incapacitated (diagnosis by a physician indicating limitations in physical activities such as walking, lifting, or environmental conditions to be avoided such as dust, dampness, or currently unable to work) and

      2) are unable to work full time, and

      3) are age 16 or over, but below age 50, and

      4) might benefit from vocational rehabilitation services (e.g. doctor recommends referral to DVR) to assist them in obtaining, retaining, or preparing for employment.

   B. PWD Referring Units will refer AFDC recipients who:

      1) are physically or mentally incapacitated, and

      2) are exempt from WIN registration

         a. The PWD Referring Unit sends VR-PW 1 referral to the appropriate VRSBD Branch Office (Oahu, Services for the Blind on Oahu, Hawaii, Maui, and Kauai) and, in addition, sends out an attached letter (see Attachment C) to the recipient to inform recipient of referral to VRSBD and which office to call, if interested.

         b. The VRSBD Branch Office will hold the VR-PW 1 referral for thirty (30) days. If recipient calls to indicate interest, the VR-PW 1 will be sent to the field office for follow-up.

            If recipient does not call within thirty (30) days or indicates disinterest, Part 3 of the VR-PW 1 form will be executed and returned to the referring PWD-IM Unit by the VRSBD Branch Office.

   C. PWD Referring Units will not refer the following types of cases:

      1) recipients who have no disability (no medical or psychiatric diagnosis);

      2) recipients who have temporary disabilities which may be indicated by physician's indication that client is employable now or within 6 months;

         Persons with temporary disabilities who are screened out may be considered during continuing eligibility reviews if the condition still persists in spite of treatment.

      3) recipients whose disabilities are slight so that no restrictions are imposed--physicians usually indicate such persons to be employable;

Effective

4) recipients whose disabilities are so severe that death is predicted within a short period of time or physician recommends against employment (consider SSI);

5) recipients who are below age 16, except blind persons--blind persons are to be referred to Services for the Blind Branch (Ho'opono) if they reside on Oahu.

6) individuals 50 years or over, except on a voluntary basis; and

7) Other mutually agreed-upon exemptions

2. Referral to PWD

VR Specialist will refer clients for public assistance and/or report VR status of clients receiving public assistance but were not referred to VRSBD by PWD.

3. Procedures for referral/feedback

Whenever possible, determine client's willingness to participate in vocational rehabilitation services for employment, and explain the consequences of not cooperating (GA cases) with VRSBD.

A. Referral - PWD Referring Units

1) Prepare VR-PW 1 Referral and Feedback Form for submittal to VRSBD Branch Offices. Use ballpoint pen or type information so that information is legible on all copies of the VR-PW 1.

2) Attach current, complete medical and/or psychiatric reports to the VR-PW 1.

B. Feedback on referrals - VRSBD

1) Complete designated copies of VR-PW 1 and submit to PWD to report decision/progress/closure of referral/case.

2) Notify PWD through VR-PW 1a of public assistance recipients who are referred by other referral sources.

C. Follow-up - PWD Referring Units

1) Upon receipt of VR-PW 1a from VRSBD, IM Worker will follow up on GA clients who refuse VRSBD services or do not cooperate in the implementation of the Individualized Written Rehabilitation Program (IWRP).

2) IM Worker will notify VRSBD of cases which are terminated by PWD.

Effective

Dear

We have determined that you are exempt from registration for the Work Incentive Program (WIN) because of your disability. Many persons with disabilities, however, continue to be interested in employment. Our Department's vocational rehabilitation program may be helpful to you in this regard.

Services which are available are:

1. Medical and related services to remove or lessen your disability.

2. Training, if needed, to provide you with job skills based on your interests and aptitudes.

3. Help in securing a job.

In addition, other necessary services can be made available through our Department, such as child care during employment.

You have been referred to the Vocational Rehabilitation and Services for the Blind Division as required. Your acceptance or non-acceptance of vocational rehabilitation services will in no way affect your financial aid from public welfare.

If you are interested in vocational rehabilitation services, please call the number in your area listed below:

| | |
|---|---|
| Oahu | - 548-4639 |
| Hawaii | - 961-7331 |
| Kona Office | - 323-2629 |
| Maui | - 244-4291 |
| Molokai Office | - 533-5323 |
| Kauai | - 245-4333 |

Sincerely,

_____
Worker

_____
Unit

TN 88-1 Approval Date 10/22/87 Effective Date 7/1/87

Trans. No. NCAS-77-4
SRS Approved 1/19/78

Revision: SRS-AT-76-116 (MSA)
July 23, 1976

Attachment 4.16-C

State HAWAII

PAYMENT FOR RESERVING BEDS IN LONG-TERM CARE FACILITIES

Payments for reserving beds in skilled nursing and intermediate care facilities are limited to the following:

1. Leave of no more than two days at a time for trial community placement in other than patient's own home.

2. Home visit of no more than two days at a time due to illness or death of a family member, or for other emergencies.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**
**State/Territory: HAWAII**

## LIENS AND ADJUSTMENTS OR RECOVERIES

**(1) The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and returned home:**

a) Send notification to inform recipients in nursing facilities that the State intends to determine if the individual can reasonably be expected to be discharged from the facility and return home for the purpose of placing a lien on the recipient's home property. The notice will include an explanation of liens and that the lien will not effect the individual's ownership of the property.

b) The individual or the individual's representative will be given an opportunity to self-certify that the stay in the institution is expected to be permanent or not.

c) If the individual does not indicate the stay in the institution is likely to be permanent, the State will make an assessment based on an evaluation of the individual's medical condition and the social-economic factors involved in caring for the individual in the home. The recipient will be determined permanently institutionalized for the purposes of lien placement by such evaluation made by a physician and a social worker, or if the recipient has been continuously authorized to receive institutional care or has been institutionalized for six months or longer with no discharge plan.

d) The notice will contain information regarding the right to an administrative hearing if they disagree with the State's determination, and the process to file for a hearing.

e) Before a lien is filed, a notice shall be sent by certified mail, informing the recipient of the Department's intent to place a lien on the home property. The recipient will have 90 days from the date of the notice, to file a request for a fair hearing if he or she does not agree with the decision to place a lien on the home property.

**2) The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):**

The son or daughter provided the following or insured that the following care was provided:

a) Access to medical services by transporting the individual, scheduling appointments, or calling for emergency services.

b) Medical care such as administration of medication, changing of dressing, etc.

c) Basic daily needs such as feeding, bathing, cleaning, and supervision.

d) Financial support to meet the parents need for food, shelter, and clothing.

(STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

e) Other services that contributed to the emotional well being of the parent.

3. **The State defines the following terms as follows:**

a) **estate:** shall mean the real and personal property included in an estate under the State's probate law and any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

b) **individual's home:** shall mean the property that the individual resided and had an equity interest in prior to becoming medically institutionalized.

c) **equity interest in the home:** shall mean the value of the property that the individual holds legal title to beyond the amount owed on it in mortgages and liens.

d) **residing in the home for at least one or two years on a continuous basis** shall mean continuously lived in the home as the sole residence.

e) **lawfully residing** shall mean permitted by law to live in.

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State/Territory: HAWAII

4. **The State defines hardship as follows:**

Undue hardship exists if the family and heirs of the deceased recipient do not have income greater than the Federal Poverty Level, and the estate of the deceased recipient is providing the sole source of income to meet their basic living expenses, or the estate is their sole place of residence.

5. **The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost effective:**

a) Recovery will not be made if estate subject to recovery is the sole income producing asset of the family and heirs of the recipient, and is a family farm or business that does not produce income greater than the Federal Poverty Limit for the number of family or heirs solely dependent on the income from the asset.

b) The estate is a home of modest value (based on the median sale price of homes obtained by the Honolulu Board of Realtors) and the family members and heirs meet the following conditions:

i) Resided in the home at least three months prior to the admission of the owner to a medical institution and provided care that delayed the admission.

ii) Have continuously resided in the home since the admission of the recipient to the medical institution.

iii) Do not have an interest in real property other than the home of the recipient.

iv) Have income not greater than the Federal Poverty Level.

c) The State will determine cost effectiveness of recovery based on the amount to be recovered, the value of the assets from which recovery will be made, and the administrative and related costs to make the recovery.

6. **The State defines cost effective as follows (include methodology/thresholds used to determine cost effectiveness):**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

If a contractor is performing the recovery work, it is cost effective if the amount of the recovery is sufficient to yield a contingency fee payment to the contractor which exceeds its cost to recover the asset. If the State is performing the recovery, it is cost effective if the amount of the recovery exceeds the administrative costs, legal fees, travel expenses and other cost factors that may be involved.

7. **The State uses the following collection procedures (includes specific elements contained in the advance notice requirement, the method for applying the waiver, hearing and appeals procedures, and time frames involved):**

a) Notify the family and heirs that the State shall seek to recover Medicaid payments from the estate of the deceased recipient 45 days prior to initiating collection activities. The notice will specify the amount to be recovered, the requirements for waiving recovery due to undue hardship, and the appeal rights and procedures.

b) The family and heirs shall file for a waiver of recovery within 30 days of the mailing of the recovery notification on a form designated by the State with the State agency or private contractor designated by the State.

c) Family and heirs must submit documentation of their finances and other requested information to support their request for waiver within 10 days of the request from the State unless there are circumstances beyond their control.

d) Family and heirs may appeal the denial of waiver by requesting an administrative hearing within 90 days of the waiver denial.

State of Hawaii

LIENS AND RECOVERIES

(1) Recovery may be waived due to hardship for the period the following conditions exist:

(A) The estate subject to recovery is the sole income producing asset of the survivors and meet the following conditions:

(1) The estate is a family farm or other family business;

(2) The income produced by the asset is not greater than one hundred percent of the Federal Poverty Level (FPL) for the number of survivors solely dependent on such asset.

(B) The estate is a homestead of modest value that is occupied by survivors who meet the following conditions:

(1) Lawfully resided in the home for a continuous period that started at least three (3) months immediately before the recipient's admission to a medical institution and provided care to the recipient during that period that allowed the recipient to reside at home rather than in an institution and has continuously lived int he home since the admission;

(2) Do not own any real property other than an interest in the home; and

(3) Have income not greater than one hundred percent of the FPL.

(2) Before a lien is filed, a notice shall be given to allow 30 days for a fair hearing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

| Service | Type Charge Deduct. | Coins. | Copay. | Amount and Basis for Determination |
|---|---|---|---|---|
| NOT APPLICABLE | | | | |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

B. The method used to collect cost sharing charges for categorically needy individuals:

/ Providers are responsible for collecting the cost sharing charges from individuals.

/ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

NOT APPLICABLE

MSA-PI-74-6
February 26, 1974

Attachment 4.18-B

State Hawaii

The following enrollment fee, premium or similar charge is imposed on the medically needy:

| Gross Family Income (per mo.) | Charge Family Size | | | Liability Period | Freq of C |
|---|---|---|---|---|---|
| | 1 or 2 | 3 or 4 | 5 or more | | |
| (1) | (2) | (3) | (4) | (5) | ( |
| $150 or less | | | | | |
| 151 - 200 | | | | | |
| 201 - 250 | | | | | |
| 251 - 300 | | | | | |
| 301 - 350 | | | | | |
| 351 - 400 | | | | | |
| 401 - 450 | | | | | |
| 451 - 500 | | | | | |
| 501 - 550 | | | | | |
| 551 - 600 | | | | | |
| 601 - 650 | | | | | |
| 651 - 700 | | | | | |
| 701 - 750 | | | | | |
| 751 - 800 | | | | | |
| 801 - 850 | | | | | |
| 851 - 900 | | | | | |
| 901 - 950 | | | | | |
| 951 - 1000 | | | | | |
| More than $1000 | | | | | |

DHEW Trans. No. MCAS-78-5
Trans. Date
HCFA Approval 9/1/78

State Hawaii

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

☐ Non-payment does not affect eligibility

☐ Effect is as described below:

☒ Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

A. The following charges are imposed on the medically needy for services:

| Service | Type of Charge Deduct. | Coins. | Copay. | Amount and Basis for Determination |
|---|---|---|---|---|
| NOT APPLICABLE | | | | |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

B. The method used to collect cost sharing charges for medically needy individuals:

☑ Providers are responsible for collecting the cost sharing charges from individuals.

☑ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /X/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /X/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

**A. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:**

1. Cost sharing

a. _X_ / No cost sharing is imposed.
b. ___ / Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):

Type of Charge

| Group of Individuals | Item/Service | Deductible | Co-insurance | Co-payment | *Method of Determining Family Income (including monthly or quarterly period) |
|---|---|---|---|---|---|
| | | | | | |

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

---

b. Limitations:
The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

family involved, as applied on a monthly and quarterly basis as specified by the State above.

- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. __/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

2. __/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

**B. For groups of individuals with family income above 150 percent of the FPL:**

1. Cost sharing amounts

a. _X_ / No cost sharing is imposed.
b. ___/ Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):

Type of Charge

| Group of Individuals | Item/Service | Deductible | Co-insurance | Co-payment | *Method of Determining Family Income (including monthly or quarterly period) |
|---|---|---|---|---|---|
| | | | | | |

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Attach a copy of the schedule of the cost sharing amounts for specific items and the various eligibility groups.

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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d. Enforcement

1. ___/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

2. ___/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

a. ___/ No premiums are imposed.
b. _X_/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

| Group of Individuals | Premium* | Method of Determining Family Income (including monthly or quarterly period)** |
|---|---|---|
| 250% - 265% FPL | $15 per child/per month | For a child under age 19, countable family income is determined in the following manner:<br>• Substract a standard deduction of $90 from the monthly gross earned income of each employed person; and<br>• Add the monthly net earned income for each employed person as well as any monthly unearned income to determine the countable family income. |
| 265% - 280% FPL | $30 per child/per month | |
| 280% - 300% FPL | $60 per child/per month | |

*The assessment of premium-share shall not exceed 5% of countable family income. A maximum of five enrollees in a family shall be assessed a premium-share in the following manner:

- Determine the number of persons in a family eligible for coverage who are responsible for a premium-share; and
- Assess premium-shares to a maximum of five enrollees in descending order by date of birth.

**For children under age 19 who are covered under §1902(a)(10)(A)(ii)(XIV) of the Act, the State uses §1902(r)(2) to disregard the difference in countable income between 300% and 250% of the FPL.

Attach a schedule of the premium amounts for the various eligibility groups.

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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c. No premiums shall be imposed for the following individuals:
- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. ___/ Prepayment required for the following groups of individuals who are applying for Medicaid:

2. _X_/ Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:

   Children with countable family income from 250% - 300% FPL.

3. ___/ Payment will be waived on a case-by-case basis for undue hardship.

**C. Period of determining aggregate 5 percent cap**

Specify the period for which the 5 percent maximum would be applied.

_X_/ Quarterly
___/ Monthly

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

**D. Method for tracking cost sharing amounts**

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

1. Process used for informing beneficiaries of premium liability:

   - Applicants who are determined eligible (250%-300% FPL): The eligibility determination staff completes and sends a notice to inform the family that the child would be assessed a premium liability, and how the premium amount is determined. If the family agrees to pay the premium liability, the child is enrolled in a health plan. Each month thereafter, an invoice is mailed.

   - Current enrollees with increased income (250%-300% FPL): The eligibility determination staff sends an advance notice (in accordance with 42 CFR §431.210 and §431.211) to inform the family that the child will be assessed a premium liability, and how the amount is determined. If the family agrees to pay the premium liability, the child's enrollment in the health plan continues. Each month thereafter, an invoice is mailed.

   As the assessment of premium-shares shall not exceed 5% of countable family income, an income review is conducted each quarter.

   Disenrollment procedures will be initiated when an enrollee whose premium-share payments are two months in arrears. During the first week of each month, the Finance Office generates a list of enrollees who have not paid their premium-shares for two months. The list is sent to the Eligibility Branch for action. The eligibility determination staff will complete and send an advance notice (in accordance with 42 CFR §431.210 and §431.211) to inform the enrollee that medical coverage will terminate at the end of the month.

2. Process used for informing providers when an individual has reached his/her maximum so further costs are no longer charged: Because Hawaii charges only premiums and collects these directly from the beneficiaries, information to providers about cost-sharing maximums are not applicable.

3. Tracking premium-shares: The State operates an accounts receivable system. This system allows the State to track all paid premiums.

# 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 acute care 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 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. The Hawaii Medicaid Program shall reimburse Providers for inpatient institutional services based primarily on the prospective 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 no 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.

2. 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.

3. 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.

4. 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.

5. 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 on the basis of 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.

6. The freestanding rehabilitation hospital shall be excluded from Classifications I, II, and III and designated as Classification IV, and shall receive payment based on All-Inclusive Rates, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and/or per discharge rates.

7. 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 those days not previously included in an interim claim.

8. 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.

9. 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.

10. 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 TEFRA target amounts. Outpatient, waitlisted and acute swing to continue to be reimbursed under the current method.

11. 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 negotiated with providers by the contractor and will be approved by the State. The negotiated case rate will not exceed Medicare or prevailing regional market rates.

**Citation:** 42 CFR 434, 438 and 447; and Social Security Act 1902(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 Health Care-Acquired 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 for 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 reimbursed 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 higher level of care, and reimbursement will be adjusted for the length of stay or increased acuity that can be directly and independently attributable to the HCAC or OPPC. For hospitals reimbursed on a DRGs basis, the DRG 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.

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.

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:

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

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

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.

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:

(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

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 2012 and the 1st, 2nd, and 3rd quarter of FFY 2013.

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.

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.24.). The Inflation Factor shall be used both to update the historical costs of delivering services and to project future increases in those costs.

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.

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.

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

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

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

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

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;

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:

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;

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

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.

(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

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;

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

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.

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 varing 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 varing 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 persuant to Section III.G.6.,

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

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

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

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.

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

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

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,

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.

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

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:

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

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

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.

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.

## 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

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.

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:

a. DSH providers (which do not include Governmental DSH providers) shall receive payments from a pool of funds in the amount of nineteen million, two hundred eighty-two thousand and six hundred eighty four dollars ($19,282,684) (total computable) in which ten million thousands dollars ($10,000,000) is the federal share.

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.

2. In no event shall the total payments to a DSH provider for DSH State plan rate year ending September 30, 2013 exceed the uncompensated care costs of the provider for DSH State plan rate year ending September 30, 2013. If the provider has uncompensated care costs attributable to DSH State plan rate year ending September 30, 2013 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 year ending September 30, 2013 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 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 government 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 ten million dollars ($10,000,000.00).

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 government 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 sections B.1. and B.3.a. 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 2012 and June 30, 2012 for DSH State plan rate year 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.

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 Service 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 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 hospitals' 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), Medicaid QUEST Expanded (QEx), and Uninsured population, less payments received from Medicaid FFS, QEx, and uninsured patients.

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 Payments to cover Uncompensated Care Costs (UCC)**

To determine governmentally operated hospitals' (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.

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 room 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 QEx 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 DSH 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. 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 service period. The hospital will update the program charges to include only paid claims from Medicaid FFS and QEx in computing program costs 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 provider's 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.

Payments 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, fundings, 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 the DSH amounts used for federal claiming.

If a hospital's 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 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.

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.

| State: | HAWAII |
|---|---|

**NONINSTITUTIONAL ITEMS AND SERVICES:**

The State assures that the reimbursement to public and private providers of Medicaid services, products or items are the same and does not subdivide or subclassify its payment rates.

All payment rates and their effective dates shall be reflected in the Division's website at www.med-quest.us.

1. HAWAII MEDICAID FEE SCHEDULE:

The Hawaii Medicaid Fee Schedule was updated on January 1, 2013 and made effective for services rendered on or after that date. The current Hawaii Medicaid Fee Schedule is based on sixty percent of the 2006 Medicare Fee Schedule and it is located at http://www.med-quest.us.

Reimbursement rates, expect as specified below and other parts of this Attachment, for providers of medical care who are individual practitioners and other providing non-institutional items and services shall not exceed the maximum permitted under federal laws and regulations and shall be the lower of the Medicare Fee Schedule, the State limits as provided by the Appropriation Act, the Hawaii Medicaid Fee Schedule or the provider's billed amount.

These services include:

(a) Physician services;

(1) Payment shall be sixty per cent of the 2006 Medicare Fee Schedule for physician services. The rate was set and effective on or after January 1, 2013.

(2) For calendar years (CYs) 2013 and 2014, the methodology for the calculation of enhanced payments for primary care physician services delivered to Medicaid recipients is described in Supplement 2 to Attachment 4.19-B. The reimbursement rates are published and located at http://www.med-quest.us.

(b) Podiatric services;

(c) Optometric services;

(d) Other practitioner services including nurse midwife, and pediatric nurse practitioner, advanced practice registered nurse in behavioral health are reimbursed at seventy-five per cent of the Medicaid reimbursement rate for a psychiatrist. Services provided by a licensed clinical social worker, marriage and family therapist, and licensed mental health counselor are reimbursed at seventy-five per cent of the Medicaid reimbursement rate for a psychologist;

(e) Physical therapy;

(f) Occupational therapy;

(g) Services for persons with speech, language, and hearing disorders;

(h) Smoking cessation services;

- Smoking cessation counseling services shall be billed according to the appropriate Healthcare Common Procedures Coding System (HCPCS) code of three to ten minutes or greater than ten minutes.

(i) Telehealth services:

- Spoke site or Originating site / Providers:

  The spoke site (originating site) is only eligible to receive a facility fee not to exceed the published Medicare payment for telemedicine services for spoke sites. If the spoke or originating site is an FQHC/RHC, then the FQHC/RHC is eligible to receive prospective payment system (PPS) visit rate.

  No payments will be made to Medicaid providers to facilitate telehealth.

  Providers are required to identify asynchronous, store and forward technology, with HIPAA compliance coding.

- Hub site or Distant site / Providers:

  Providers, physicians, psychologists, nurse midwives, pediatric or family nurse practitioners, advanced practice registered nurses in behavioral health and licensed clinical social workers in behavioral health, at the hub site or distant site will be reimbursed according to the payment methodology of the appropriate service provided as described in other parts of this Attachment.

  If the hub or distant site is an FQHC/RHC, then the FQHC/RHC is eligible to receive PPS visit rate.

- Transmission fees and items such as technical support, line charges, depreciation on equipment, etc. are not reimbursable services under telehealth.

2. MEDICAID PAYMENTS FOR OTHER NONINSTITUTIONAL ITEMS AND SERVICES ARE DETERMINED AS FOLLOWS:

(a) The reimbursement rates for the following services are based on a rate that is published on the agency's website at www.med-quest.us:

- Durable Medical Equipment (including eyeglass frames and hearing aids), prosthetic devices and appliances except, that Intraocular lens, cochlear implants, and neurostimulators are provided as part of an outpatient surgical procedure and are limited to invoice cost, not to exceed the Medicare fee schedule for the surgical service.

  The rates for durable medical equipment, prosthetic devices and appliances were set and are effective on or after July 1, 2006.

- Dental services (including dentures):

  The dental rates for the neighbor islands (Kauai, Maui, Hawaii, Molokai and Lanai) were set as of 08/07/08 and are effective for services on or after that date. All rates are published on the agency's website at www.medquest.us.

  The dental rates for the island of Oahu were set as of 07/01/08 and are effective for services on or after that date. All rates are published on the agency's website at www.med-quest.us.

- EPSDT (comprehensive periodic examination, case management, skilled nursing and personal care services.)

  The rates for EPSDT were set and are effective on or after July 1, 2006.

- Home pharmacy services;

  The rates for home pharmacy services were set and are effective on or after July 1, 2006.

- Medical supplies;

  The rates for medical supplies were set and are effective on or after July 1, 2006.

- Home Health Agency Services

  The rates for home health agency services were set and are effective on or after July 1, 2006.

(b) Payment for laboratory services and X-ray services shall be at the current Medicare fee schedule for participating providers.

(c) Payments for outpatient hospital treatment room services shall not exceed the lowest of:

1. The rate established by the Department;

2. Seventy-five percent of billed charges; or

3. The Medicare fee schedule for providers who participate in Medicare.

(d) Payments for an emergency room shall not exceed the lowest of the rate established by the department, seventy-five per cent of billed charges, or the Medicare fee schedule for providers who participate in Medicare.

(e) Payments for lenses for eyeglasses shall be limited to the lower of billed charges, not to exceed the lower of the cost plus ten per cent or the Medicare fee schedule for providers who participate in Medicare.

(f) Payments for hearing devices shall be the actual claim charge or $300, whichever is lower. Exceptions may be made for special models or modifications.

(g) Payments for nurse midwife services shall be limited to seventy-five per cent of the Medicaid reimbursement rate for obstetricians and gynecologists.

(h) Payments to pediatric nurse practitioners and family nurse practitioners shall be limited to seventy-five per cent of the prevailing customary Medicaid allowance for pediatric physicians and family practice physicians.

(i) Payments for clinic services (other than physician-based clinics) shall be limited to rates established by the department. The types of clinics include government sponsored non-profit, and hospital-based clinics.

(j) Payments for teaching physicians shall be limited to rates established by the department. Payments are made to the teaching hospital, not to the physician, and per visit payment of $24.

(k) Payment for medical supplies shall be the lowest of billed charges, the rate established by the department, or the Medicare fee schedule for providers who participate in Medicare.

(l) Payments for home pharmacy services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(m) Payments for sleep services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(n) Payments for targeted case management services:

1. Payment is based on negotiated rates which take into consideration Medicaid allowable costs.

   The State has a system in place to accumulate claim costs for the services. Rates are reassessed annually based on historical information provided by the Department of Health and verified by the Department of Human Services. Historical data will be used to set the base each year and any new add-ons will be calculated into the new rate.

   A. Services shall be reimbursable only for calendar months during which at least one face to face or telephone contact is made with the recipient or collaterals.

   B. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

option #1 add telephone services

C. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

D. Requests for payments shall be submitted on a form specified by the Department and shall include the:

(i) Date of service;

(ii) Recipient's name and identification number;

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and

(v) Place of service.

2. Payments for Medicaid recipients, who are medically-fragile, are based on negotiated rates. The negotiated rates are based on cost data submitted by each provider agency which take into consideration allowable Medicaid cost, expenditures related to case management services, and administrative expenditures. These costs will serve as the basis from which the final rate will be negotiated. Negotiation of the rate will take into consideration items such as but not limited to type of existing services, new add-on services, and area availability.

Negotiated rates will be re-calculated by the Department of Human Services each year using the last full year of available data.

A. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

B. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

C. Requests for payments shall be submitted on a form specified by the Department and shall include:

(i) Date of Service;

(ii) Recipient's name and identification number;

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and;

(v) Place of service.

3. Payments shall be limited to agencies that are authorized Medicaid providers for the following case management services:

A. Case Management – Inpatient hospital for ventilator dependent/tracheostomized child prior to initial discharge to home/community - requires authorization.

B. Case Management for ventilator dependent/tracheostomized child living in the home/community – requires authorization.

C. Case Management for non-ventilator dependent/non tracheostomized child with significant medical needs – requires authorization.

D. Maintenance Case Management for children with significant medical needs whose caregivers are able to access services and supplies with little assistance from case managers – requires authorization.

E. Additional case management hours to address changing medical needs – requires authorization and a report.

(o) Effective July 1, 2001, the Department will adopt the following statewide, fee-for-service reimbursement rates for each community mental service:

| SERVICE | PROVIDER TYPE | UNITS OF SERVICE | REIMBURSEMENT METHODOLOGY |
|---|---|---|---|
| Crisis management:<br>1. Telephone contact | Agency | Per contact | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers who participate in Medicare.<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| 2. Telephone contact followed by face to face | Agency | Per contact | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. |

| | | | |
|---|---|---|---|
| 2. Telephone contact followed by face to face (continued) | | | • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| Crisis residential | Agency | Daily | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers who participate in Medicare.<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| Biopsychosocial rehab | Agency | Billed in 15 minute increments. | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule |

| | | | |
|---|---|---|---|
| Biopsychosocial rehab (continued) | | | • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare.<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability. |
| Intensive family intervention | Agency | Billed in 15 minute increments. | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers participating in Medicare<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| Therapeutic supports | Agency | Daily | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the |

| | | | |
|---|---|---|---|
| Therapeutic supports (continued) | | | established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers participating in Medicare<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| Intensive outpatient hospital services | Agency | Daily | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule<br>• Rate will not exceed the Medicare fee schedule for providers participating in Medicare<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |
| ACT | Agency | Billed in 15 minute increments. | Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors:<br>• Cost to provide the service<br>• Comparison to comparable services by comparable Medicaid provider types<br>• Relative value to other services within the established fee schedule |

| | | | |
|---|---|---|---|
| ACT (continued) | | | • Rate will not exceed the Medicare fee schedule for providers participating in Medicare<br>• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability |

(p) Medicaid reimbursement for school-based health-related services (SBHRS) is available to the Department of Education (DOE) under an interagency service agreement (ISA) with the Med-QUEST Division. The ISA provides that the DOE is responsible for:

1. Payment of the state share of Medicaid reimbursement for SBHRS provided by or through the DOE;

2. Documenting the delivery of SBHRS as required by the Med-QUEST Division;

3. Supervising or overseeing the delivery of SBHRS; and

4. Otherwise complying with all applicable Federal and State requirements.

The DOE will be reimbursed on a fee-for-service basis. Each service that is reimbursable as a SBHRS will be reimbursed in accordance with the fee schedule maintained by the Med-QUEST Division for medical services rendered by authorized Medicaid providers.

Note: The Hawaii Medicaid fee schedule has separate rates for group therapy and individual therapy.

(q) Payments to a facility for non-emergency care rendered in an emergency room shall not exceed:

1. The rate negotiated by the Department;

2. Seventy-five per cent of billed charges; or

3. The Medicare fee schedule for providers participating in Medicare.

The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straight forward medical decision making.

(r) The upper limits on payments for all non-institutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes.

3. PAYMENT FOR MEDICATIONS AND DISPENSING FEES

a. Payment for medications:

1. Payment for ingredient cost of prescription drugs:

A. For single source drugs, shall not exceed the lower of:
i. The provider's invoice price;
ii. The provider's usual and customary charge to the general public; or
iii. The estimated acquisition cost (EAC).

B. For multiple source drugs, shall not exceed the lower of:

i. The provider's invoice price;
ii. The provider's usual and customary charge to the general public;
iii. The EAC;
iv. The Federal Upper Limit (FUL) price; or
v. The State Maximum Allowable Cost (SMAC)

C. Over-the-counter medications may be covered and, if covered, the payment shall be according to the methodology described in a.1.

D. The FUL price does not apply if a physician:

i. Certifies in his or her own handwriting or by an electronic method compliant with national standard approved by CMS, that a specific brand is medically necessary for a particular recipient. A check-off box on a form is not acceptable but a notation of "brand medically necessary" or "do not substitute" is allowable.

ii. Obtains medical authorization for medical necessity from the state medical assistance program for specific brands of medication designated by the program.

iii. In such cases, the payment shall be according to the methodology described in a.1.

E. The EAC, for the purpose of this section, is defined as the Wholesale Average Cost (WAC).

F. The SMAC will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department agent. A generic drug may be considered SMAC for the pricing if there are two or more therapeutically equivalent, multi-source, non-innovator drugs with a cost difference. The SMAC will be based on drug status (including non-rebatable, rebatable, therapeutic equivalency rating, etc.), marketplace availability in Hawaii and cost. The drug status will be taken into account to ensure that the SMAC pricing is not influenced by the process listed for drugs.

G. Payment will not be made for innovator multiple source drugs subject to the Federal Upper Limits (42 C.F.R. 447.332(a)) when a less expensive non-innovator multiple source drug is available for dispensing from the pharmacy. Substitution may not be prohibited by Part VI, Drug Product Selection of 328 HRS.

2. Payment of dispensing fees for prescription drugs dispensed by a licensed pharmacy:

A. $5.00 per prescription.
B. The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program.

3. to 10. INTENTIONALLY BLANK

11. In compliance with section 1927(b)(2) of the Social Security Act invoice reports will be submitted to each qualifying rebate manufacturer and the Department of Health and Human Services Secretary within sixty days after the end of each calendar quarter including information on the total number of dosage units of each covered outpatient drug dispensed under the rebate plan. This report will be consistent with the standard reporting format established by the Secretary and include the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter.

b. Payments for transportation services are limited as follows:

1. Payments for ground ambulance and air ambulance services are limited to billed charges, the rate negotiated by the Department or the Medicare reasonable charge, whichever is lower. In the case of neonatal ground transportation, the upper limit on payment shall be at a rate set by the Department;

2. Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island or out-of-state airfare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the Department for emergency chartered flights. For transportation of a stretcher patient by the scheduled carrier, payment shall not exceed the airfare charged for four seats on the recipient's flight.

3. A round trip airfare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the Department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the Department's medical consultant's review. In addition, payment shall be made for the attendant's service, provided the attendant is unrelated to the patient. The amount of payment for the attendant's service shall not exceed the following applicable rates:

(a) Leave and return same day .....$20

(b) Requiring overnight stay .....$40

4. Payments for emergency air ambulance services shall be based upon prearranged contracted rates between the air carrier and the Department, not to exceed the rates charged the general public or the amounts paid by Medicare, whichever is lowest. The emergency trip shall be authorized by the attending physician using the form designated by the Department;

5. Payments for emergency ground ambulance services shall be based upon prearranged contracted rates between the provider and the Department, not to exceed rates charged the general public or the amounts paid by Medicare, whichever is lowest. Additional amounts shall be paid for life-saving measures administered in the ambulance such as oxygen. The charge shall not exceed the provider's customary charge to the general public, the rate set by the Department, or Medicare's reimbursement level for the same service. Recipients requiring ambulance service shall have the emergency trip authorized by the attending physician using the form designated by the Department or by the medical consultant of the Department;

(6) Payments for medical taxi services shall be by purchase order issued by the branch office and only for trips to or from a physician's office, clinic, hospital, or airport (for covered medical transportation) and the patient's home.

Further limitations on reimbursement for such services include:

(a) No detours or side trips shall be permitted;

(b) The amount of payment shall be made on the basis of metered rates charged the public; or

(c) Payments shall not include compensation for the driver's waiting time at the clinic, hospital, physician's office, or a location of other providers of medical services.

7. Lodging and meals for Medicaid patients or attendants authorized by the attending physician, in an emergency situation, or the Department's medical consultant shall be paid through purchase orders to the providers issued by the branch unit.

8. Payments for non-emergency transportation (e.g., Handicabs, but no taxis), are limited to rates established by the Department.

c. Reimbursement for hospice services shall be based on the rates established under Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. The rates, which went into effect on October 1, 1990, will continue through December 31, 1990

ATTACHMENT 4.19-B

## 6. MAXIMUM MEDICAID PAYMENT RATES FOR PEDIATRIC PRACTITIONER PEDIATRIC SERVICES (EFFECTIVE 01/01/97)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| | **EVALUATION AND MANAGEMENT:** | | |
| | *OFFICE OR OTHER OUTPATIENT SERVICES* | | |
| | **New Patients:** | | |
| * 99201 | Physicians typically spend 10 minutes | 25.20 | 26.81* |
| * 99202 | Physicians typically spend 20 minutes | 40.50 | 40.50 |
| * 99203 | Physicians typically spend 30 minutes | 60.70* | 60.70* |
| * 99204 | Physicians typically spend 45 minutes | 55.00 | 79.80 |
| * 99205 | Physicians typically spend 60 minutes | 61.15 | 91.80 |
| | **Established Patients:** | | |
| * 99211 | Typically 5 minutes are spent supervising or performing these services | 11.04 | 11.40 |
| * 99212 | Physicians typically spend 10 minutes | 16.63 | 18.00 |
| * 99213 | Physicians typically spend 15 minutes | 23.04 | 23.73 |
| * 99214 | Physicians typically spend 25 minutes | 42.00 | 40.50 |
| *99215 | Physicians typically spend 40 minutes | 47.50 | 56.52 |
| | *OFFICE OR OTHER OUTPATIENT CONSULTATIONS* | | |
| | **New or Established Patients:** | | |
| 99241 | Physicians typically spend 15 minutes | 51.92* | 51.92* |
| 99242 | Physicians typically spend 30 minutes | 71.21* | 71.21* |
| 99243 | Physicians typically spend 40 minutes | 82.63* | 82.63* |
| 99244 | Physicians typically spend 60 minutes | 117.32* | 117.32* |

ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
## (Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| 99245 | Physicians typically spend 80 minutes | 134.40* | 134.40* |
| | *CONFIRMATORY CONSULTATIONS* | | |
| | **New or Established Patients:** | | |
| 99271 | Usually the presenting problem(s) are self limited or minor | 41.14* | 41.14* |
| 99272 | Usually the presenting problem(s) are of low severity | 75.47* | 75.47* |
| 99273 | Usually the presenting problem(s) are of moderate severity | 69.20 | 69.20 |
| 99274 | Usually the presenting problems(s) are of moderate to high severity | 98.92* | 98.92* |
| 99275 | Usually the presenting problem(s) are of moderate to high severity | 129.97* | 129.97* |
| | *HOME SERVICES* | | |
| | **New Patient:** | | |
| 99341 | Usually the presenting problem(s) are of low severity | 50.77* | 50.77* |
| 99342 | Usually the presenting problem(s) are of moderate severity | 58.50 | 58.50 |
| 99343 | Usually the presenting problem(s) are of high severity | 79.97* | 79.97* |
| | **Established Patient:** | | |
| 99351 | Usually the patient is stable, recovering or improving | 39.29* | 39.29* |

ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
## (Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| 99352 | Usually the patient is responding inadequately to therapy or has developed a minor complication | 31.49 | 37.27 |
| 99353 | Usually the patient is unstable or has developed a significant complication or a significant new problem | 48.16 | 47.85 |
| | *PROLONGED SERVICES* | | |
| | **Prolonged Physician Services with Direct (Face-to-Face) Patient Contact:** | | |
| 99354 | Prolonged Physician Service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour | By Report | By Report |
| 99355 | Each additional 30 minutes | By Report | By Report |
| | **Prolonged Physician Service without Direct (Face-to-Face) Patient Contact:** | | |
| 99358 | Prolonged evaluation and management service before and/or after direct patient care; first hour | Ineligible | Ineligible |
| 99359 | Each additional 30 minutes | Ineligible | Ineligible |
| | *PREVENTIVE MEDICINE SERVICES* | | |
| | **New Patients:** | | |
| * 99381 | Initial preventive medicine evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; new patient; infant (age under 1 year) | 27.00 | 36.00 |
| * 99382 | Early childhood (age 1-4 years) | 46.37 | 31.50 |

ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
## (Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| * 99383 | Late childhood (age 5-11 years) | 33.00 | 33.60 |
| * 99384 | Adolescent (age 12-17 years) | 36.00 | 35.28 |
| | **Established Patient:** | | |
| * 99391 | Periodic preventive medicine reevaluation and management of individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year) | 24.00 | 25.20 |
| * 99392 | Early childhood (age 1-4 years) | 29.25 | 28.50 |
| * 99393 | Late childhood (age 5-11 Years) | 30.00 | 31.50 |
| * 99394 | Adolescent (age 12-17 years) 12-24 hr continuous recording, infant | 31.20 | 37.80 |
| | *COUNSELING AND/OR RISK FACTOR* | | |
| | *REDUCTION INTERVENTION* | | |
| | **New or Established Patient:** | | |
| | **Preventive Medicine, Individual Counseling:** | | |
| 99401 | Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes | Ineligible | Ineligible |
| 99402 | Approximately 30 minutes | " | " |
| 99403 | Approximately 45 minutes | " | " |
| 99404 | Approximately 60 minutes | " | " |
| | | | |

ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| | **Preventive Medicine, Group Counseling:** | | |
| 99411 | Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes | Ineligible | Ineligible |
| 99412 | Approximately 60 minutes | " | " |
| | **Other Preventive Medicine Services:** | | |
| 99420 | Administration and interpretation of health risk assessment instrument(e.g., health hazard appraisal) | " | " |
| 99429 | Unlisted preventive medicine service | By Report | By Report |
| | *NEWBORN CARE* | | |
| 99432 | Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conferences(s) with parent(s) | 27.00 | 36.00 |
| | *MEDICINE* | | |
| | **Immunization Injections:** | | |
| 90700 | Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine(DTP) | Physicians are paid $2. for administration & AWP (Blue Book) current price less 10.5%. For VFC (Vaccines For Children) vaccines, no reimbursement is made | |
| * 90701 | Diphtheria and tetanus toxoids and pertussis vaccine (DTP) | | |
| 90702 | Diphtheria and tetanus toxoids (DT) | | |
| 90703 | Tetanus toxoid | | |

ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| 90704 | Mumps virus vaccine, live | for vaccines, but a $2.00 Administrative charge is allowed. | |
| 90705 | Measles virus vaccine, live | | |
| 90706 | Rubella virus vaccine, live | | |
| * 90707 | Measles, mumps and rubella virus vaccine, live | " | " |
| 90708 | Measles and rubella virus vaccine, live | " | " |
| 90709 | Rubella and mumps virus vaccine, live | " | " |
| 90710 | Measles, mumps, rubella, and varicella vaccine | " | " |
| 90711 | Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine | " | " |
| * 90712 | Poliovirus vaccine, live, oral (any type s) | " | " |
| 90713 | Poliomyelitis vaccine | " | " |
| 90714 | Typhoid vaccine | " | " |
| 90716 | Varicella (chicken pox) vaccine | " | " |
| 90717 | Yellow fever vaccine | " | " |
| 90719 | Diphtheria toxoid | " | " |
| 90720 | Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine | " | " |
| 90721 | Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) and Hemophilus influenza B (HIB) vaccine | " | " |
| 90724 | Influenza virus vaccine | " | " |
| 90725 | Cholera vaccine | " | " |

## PEDIATRIC PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | PED |
| 90726 | Rabies vaccine | " | " |
| 90727 | Plague vaccine | " | " |
| 90728 | BCG vaccine | " | " |
| 90730 | Hepatitis A vaccine | " | " |
| 90732 | Pneumococcal vaccine, polyvalent | " | " |
| 90733 | Meningococcal polysaccharide vaccine (any group(s)) | " | " |
| * 90737 | Hemophilus influenza B | " | " |
| 90741 | Immunization, passive; immune serum globulin, human (ISG) pertussis, rabies, | " | " |
| 90742 | Specific hyperimmune serum globulin (e.g. hepatitis B, measles, pertussis, rabies, RHO (D), tetanus, vaccinia, varicella-zoster) | " | " |
| * 90744 | Immunization, active, hepatitis B vaccine; newborn to 11 years | " | " |
| * 90745 | 11 - 19 years | " | " |
| 90749 | Unlisted immunization procedure | " | " |
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ATTACHMENT 4.19-B

## PEDIATRIC PRACTITIONER SERVICES
(Continued)

** Ineligible = Services are included in other E & M services, in global perinatal care, complete EPSDT periodic screens are reimbursed at $95.00 (global fee), targeted case management is reimbursed at $9.75 per 15 minutes, complete perinatal is reimbursed at $900.00 for vaginal and $1,400.00 for C-section deliveries.

ATTACHMENT 4.19-B

## 7. MAXIMUM MEDICAID PAYMENT RATES FOR OBSTETRICAL SERVICES

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | OB-GYN |
| | *MATERNITY CARE AND DELIVERY* | | |
| | **Incision:** | | |
| 59000 | Amniocenteses, any method | 81.00 | 81.00 |
| 59012 | Cordocentesis (intrauterine), any method | 216.96* | 216.96* |
| 59015 | Chorionic villus sampling, any method | 118.08* | 118.08* |
| 59020 | Fetal contraction stress test | 72.44* | 72.44* |
| 59025 | Fetal non-stress test | ... | 43.24* |
| 59030 | Fetal scalp blood sampling | 63.37 | 56.88 |
| 59050 | Fetal monitoring during labor by consulting physician with written report (separate procedure); supervision and interpretation | 84.28* | 84.28* |
| | **Excision:** | | |
| 59051 | Interpretation only | 62.37 | 56.88 |
| 59100 | Hysterotomy, abdominal (e.g. for hydatidiform mole, abortion) | 375.00* | 375.00* |
| 59120 | Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach | 563.92* | 563.92* |
| 59121 | Tubal or ovarian, without salpingectomy and/or oophorectomy | 457.05* | 457.05* |
| 59130 | Abdominal pregnancy | 494.92* | 494.92* |
| 59135 | Interstitial, uterine pregnancy requiring total hysterectomy | 567.18* | 567.18* |
| 59136 | Interstitial, uterine pregnancy with partial resection of uterus | 555.58* | 555.58* |

TN No. 97-001
Supersedes
TN No. 96-003

Approval Date JUN 12 1997 Effective Date APR - 1 1997

ATTACHMENT 4.19-B

## OBSTETRICAL PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | OB-GYN |
| 59140 | Cervical, with evacuation | 343.04* | 343.04* |
| 59150 | Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy | 404.44 | 404.44 |
| 59151 | With salpingectomy and/or oophorectomy | 566.46 | 566.46* |
| 59160 | Curettage, postpartum (separate procedure) | 209.97* | 209.97* |
| | **Introduction:** | | |
| 59200 | Insertion of cervical dilator | 49.15 | 49.15* |
| | **Repair:** | | |
| 59300 | Episiotomy or vaginal repair, by other than attending physician | 117.43* | 117.43* |
| 59320 | Cerclage or cervix, during pregnancy; vaginal | 158.24* | 158.24* |
| 59325 | Abdominal | 246.03* | 246.03* |
| 59350 | Hysterorrhaphy of ruptured uterus | 316.14* | 316.14* |
| | **Vaginal Delivery, Antepartum, & Postpartum Care:** | | |
| 59400 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care | 630.20 | 588.80 |
| * 59409 | Vaginal delivery only (with or without episiotomy and/or forceps); | 415.80 | 379.20 |
| * 59410 | Including postpartum care | 472.80 | 472.80 |
| * 59412 | External cephalic version, with or without tocolysis | By Report | By Report |
| * 59414 | Delivery of placenta (separate procedure) | 102.79* | 102.79* |

TN No. 97-001
Supersedes
TN No. 96-003

Approval Date JUN 12 1997 Effective Date APR - 1 1997

ATTACHMENT 4.19-B

## OBSTETRICAL PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | OB-GYN |
| * 59425 | Antepartum care only; 4-6 visits | 124.74 | 113.76 |
| * 59426 | 7 or more visits | 249.48 | 227.52 |
| * 59430 | Postpartum care only (separate procedures) | 48.71 | 54.00 |
| | **Cesarean Delivery:** | | |
| * 59510 | Routine obstetric care including antepartum care, cesarean delivery, and post partum care | 1042.80 | 1042.80 |
| * 59514 | Cesarean delivery only; | 675.65 | 675.65 |
| * 59515 | Including postpartum care | 675.65 | 675.65 |
| * 59525 | Subtotal or total hysterectomy after cesarean delivery | 380.10* | 380.10* |
| | **Abortion:** | | |
| 59812 | Treatment of incomplete abortion, any trimester, completed surgically | 199.98* | 199.98* |
| 59820 | Treatment of missed abortion, completed surgically; first trimester | 270.00 | 243.00 |
| 59821 | Second trimester | 243.00* | 243.00* |
| 59830 | Treatment of septic abortion, completed surgically | By Report | By Report |
| 59840 | Induced abortion, by dilation and curettage | 280.61* | 280.61* |
| 59841 | Induced abortion, by dilation and evacuation | 255.47* | 255.47* |
| 59850 | Induced abortion, by one or more intra-amniotic injections | 349.85* | 349.85* |
| 59851 | With dilation and curettage and/or evacuation | 366.61* | 366.61* |
| 59852 | With hysterotomy (failed intra-amniotic injection) | 491.77* | 491.77* |

ATTACHMENT 4.19-B

## OBSTETRICAL PRACTITIONER SERVICES
(Continued)

| PROCEDURE CODE | PROCEDURE DESCRIPTION | MAXIMUM PAYMENT | |
|---|---|---|---|
| | | GEN PRAC | OB-GYN |
| 59855 | Induced abortion, by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g., laminaria); | 372.22 | 372.22 |
| 59856 | With dilation and curettage and/or evacuation | 561.62 | 561.62 |
| 59857 | With hysterotomy (failed medical evaluation) | 663.60 | 683.08 |
| | **Other Procedures:** | | |
| 59870 | Uterine evacuation and curettage for hydatidiform mole | By Report | By Report |
| 59899 | Unlisted procedure, maternity care and delivery documentation; complete | By Report | By Report |
| | | | |
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ATTACHMENT 4.19-B

# ADEQUACY OF ACCESS BASED ON PRACTITIONER PARTICIPATION DURING 1994

## I. OBSTETRICAL STANDARD:

| County | No. of Providers | No. of Participants | % Participants |
|---|---|---|---|
| Hawaii | 15 | 10 | 66.7% |
| Kauai | 6 | 3 | 50.0% |
| Maui * | 12 | 4 | 33.3% |
| Honolulu | 167 | 40 | 24.0% |
| **TOTAL** | **200** | **57** | **29.0%** |

* = Also includes Lanai and Molokai

## II. PEDIATRIC STANDARD:

| County | No. of Providers | No. of Participants | % Participants |
|---|---|---|---|
| Hawaii | 18 | 13 | 72.2% |
| Kauai | 9 | 3 | 33.3% |
| Maui * | 17 | 11 | 64.7% |
| Honolulu | 215 | 70 | 32.6% |
| **TOTAL** | **259** | **97** | **37.5%** |

Source: MMIS

* Hawaii QUEST was implemented August 1, 1994. The statistics above is based on fee-for-service access from January 1, 1996 through December 31, 1996, which covers the total eligible Medicaid population. Effective August 1, 1994, only ABD is covered through fee-for-service.

* There are approximately 1200 children statewide in the fee-for-service medical program.

8. HMO RATES FOR OBSTETRICAL AND PEDIATRIC SERVICES:

Payment for obstetrical and pediatric services are included in the monthly capitation rate for eligible Medicaid recipients enrolled in HMO. Currently, Hawaii has an 1115 Waiver with five managed care health plans. The capitation rate is actuarially calculated by the HMO based on historical and projected costs for the region (Hawaii). The State calculates the fee-for-service cost of service provided by the HMO to an actuarially equivalent non-enrolled population group. Following are the current monthly capitation rates which reflect annual increases to assure adequacy of access to obstetric and pediatric services:

**Capitation Rates as of 07/01/97:**

(+) Capitation rate for Kapiolani Health Hawaii is effective 09/01/97

| | AlohaCare | HMSA | Kaiser | Kapiolani Health Hawaii (+) | Queen's Hawaii Care | Straub |
|---|---|---|---|---|---|---|
| Oahu | $151.67 | $142.00 | $146.71 | $149.71 | $146.92 | $143.00 |
| Hawaii | $135.88 | $139.00 | $135.88 | $139.00 | $138.12 | |
| Maui | $135.21 | $135.21 * | $127.11 | | $133.43 | |
| Molokai | | $135.02 | | | $135.02 | |
| Kauai | $139.88 | $145.00 * | | $145.00 | $137.08 | |
| Lanai | | $148.70 | | | | $148.70 |

*coverage only until 08/31/97

**Capitation Rates as of 07/01/96:**

| | AlohaCare | HMSA | Kaiser | Queen's Hawaii Care | Straub |
|---|---|---|---|---|---|
| Oahu | $167.06 | $167.06 | $167.06 | $167.06 | $167.06 |
| Hawaii | $159.32 | $159.32 | $159.32 | $159.32 | |
| Maui | $152.21 | | | $152.21 | |
| Molokai | $148.57 | | | $148.57 | |
| Kauai | $158.19 | $158.19 | | $158.19 | |
| Lanai | | | $163.78 | | $163.78 |

**Capitation Rates as of 08/01/95:**

| | AlohaCare | HMSA | Kaiser | Queen's Hawaii Care | Straub |
|---|---|---|---|---|---|
| Oahu | $174.00 | $176.26 | $177.11 | $167.06 | $177.50 |
| Hawaii | $175.00 | $166.78 | $166.78 | $159.32 | |
| Maui | $152.21 | | | $166.78 | |
| Molokai | $148.57 | | | $166.78 | |
| Kauai | $169.50 | $166.78 | | $158.19 | |
| Lanai | | | $163.78 | | $164.15 |

**Capitation Rates as of 08/01/94:**

| | AlohaCare | HMSA | Kaiser | Queen's Hawaii Care | Straub |
|---|---|---|---|---|---|
| Oahu | $163.22 | $168.35 | $151.40 | $155.74 | $153.16 |
| Hawaii | $161.25 | $156.66 | $156.66 | $144.78 | |
| Maui | $144.08 | | | $166.13 | |
| Molokai | $126.84 | | | $155.44 | |
| Kauai | $154.29 | $162.20 | | $144.04 | |
| Lanai | | | $136.12 | | $177.57 |

9. PAYMENTS FOR ALL OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

Payments for all other non-institutional items and services shall be at a rate set by the Department. In the case of Qualified Medicare Beneficiaries, deductibles and co-insurance payments for any Medicare covered services that are not otherwise covered under the Hawaii State Plan, are based on the Medicare reasonable charge.

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

### 10.0 Introduction

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

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

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

### 10.1 Prospective Payment System

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

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

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

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

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

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

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

(g) Starting January 1, 2002, PPS rates will be adjusted annually using the Medicare Economic Index ("MEI"), as defined in Section 1842(i)(3) of the Social Security Act applicable to primary care services as defined in Section 1842(i)(4) of the Social Security Act, for that calendar year as published in the Federal Register.

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

**10.2** Supplemental Managed Care Payments

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

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

**10.3** Adjustments for Changes in Scope of Service

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

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

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

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

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

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

(g) Payment adjustments will be made for the period from the effective date of the change in scope of services through the date of the final adjustment of the PPS rate.

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

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

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

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

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

**10.4** Other Payment Adjustments

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

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

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

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

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

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

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

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

**10.5** Cost Reporting, Record Keeping and Audit Requirements

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

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

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

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

iii. In either of the circumstances described above, the following documentation must be submitted no later than five months after the close of the FQHC's or RHC's fiscal year:

- Uniform cost report;
- Working trial balance;
- Provider cost report questionnaire;
- Audited financial statements, if available;
- Disclosure of appeal items included in the cost report;
- Disclosure of increases or decreases in scope of services; and
- Other schedules as identified by the Department.

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

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

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

**10.6** Rebasing

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

**10.7** Eligible Services

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

i. Within the legal authority of an FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended;
ii. Actually provided by the FQHC or RHC, either directly or under arrangements;
iii. Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan;
iv. Provided to a recipient eligible for Medicaid benefits;
v. Delivered exclusively by licensed health care professionals (physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, or licensed dieticians);
vi. Provided in an outpatient settings during business or after hours on the FQHC's or RHC's site. For full-benefit dual eligibles only, services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's

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

vii. Within the scope of services provided by the State under its fee-for-service Medicaid program and its Health QUEST program, on and after August 1994.

(b) Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day and at a single location shall constitute a single encounter unless:

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

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

**10.8** Non-FQHC Services

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

**10.9** Appeal

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

11. REIMBURSEMENT METHODOLOGOES FOR NON-PLAN SERVICES FOR EPSDT ELIGIBLE INDIVIDUALS

a. Reimbursement of services for organ transplant patients, whether EPSDT eligible or not, are described below in Attachment 4.19-B, item 12 titled "Reimbursement Methodologies for organ transplants".

b. Chiropractor Services

Payment for chiropractor services shall not exceed the Medicare fee schedule for provider's participating in Medicare.

c. Private Duty Nursing, Personal Care, and Case Management Services

Reimbursement for these services shall be made according to the rates established by the Department.

12. REIMBURSEMENT METHODOLOGIES FOR ORGAN TRANSPLANTS

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.

a. Reimbursement of services related to organ transplants will be negotiated with providers by the contractor and will be approved by the State. The negotiated case rate will not exceed Medicare or prevailing regional market rates.

b. Reimbursement of services that are not related to organ transplants shall be the lower of the actual amount billed by the provider or the fee in the Hawaii Medicaid Fee Schedule, either of which will not exceed the Medicare upper payment limit or the rate established by the Department.

**Citation:** 42 CFR 434, 438 and 447; and Social Security Act 1902(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.

**Other Provider-Preventable Conditions.**

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

☒ 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 outpatient/non-institutional reimbursement to account for non-payment of 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 for 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.

The Med-QUEST Division will utilize medical review to identify potential OPPCs on claims. For claims with identified OPPCs that were not previously existing, reimbursement associated with the OPPC will be recovered.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

### Payment of Medicare Part A and Part B Deductible / Coinsurance

| | | | | | |
|---|---|---|---|---|---|
| QMBs: | Part A | NR | Deductibles | NR | Coinsurance |
| | Part B | NR | Deductibles | NR | Coinsurance |
| Other Medicaid Recipients | Part A | NR | | NR | Coinsurance |
| | Part B | NR | | NR | Coinsurance |
| Dual Eligibles (QMB Plus) | Part A | NR | Deductibles | NR | Coinsurance |
| | Part B | NR | Deductibles | NR | Coinsurance |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

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

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

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

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

**PHYSICIAN SERVICES**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

Hawaii is using the Deloitte fee schedule and will not adjust rates throughout the year to account for changes in Medicare rates.

☐ The rates reflect all Medicare sites of service adjustments.
☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
☒ The rates reflect all Medicare geographic/locality adjustments.
☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

**Method of Payment**

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405. The difference between the reimbursement rates as of July 1, 2009 and the minimum payment at 42CFR 447.405 will receive 100% FFP.

Supplemental payment is made: ☐ monthly ☒ quarterly

**Primary Care Services Affected by this Payment Methodology**

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

| Description | Code |
|---|---|
| **Hospital Inpatient** | |
| Subsequent Observation Care, 15 minutes | 99224 |
| Subsequent Observation Care, 25 minutes | 99225 |
| Subsequent Observation Care, 35 minutes | 99226 |
| **Consultations* Eliminated by Medicaid on June 1, 2010** | |
| Office/Outpatient New or Established patients, 15 minutes | 99241 |
| Office/Outpatient New or Established patients, 30 minutes | 99242 |
| Office/Outpatient New or Established patients, 40 minutes | 99243 |
| Office/Outpatient New or Established patients, 60 minutes | 99244 |
| Office/Outpatient New or Established patients, 80 minutes | 99245 |
| Inpatient New or Established patients, 20 minutes | 99251 |
| Inpatient New or Established patients, 40 minutes | 99252 |
| Inpatient New or Established patients, 55 minutes | 99253 |
| Inpatient New or Established patients, 80 minutes | 99254 |
| Inpatient New or Established patients, 110 minutes | 99254 |
| **Standby Services** | |
| Stand-by service requiring prolonged attendance, each 30 minutes | 99360 |

| Description | Code |
|---|---|
| **Interdisciplinary Conferences** | |
| Medical team conference with interdisciplinary team (IDT) of health care professionals, face to face with patient or family, 30 minutes or more, participation by non-physician qualified health professional | 99366 |
| Medical team conference with interdisciplinary team (IDT) of health care professionals, patient or family not present, 30 minutes or more, participation by non-physician qualified health professional | 99367 |
| Participation by non-physician qualified health professional | 99368 |
| **Care Plan Oversight: Patient under care of Home Health Agency (HHA), Hospice, or Nursing Facility (NF)** | |
| Supervision of a patient under care of HHA; 15-29 min | 99374 |
| Supervision of a patient under care of hospice; 15-29 min | 99377 |
| Supervision of a patient under care of NF; 15-29 min | 99379 |
| Supervision of a patient under care of NF; 30 min or more | 99380 |
| **Counseling Services: Risk Factor and Behavior Change** | |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 15 min | 99401 |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 30 min | 99402 |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 45 min | 99403 |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 60 min | 99404 |
| Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT,DAST) and brief intervention; 15 to 30 min | 99408 |
| Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT,DAST) and brief intervention; greater than 30 min | 99409 |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 min | 99411 |
| Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 min | 99412 |
| Administration and integration of health risk assessment instrument (e.g., health hazard appraisal) | 99420 |
| **Telephone calls for Patient Management** | |
| Telephone evaluation and management services; 5 to 10 minutes of medical discussion | 99441 |
| Telephone evaluation and management services; 11 to 20 minutes of medical discussion | 99442 |
| Telephone evaluation and management services; 21to 30 minutes of medical discussion | 99443 |
| **Online Patient Management Services** | |
| Online evaluation and management services performed with an already established patient not originating from a previous E&M within the previous 7 days | 99444 |
| **Life/Disability Insurance Eligibility Visits** | |
| Basic Life/Disability examination | 99450 |
| Work Related/Medical Disability examination by a physician | 99455 |
| Work Related/Medical Disability examination by a non-physician | 99456 |

| | |
|---|---|
| **Critical Care Transport Age 24 months or younger** | |
| Supervision by a control physician of interfacility transport care; first 30 minutes | 99485 |
| Supervision by a control physician of interfacility transport care; each additional 30 minutes | 99486 |
| **Coordination of Complex Services for Chronic Care** | |
| Complex chronic care coordination services, first hour of clinical staff time, directed by the physician or other qualified health care professional with no face-to-face visit, per calendar month | 99487 |
| Complex chronic care coordination services, first hour of clinical staff time, directed by the physician or other qualified health care professional with one face-to-face visit, per calendar month | 99488 |
| Complex chronic care coordination services, each additional 30 minutes of clinical staff time, directed by the physician or other qualified health care professional per calendar month | 99489 |
| **Management of Transitional Care Services** | |
| Transitional care management services with the patient or caregiver within two (2) business days of discharge. Medical decision making of at least moderate complexity during face-to-face visit within 14 calendar days of discharge | 99495 |
| Transitional care management services with the patient or caregiver within two (2) business days of discharge. Medical decision making of at least moderate complexity during face-to-face visit within 7 calendar days of discharge | 99496 |

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

N/A

**Physician Services - Vaccine Administration**

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☒ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $4.00.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

**Effective Date of Payment**

**E & M Services**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at www-med-quest.us.

Effective January 1, 2015, the reimbursement methodology will return to that in effect on December 31, 2012.

**Vaccine Administration**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at www-med-quest.us.

Effective January 1, 2015, the reimbursement methodology will return to that in effect on December 31, 2012.

State HAWAII

PAYMENT FOR RESERVING BEDS IN LONG-TERM CARE FACILITIES

Payments for reserving beds in skilled nursing and intermediate care facilities may be allowed if:

1. The recipient's plan of care provides for absences other than for hospitalization, and is approved by the recipient's attending physician;
2. Any single episode of bed-holding does not exceed a period of three consecutive days, unless prior approval request is submitted to the program, reviewed, and approved by its medical consultant;
3. A total number of bed-holding days per patient per calendar year does not exceed twelve days; and
4. A record is maintained in the recipient's medical charts which accounts for the number of days and specific dates that bed-holding was in effect for the year, subject to periodic review by the department's representatives.

STATE OF HAWAII

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR LONG-TERM CARE FACILITIES

## I. DEFINITIONS

When used in this Plan, the following terms shall have the indicated meanings:

A. "Acuity based reimbursement system" means the Medicaid reimbursement system for nursing facility (NF) level of care described in Supplement to Attachment 4.19-D. The acuity based reimbursement system applies to Acuity A and Acuity Level C services, excluding services in critical access hospital.

B. "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.

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

D. "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.

E. "Acuity Level D" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care that is relatively higher than Acuity Level C but less than acute.

F. "Acuity Ratio" means the estimated average 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.

G. "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 VIII.E.2.

H. "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.

I. "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.

J. "Basic PPS Rate" means the sum of the applicable per diem amounts for the direct nursing, capital, and G&A 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 Plan. It does not include the various adjustments or increases to the basic PPS rate defined in this Plan.

K. "Base Year" means the state fiscal year chosen to identify the Provider-specific cost reports that are used to calculate the Basic PPS Rates.

L. "Base Year Cost Report" means the cost report of a Provider that covers the reporting period that ends during the Base Year.

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

N. 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.

O. "Capital Incentive Adjustment" means an increase to a Provider's Basic PPS Rates 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 35% 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 25% 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.

P. "Critical access hospital (CAH)" means a hospital designated and certified as such under the Medicare rural Hospital Flexibility Program.

Q. "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.

R. "Department" means the Department of Human Services of the State of Hawaii, which is the single state agency responsible for administering the Medicaid program.

S. "Distinct part" refers to a portion of an institution or institutional complex (e.g. nursing home or hospital) that is certified to provide SNF or NF services, or both.

T. "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.

U. "G&A" means general and administrative.

V. "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 35% 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 25% 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.

W. "G&A Small Facility Adjustment" means an adjustment to a small freestanding Nursing Facility's basic PPS rates.

To qualify for this adjustment, the freestanding Nursing Facility must:

1. Have 50 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 "50 beds or less" and
   b. F/S NFs with "more than 50 beds but less than 125".

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.

X. "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.

Y. "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.

Z. "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.

AA. "Grandfathered PPS Rate" means the Total PPS Rate that a Provider was receiving prior to the FY 98 Rebasing.

BB. "ICF" means intermediate care facility.

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

DD. "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.

EE. "Insufficient Experience" means that a Provider's Base Year cost report indicates that the Provider delivered less than 100 days of care at a particular Acuity Level in the Base Year.

FF. "Level A Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level A Resident in a Nursing Facility.

GG. "Level B Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level B Resident in an ICF/MR.

HH. "Level C Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level C Resident in a Nursing Facility.

II. "Level D Rate" means the PPS rate for care delivered by a Provider to an Acuity Level D Resident in a Nursing Facility.

JJ. "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.

KK. "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.

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

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

NN. "NF Sustainability Fee" means the fee imposed on a resident day basis pursuant to Session Laws of Hawaii 2012 for non-governmental providers of nursing facilities.

OO. "Nursing Facility" or "NF" means a Provider that is certified as a nursing facility under Medicaid.

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

QQ. "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 Plan during the period beginning July 1, 1993, and ending June 30, 1997.

RR. "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.

SS. "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.

TT. "Plan" means this document, 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.

UU. "PPS" means the prospective payment system defined in this Plan.

VV. "Proprietary provider" means a for profit provider.

WW. "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.

XX. "Rebasing" means calculating the Basic PPS Rates by reference to anew Base Year and new Base Year Cost Reports. "Rebased" Basic PPS Rates are the end product of a Rebasing.

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

ZZ. "ROE" means return on equity.

AAA. "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 Plan. The Return on Equity for a facility classified as for profit, will be determined in the base period by dividing the provider's equity capital invested in the facility by the number of days in the base period and adding the per diem amount to the facility's PPS rate.

BBB. "Routine Cost Limit" (RCL) means the federal routine operating

CCC. "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 times 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.

DDD. "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 Plan.

EEE. "Upper Limit" means the limit on aggregate payments to Providers imposed by 42 C.F.R. § 447.272.

FFF. "Dental Allowance add-on" means a per diem amount added on to a ICF/MR facility's basic PPS rate for dental services rendered to the facility's inpatients. This add-on only applies to ICF/MR facilities only. The per diem amount will be the same for all ICF/MR facilities. The department determines the per diem add-on amount using available surveys of dental payments made by State Medicaid programs or historical paid claims data.

GGG. "DRR add-on" means Drug Regiment Review add-on. The add-on is a per diem amount added to an SNF and/or ICF facility's basic reimbursement rate for monthly drug regiment reviews performed by a license pharmacist as required by federal regulations. Only SNF and/or ICF facilities without pharmacy staff may qualify for this add-on. The department determines this per diem amount by converting current reimbursement rates to pharmacy providers to per diem amounts.

## II. GENERAL PROVISIONS

### A. Purpose

The purpose of this Plan is to establish a prospective payment reimbursement system for long-term care facilities that complies with the Social Security Act and the Code of Federal Regulations. The Plan describes principles to be followed by Providers in making financial reports and describes procedures to be followed by the Department in setting rates, making adjustments to those rates, and auditing cost reports.

### B. Objective

Pursuant to the requirements of the Balanced Budget Act of 1997, the objective of this Plan is to establish rates for long-term care facilities in conformity with applicable State and Federal laws, and regulations and include Medicaid provisions for the Rural Hospital Flexibility Program.

C. Reimbursement Principles

1. Except as noted herein, the Hawaii Medicaid program shall reimburse Providers based on the number of days of care that the Provider delivers to the Resident, the acuity level that is medically necessary for each day of care, and the Provider's PPS Rate. The Provider shall receive payment at the Level A Rate for residents who require care at Acuity Level A, at the Level B Rate for Residents who require care at Acuity Level B, at the Level C Rate for Residents who require care at Acuity Level C, and at the Level D Rate for Residents who require care at Acuity Level D. Any payments made by Residents (or other third parties on behalf of Residents) shall be deducted from the reimbursement paid to Providers.

2. Except as noted herein, the Medicaid program shall pay for institutional long-term care services through the use of a facility-specific, prospective per diem rate.

3. The Basic PPS Rate shall be developed based on each Provider's historical costs (as reflected in its Base Year Cost Report) and allocated to three components, which are subject to component cost ceilings.

4. A proprietary Provider shall receive the GET and ROE Adjustments to its Basic PPS Rate to account for gross excise taxes and return on equity.

5. Rates for acute care facilities with federally designated swing beds shall be established according to 42 C.F.R. §447.280.

6. Changes in ownership, management, control, operation, and leasehold interests which result in increased costs for the successor owner, management, or leaseholder, shall be recognized for reimbursement purposes only to the following extent: Pursuant to the provisions of Section 9509 (a)(4)(C) of P.L. 99-272, the valuation of capital assets shall not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of:

   a) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary of Health and Human Services) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have

undergone a change in ownership during the fiscal year; or

b) one half of percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumer (United States city average).

7. The Department shall pay the Providers separately for ancillary services based on a fee schedule or through an Ancillaries Payment.

8. Nursing Facilities that have G&A or capital costs below the median for their peer group are rewarded with an incentive payment. A formula to determine the G & A Incentive Adjustment is defined in Section I. Q. A formula to determine the Capital Incentive Adjustment is defined in Section I. M.

9. The Department may contract with Providers to provide Acuity Level D care to selected Residents.

10. The Department shall reimburse Level A and Level C services of a Medicare and Medicaid certified CAH on a reasonable cost basis following Medicare principles of reimbursement. Reimbursement for Level A and Level C routine services provided in a long term care distinct part by a CAH will be actual costs up to 200% of each provider's Medicaid Routine Cost Limit. However, for CAH providers whose routine costs exceed the Routine Cost Limit, reimbursement of costs will be limited to 200% of each provider's RCL, and only when a RCL exception request has been filed and only up to the amounts approved by the State.

D. Access to Data

Members of the public may obtain the data and methodology used in establishing payment rates for Providers by following the procedures defined in the Uniform Information Practices Act, Haw. Rev. Stat. chapter 92F, (A copy of Hawaii Revised Statutes 92F is appended to Plan as Exhibit 92F).

## III. SERVICES INCLUDED IN THE BASIC PPS RATE

A. The reasonable and necessary costs of providing the following items and services shall be included in the Basic PPS Rate and shall not be separately reimbursable unless specifically excluded under Section III.B.

1. Room and board;

2. Administration of medication and treatment and all nursing services;

3. Development, management, and evaluation of the written patient care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the recipient's care needs, promote recovery, and ensure the recipient's health and safety;

4. Observation and assessment of the recipient's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the recipient's need for possible medical intervention, modification of treatment, or both, to stabilize the recipient's condition;

5. Health education services, such as gait training and training in the administration of medications, provided by skilled technical or professional personnel to teach the recipient self-care;

6. Provision of therapeutic diet and dietary supplement as ordered by the attending physician;

7. Laundry services, including items of recipient's washable personal clothing;

8. Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton balls, gauze, adhesive tape, Band-Aids, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment, and douche equipment;

9. Non-customized durable medical equipment and supplies that are used by individual recipients, but which are reusable. Examples include items such as ice bags, hot water bottles, urinals, bedpans, commodes, canes, crutches, walkers, wheelchairs, and side-rail and traction equipment;

10. Activities of the patient's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well being;

11. Social services provided by qualified personnel;

12. Maintenance Therapy; provided, however, that only the costs that would have been incurred if nursing staff had provided the Maintenance Therapy will be included in calculating the Basic PPS Rates;

13. A review of the drug regimen of each resident at least once a month, by a licensed pharmacist, as required for a nursing facility to participate in Medicaid.

14. Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the Provider. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the Provider and the person or entity that contracts to provide the service; and

15. Recurring, reasonable and incremental costs incurred to comply with OBRA 87.

B. The costs of providing the following items and services shall be specifically excluded from reimbursement under this Plan and shall be billed separately to the Department by the Providers:

1. Physician services, except those of the medical director and quality assurance and/or utilization review committees;

2. Drugs that are provided to Residents in accordance with Title XIX policy;

3. Laboratory, X-ray, and EKG;

4. Ambulance and any other transportation for medical reasons that is not provided by the Provider and not included in the costs used to calculate the Basic PPS Rates;

5. Dental; (Except for ICF/MR facilities)

6. Optical;

7. Audiology;

8. Podiatry;

9. Physical therapy, excluding Maintenance Therapy;

10. Occupational therapy, excluding Maintenance Therapy;

11. Speech, hearing and respiratory therapies; and

12. Customized durable medical equipment and such other equipment or items that are designed to meet special needs of a Resident and are authorized by the Department.

13. Charges for ancillary services are not included in calculating the Basic PPS Rates and shall be paid as follows:

a) Providers that have the capability shall bill the Department separately for ancillary services.

b) The Department shall make an Ancillaries Payment to Providers that it designates as incapable of billing for ancillary services on an itemized basis.

c) In order to receive an Ancillaries Payment, the Provider must make assurances satisfactory to the Department that it is committed to acquiring the ability to bill on an itemized basis for ancillaries, and is pursuing that goal with all deliberate speed.

d) As part of the FY 98 Rebasing, the Department shall identify ancillary services for which a Provider lacks the ability to bill separately and calculate a per diem amount as an Ancillaries Payment.

e) No Provider that receives an Ancillaries Payment shall otherwise bill the Department separately on behalf of a Title XIX Resident for any type of ancillary service that is included in calculating its Ancillaries

Payment. A Provider that receives an Ancillaries Payment must also implement procedures and assure the Department that no other person or entity will bill separately for any type of ancillary service that is included in calculating the Ancillaries Payment.

f) The Provider shall provide to the Department upon request the progress that it is making in its efforts to acquire the ability to bill separately for ancillary services. If and when the Provider acquires that ability, then it shall promptly notify the Department in writing.

g) Once the Department determines that a Provider is capable of billing for some or all ancillary services on an itemized basis, then it shall provide advance written notice to that Provider of a date upon which it will either cease making or reduce the Ancillaries Payment. If the Provider acquires the capability of billing for some (but not all) ancillary services that were included in calculating its Ancillaries Payment, then the Department shall reduce the Ancillaries Payment accordingly.

h) The Department shall make available all necessary data to ensure the appropriate accounting for ancillary services.

C. The personal funds of Medicaid recipients may not be charged any costs for routine personal hygiene items and services provided by the Provider.

**IV. CLASSIFICATION OF LONG-TERM CARE PROVIDERS INTO PEER GROUPS**

**For the purpose of establishing the Basic PPS Rates, Providers and costs shall be grouped into the following five mutually exclusive classifications or peer groups:**

**A. The costs of delivering care to Acuity Level A Patients in freestanding Nursing Facilities;**

B. The costs of delivering care to Acuity Level C Patients in freestanding Nursing Facilities;

C. The costs of delivering care to Acuity Level A Patients in hospital-based Nursing Facilities;

D. The costs of delivering care to Acuity Level C Patients in hospital-based Nursing Facilities;

E. The costs of delivering care to Acuity Level B Patients in ICF/MRs.

V. BASIC PPS RATE CALCULATION METHODOLOGY

Unless otherwise noted, the Basic PPS Rates shall be calculated using the methodology set forth in this Section V.

A. Data Sources for Rate Calculation

1. The Department shall select the Base Year. The Base Year selected shall be the most recent state fiscal year for which cost reports for the significant majority of Providers are available. The Department shall select the most recent year for which cost reports for the significant majority of Providers are available but are not finally settled (i.e., the "as filed" cost reports). The Department shall identify and apply an Audit Adjustment Factor to the "as filed" cost reports.

2. Cost and census day data to be used in the development of the Basic PPS Rates shall be abstracted from the uniform cost report that is submitted to the Medicaid agency by each Provider. If the Department determines that additional data is required, then additional cost and census data shall be solicited from the Provider.

B. Calculation of Component Per Diem Costs by Reference to Each Provider's Base Year Cost Report

1. Cost data shall be abstracted from the Base Year Cost Report and categorized into the following three components:

a) Direct nursing costs shall include all allowable costs involved in the direct care of the patient. Examples of such costs include the following:

(1) salaries for nurses' aides, registered nurses, and licensed practical nurses not involved in administration;

(2) the portion of employee fringe benefits that are properly allocated to those salaries;

(3) physician-ordered Maintenance Therapy, which is not billed directly to the Department. The cost of Maintenance Therapy services provided by persons other than nursing staff shall be limited to an amount equivalent to the cost if performed by nursing staff or a physical therapy aide; and

(4) costs of nursing supplies and medical supplies not separately billable to patients.

b) Capital costs shall include all allowable capital related operating costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413) of the long-term care facility or distinct part unit. Examples of such costs include the following:

(1) rent;

(2) interest;

(3) depreciation;

(4) equipment or lease rental;

(5) property taxes; and

(6) insurance relating to capital assets.

c) G&A costs shall include all additional allowable costs incurred in providing care to long-term care patients. Examples of such costs shall include the following:

(1) dietary;

(2) housekeeping;

(3) laundry and linen;

(4) operation of plant;

(5) medical records;

(6) the costs of insuring against or paying for malpractice, including insurance premiums, attorneys' fees and settlements of claims; and

(7) the costs of fringe benefits properly allocated to employees involved in general and administrative duties.

2. The costs identified in Section V.B.1 shall be adjusted as follows:

a) Costs allocated to line items on the Base Year Cost Report other than those components listed in Section V.B.1, or to inappropriate line items, shall be appropriately reclassified to the three components. Reclassification shall be performed by the Department or its fiscal agent. If Maintenance Therapy is identified as a separate line item on the Provider's cost report, then the Department shall include those costs in calculating the PPS Rates. The Department shall not, however, allow reclassifications of Maintenance Therapy costs from the physical or occupational therapy ancillary cost center to routine costs.

b) Costs of services specifically excluded from the Basic PPS Rate under Part III.B shall be deleted from the costs identified in Section V.B.1 for the purpose of

the Basic PPS Rate calculation. This process shall involve identifying line items from the Base Year Cost Report or other financial records of the Provider pertaining to the excluded services and subtracting these costs from the appropriate component. If a Provider's Base Year Cost Report does not identify the costs of excluded services, then the Department shall so advise the Provider and request additional financial records. If the Provider does not respond with appropriate information, then the Department may delete from the Provider's costs an amount reasonably estimated to represent the costs of such excluded services.

c) Cost reports for facilities which first began operations after the beginning of the Base Year are not included in calculating the statewide weighted average per diem costs or used to calculate the Provider's Basic PPS Rate.

d) Costs attributable to new beds that are placed in service after the beginning of the Base Year are also not included in calculating the statewide weighted average per diem costs or used to calculate the portion of the Provider's Basic PPS Rate that relates to the new beds.

e) Where an existing facility has partial year cost reports from more than one owner or operator, the Department may either select one of the partial year cost reports or combine the cost reports from the former and current owners/operators. In either case, the cost reports shall be adjusted to approximate the costs that would have been incurred for a twelve-month period.

f) Gross excise taxes paid on receipts, NF taxes, and any return on equity received by a for-profit Provider shall be deleted from the costs used to calculate the Basic PPS Rate and shall be reimbursed separately.

g) If a Provider received a rate increase pursuant to a rate reconsideration request in the Base Year, and that increase is for a non-recurring cost, then the Department may delete from the Base Year costs that are included in calculating the Basic PPS Rates an amount equal to the costs that were used to calculate the rate increase.

h) If a Provider received supplemental payments from the State (with no federal matching funds) for special services in the Base Year, then the Department shall adjust the Provider's Base Year costs to remove the differential costs of those special services in calculating the Provider's Basic PPS Rates.

i) The resulting component costs and return on equity shall be standardized to remove the effects of varying fiscal year ends. Costs are inflated from the end of each provider's fiscal year to a common point in time. Therefore, facilities with fiscal years that end earlier receive a higher rate (more months) of inflation.

j) To recognize annual inflationary cost increases, these standardized component costs shall be inflated as described in Section VII.A.

k) For Nursing Facility Providers, the portions of a Provider's standardized and inflated costs (except for the costs of Maintenance Therapy services included in direct nursing costs and the costs of complying with OBRA 87) that are in excess of the routine cost limits (excluding the add-on to those limits for OBRA 87 Costs) for long-term care facilities shall be deleted from the costs used to calculate the Basic PPS Rates. The Department shall apply its estimate of what the federal routine cost limits would have been for urban Honolulu facilities to all Nursing Facilities.

l) Costs that are not otherwise specifically addressed in this Plan shall be included in base year costs if they comply with HCFA Publication No. 15 standards.

m) Legal expenses for the prosecution of claims in federal or state court against the State of Hawaii or the Department incurred after September 30, 1988, shall not be included as allowable costs in determining the PPS per diem rates.

3. A Provider-specific per diem component cost shall be calculated by dividing the costs associated with each component identified in Section V.B.1, as adjusted in Section V.B.2, by the number of long-term care Provider census days for each acuity level reported on the cost report and segregated in accordance with the classifications in Part IV.

4. For Providers with both Acuity Levels A and C Residents in the Base Year, per diem component rates shall be established as follows:

a) Costs as reported on the Base Year Cost Report shall be used for the computation of the Level A and Level C per diem component rates for Providers which report costs for Acuity Levels A and C Patients separately.

b) If a Provider reports combined costs for Acuity Levels A and C and does not segregate its direct nursing costs based upon a case mix method or study, then the Department shall allocate the Provider's direct nursing costs based upon the Acuity Ratio.

c) Costs for the general and administrative component shall be allocated equally on a per diem basis between Acuity Levels A and C, or at the Provider's option, allocated by the Provider using the same case-mix index developed for nursing costs.

d) Capital costs shall be allocated equally between Acuity Levels A and C on a per diem basis.

e) In no case shall a Provider's Acuity Level A per diem costs exceed its Acuity Level C per diem costs.

5. Notwithstanding the foregoing, if a Provider's Base Year Cost Report indicates that the Provider had Insufficient Experience at a particular level of care, then its Basic PPS Rate for that level of care shall be computed as follows:

   a) The G&A and capital cost components shall remain the same for both levels of care;

   b) The Provider shall receive the Substitute Direct Nursing Component for the level of care for which it had Insufficient Experience;

   c) If the Provider allocated its costs between Levels A and C, then the costs and days allocated to the level of care for which it had Insufficient Experience shall not be considered in calculating its Basic PPS Rates; and

   d) If the Provider did not allocate its costs between Levels A and C, then no part of its costs or days shall be allocated to the level of care for which it had Insufficient Experience in calculating its Basic PPS Rates.

   e) The calculation of the Basic PPS Rate for an acuity level in which the Provider has Insufficient Experience shall also consider the adjustments that have been incorporated in to the Basic PPS Rate for which sufficient experience exists.

C. Application of Component Rate Ceilings

1. Each Provider's per diem cost components, as calculated in accordance with Section V.B, shall be subject to component rate ceilings in determining a Provider's Basic PPS Rates.

2. For each classification identified in Part IV, component rate ceilings shall be established as follows:

   a) For each Provider, multiply the Provider-specific per diem component cost by the Provider's total census days in the base period to determine total cost per

component by Provider. Any per diem component cost that is greater than two standard deviations above or below the statewide mean of the component cost shall be excluded in calculating the component rate ceilings.

b) For each classification identified in Part IV, sum the Providers and totals calculated in Section a above to determine the total cost per component for each classification.

c) Divide the classification component costs calculated in Section b above by the total census days reported in the Base Year Cost Reports for all Providers in the classification to determine an average cost per component by Provider classification; provided, however, that if any per diem costs are excluded because they deviate more than two standard deviations from the statewide mean, then the days associated with those per diem costs shall also be deleted in calculating the average cost per component for the peer group.

d) Multiply the results of Section c above by the following factors to determine the cost component rate ceilings by each Provider classification:

(1) General and Administrative--1.1

(2) Capital--1.1

(3) Direct Nursing--1.15

3. Generally, each per diem cost component of a Provider's Basic PPS Rates shall be the lesser of the Provider's per diem cost component rate calculated under Section V.B or the per diem ceiling for that component , except as noted in Section VIII. D. In the case of the capital component, no Provider shall receive less than $1.50 a day regardless of its cost per day.

4. If a Provider's rate includes a Substitute Direct Nursing Component, then all three of the component ceilings that apply to the Acuity Level for which the rate is being calculated shall be applied.

5. The component ceilings shall not be applied in the following circumstances:

   a) to a Grandfathered PPS Rate;

   b) to a Grandfathered Capital Component if a provider meets the provisions of section VI.A.

   c) to Grandfathered Direct Nursing and G&A Components;

   d) to a New Provider or Provider with New Beds whose Basic PPS Rates are, in whole or in part, calculated under the special provisions defined in Part VI. That Part defines the circumstances in which either the component ceilings or some other ceilings will be applied.

6. For the FY 98 Rebasing only, the rate calculation for all Providers shall include the higher of the rates calculated under the following two options:

   a) Sections V and/or VI, increased by the GET and ROE Adjustments and Capital and G&A Incentives, if applicable; or

   b) The Grandfathered PPS Rate, which excludes OBRA 1987 payments, but includes rate reconsideration.

   c) If the Grandfathered PPS Rate is the lower of the two options, then the Provider shall receive the Basic PPS Rate and all other appropriate adjustments that are defined in this Plan.

   d) If the Grandfathered PPS Rate is the higher of the two options, then the Provider shall also receive the following adjustments or increases to that rate:

(1) For FY 98, one-half of the Inflation Adjustment. For all subsequent PPS years, the Provider shall receive the same Inflation Adjustments that are received by all other Providers.

(2) The GET Adjustment, however, shall only be applied to the incremental increase to the Total PPS Rates that results from the adjustments or increases noted above.

**VI. SPECIAL PROVISIONS AFFECTING THE CALCULATION OF BASIC PPS RATES FOR NEW PROVIDERS, PROVIDERS THAT ADD NEW BEDS, AND ACUITY LEVEL D CARE AND CLARIFICATION OF TREATMENT OF GRANDFATHERED CAPITAL COMPONENT**

A. Treatment of New Providers Without Historical Costs

1. The following two types of Providers shall have their Basic PPS Rates calculated, in whole or in part, under this Section VI.A:

a) a Provider that began operating after the Base Year, and therefore has no Base Year Cost Report; or

b) a Provider that begins operating a new facility during the Base Year, and therefore has no Base Year Cost Report that reflects a full 12 months of operations.

2. A Provider that qualifies under one of the above criteria shall submit its projected costs to the Department on forms and in the format defined by the Department.

3. The qualifying Provider shall receive as its Basic PPS Rates the lesser of:

a) its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413 and as modified by this Plan); or

b) 125% of the sum of the statewide weighted averages (including the Inflation Adjustment) for its peer group in each Acuity Level.

4. Commencing on January 1, 1996, the qualifying provider shall receive as its Basic PPS Rates the lesser of:

a) its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413 and as modified by this plan); or

b) the sum of the component rate ceilings for its peer group in each Acuity Level.

c) Section VI.A.3 shall continue to be applied under the following circumstances;

(1) Facilities that, as of December 31, 1995, qualify for and are receiving the New Provider rate.

(2) New LTC projects with certificate of need (CON) approval (if applicable), that either:

(a) have started construction as of December 31, 1995.

(b) have not started construction but have a financial commitment as of December 31, 1995 which contains a penalty clause, in which case the Department may grant a provider's request for an exception based on review of the provider's financial situation.

5. In PPS rate years following the calculation of per diem rates under this Section, the Provider's Basic PPS Rates shall receive the same Inflation Adjustment as other providers.

B. Treatment of New Beds Without Historical Costs

1. A Provider that has expanded beds since or during the Base Year, and therefore has no Base Year Cost Report reflecting a full 12 months of operation with the new beds, shall have

its Basic PPS Rates calculated, in whole or in part, under this Section VI.B.

2. Existing Providers which add new beds during or after the Base Year shall receive Basic PPS Rates that "blend" the rates for the old and new beds.

3. Basic PPS Rates associated with the new beds shall be calculated in accordance with Sections VI.A.3. and VI.A.4. If applicable, the GET Adjustment shall be increased to cover the higher gross excise taxes that will result.

4. The result of subsection 3 above shall be multiplied by the number of new beds;

5. The Basic PPS Rates calculated on the historical costs of the existing beds as defined in Section V.A, B and C shall be multiplied by the number of existing beds;

6. The sum of subsections 4 and 5 above shall be divided by the total number of existing and new beds;

7. The rates calculated in subsection 6 above shall be the Provider's Basic PPS Rate for all beds; and

8. The computation shall be performed separately for each acuity level.

C. Transition of New Providers and New Beds into the PPS

1. A New Provider or a Provider with New Beds shall eventually have its Basic PPS Rates calculated in the same manner as other Providers. The transition will begin with the first Rebasing in which the New Provider or Provider with New Beds has a Base Year Cost Report that reflects a full twelve months of operations.

2. Unless the Provider is eligible for the Grandfathered Direct Nursing and G&A Components, the G&A and direct nursing components of the Provider's Basic PPS Rates shall be

calculated in the same manner as existing Providers (including the application of the component ceilings).

3. For New Providers or Providers that added New Beds, the capital component of the Basic PPS Rates subject to the capital component ceilings shall be determined as follows:

a) The New Provider or Provider with New Beds shall receive the lesser of the following two options as the capital component of its Basic PPS Rates:

(1) its facility-specific capital per diem costs calculated in the same manner as existing Providers (excluding the application of the capital component ceiling); or

(2) its Grandfathered Capital Component (excluding the application of the capital component ceiling); provided, however, that if Provider's facility-specific capital per diem amount after the application of the capital component ceiling is higher than its Grandfathered Capital Component, then the Provider shall receive the higher amount as the capital component of its Basic PPS Rates.

b) In order to implement the preceding section, the Department shall identify the capital component of the Basic PPS Rates for New Providers that existed immediately prior to the implementation of the FY 98 Rebasing. That amount, which is the Grandfathered Capital Component, shall be calculated as follows:

(1) The Department shall compare the New Provider's projected per diem costs (which were used to establish its initial PPS Rates) with its actual capital per diem costs as indicated on the Base Year Cost Report to determine whether the projected capital costs were reasonable. If the Department concludes that the projections were unreasonable, then the Department may adjust the Grandfathered Capital Component accordingly.

(2) If the New Provider's projected aggregate costs in all three PPS rate components exceeded 125% of the sum of the statewide weighted averages, then the Grandfathered Capital Component shall be reduced pro rata. That reduction shall be accomplished by multiplying the projected capital per diem by the Capital Component Reduction Factor.

(3) After applying the Capital Component Reduction Factor, the New Provider's initial projected capital per diem amount shall be increased by the Inflation Factor to remove the effects of varying fiscal year ends and to inflate the per diem to the PPS Year. That amount shall be the capital component of the New Provider's Basic PPS Rates.

c) The Department shall follow the same general procedure in calculating the portion of the capital component for New Beds that was used to calculate the blended capital component for Providers with New Beds.

That process shall include the following steps:

(1) identifying the Grandfathered Capital Component;

(2) if appropriate, applying the Capital Component Reduction Factor;

(3) determining whether the facility-specific or Grandfathered Capital Component rate is appropriate; and

(4) using the appropriate amount to calculate a "blended" capital per diem amount for the Provider.

4. A Provider that added New Beds and meets the defined eligibility tests is entitled to have its direct nursing and general administrative components adjusted as defined below:

a) In order to be eligible for the Grandfathered Direct Nursing and G&A Components, a Provider must meet the following requirements:

(1) The Provider must have both Old and New Beds;

(2) The Provider must have a full twelve months of historical costs for the New Beds reflected in the Base Year Cost Report; and

(3) Immediately prior to the effective date of the FY 98 Rebasing, the Provider must have had in effect a "blended" Basic PPS Rate that included the costs of both the Old and New Beds.

(4) The Provider's Adjusted PPS Rate for FY 98 (excluding the NF and OBRA 87 Adjustments) is less than its Total PPS Rate immediately prior to the Rebasing plus one-half of the FY 98 Inflation Adjustment.

b) A Provider who meets the eligibility tests defined above shall receive the Grandfathered Direct Nursing and G&A Adjustment. As part of the calculation to determine the amount of the adjustment, one-half of the Inflation Adjustment for FY 98 is included. For FY 98 only, no other Inflation Adjustment shall be included in calculating the Provider's Adjusted PPS Rates. Thereafter, the Provider shall receive the full Inflation Adjustment in calculating its Adjusted PPS Rates.

D. Treatment of Providers who provide Acuity Level D Care

1. Providers that furnish Level D services after the Base Year shall submit costs and days to the Department on forms and in the format defined by the Department.

2. Payment for Acuity Level D services will be based on the facility's its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as

defined in 42 C.F.R. chapter 413 and as modified by this Plan). However, if a Provider has historical cost data of providing Acuity Level D services under a state pilot program, the rate will be based on the lesser of the pilot program or the facility's projected costs.

## VII. INFLATION AND OTHER MISCELLANEOUS PROVISIONS

A. Application of Inflation and Other Adjustments to Establish Provider-Specific Prospective Payment Rates

1. Subject to Paragraph 4 below, annual cost increases shall be recognized by applying the Inflation Adjustment (Section I. DD) to the historical costs and/or Basic PPS Rates. This section applies to Acuity Level B facilities and Acuity Levels A and C services in critical access hospitals. The provisions of Section XI shall apply to Acuity Levels A and C services in all other facilities.

2. For years in which the Department performs a Rebasing, cost increases attributable to inflation that has occurred since the Base Year shall be recognized as follows:

   a) The Basic PPS Rates shall be standardized to remove the effects of varying fiscal year ends;

   b) The Basic PPS Rates shall be multiplied by one plus the cumulative Inflation Adjustment;

   c) For the purpose of determining the Inflation Adjustment, the Department shall use the most current and accurate data that is then available;

   d) To ensure the prospective nature of the system, that data shall not be retroactively modified or adjusted.

3. For years when the Department does not perform a Rebasing, cost increases due to inflation for the upcoming rate year shall be recognized as follows:

   a) The Department shall multiply the Adjusted PPS Rate (excluding any rate reconsideration increases) in effect on June 30th of the immediately preceding fiscal year by one plus Inflation Adjustment for the following state fiscal year;

b) To ensure the prospective nature of the payment methodology, the Inflation Adjustment shall not be retroactively modified or adjusted.

4. The Inflation Adjustment shall not be applied to rates for the 4th quarter of FFY 2012 and the 1st, 2nd, and 3rd quarter of FFY 2013.

B. Limitations on Long-Term Care Provider Reimbursement

1. Notwithstanding any other provisions of this Plan, aggregate payments to each group of facilities (i.e., Nursing Facilities or ICF/MRs) may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413). In addition, aggregate payments to each group of State-operated Providers (i.e., Nursing Facilities or ICF/MRs) may not exceed the amount that can reasonably be estimated would have been paid under Medicare reasonable cost principles of reimbursement. If a formal and final determination is made that payments in the aggregate exceeded the Upper Limit and federal financial participation is disallowed, then the Department may recoup any payments made to Providers in excess of the Upper Limit.

2. Notwithstanding any other provisions of this Plan, payment for out-of-state long-term care facility services shall be the lesser of the facility's charge, the other state's Medicaid rate, or the statewide weighted average Hawaii Medicaid rate applicable to services provided by comparable Hawaii Providers.

3. Notwithstanding any other provision of this Plan, no payments shall be made for the improper admission of or care for mentally ill or mentally retarded individuals, as those terms are defined in section 4211 (e)(7)(G) of OBRA 87.

4. Notwithstanding any other provisions of this Plan, should federal participation for CAH providers be disallowed, the Department may recoup any such payments made to these CAH facilities.

C. Adjustments to Base Year Cost

1. Adjustments to a Provider's Base Year Cost Report that occur subsequent to a Rebasing that utilizes that Base Year Cost Report shall not result in any change to the component rate ceilings for the Provider's peer group.

2. Beginning with the FY 98 Rebasing, the following rules shall apply to changes to a Base Year Cost Report that are made after a Rebasing occurs:

   (a) If a Provider's PPS Rates are based upon a cost report that is not finally settled, then the Department shall not adjust those rates based upon subsequent changes to the Base Year Cost Report.

3. The PPS rate calculation process is complex and requires an extensive commitment of the Department's resources. Occasionally, the Department may uncover or have brought to its attention minor data extraction or calculation errors that affect one or a few Providers. Unless the Department reasonably expects the correction of an error for one or a few Providers to have a significant impact on the statewide weighted averages or component ceilings, the Department need not recalculate those averages or ceilings to reflect a recalculation of the Basic PPS Rates of the one or few Providers.

D. Rebasing the Basic PPS Rates

The Department shall perform a Rebasing following the methodology but using updated cost report data as described in Section V so that a Provider shall not have its Basic PPS Rates calculated by reference to the same Base Year for more than eight state fiscal years.

## VIII. ADJUSTMENTS TO THE BASIC PPS RATES

A. Each proprietary Provider is eligible to receive the ROE Adjustment. The ROE adjustment shall be calculated by identifying the appropriate amounts from the Base Year Cost Report or other sources, and dividing those amounts by the Provider's Base Year patient days to obtain a Base Year ROE per diem. The Base Year ROE Adjustments shall receive the same increase to reflect inflation as all other base year costs.

B. All proprietary Providers shall receive the GET Adjustment. The GET Adjustment shall be paid by increasing the Basic PPS Rates plus all applicable adjustments by 1.04167.

C. Nursing Facilities who qualify shall receive the Capital Incentive Adjustment, the G&A Incentive Adjustment, or both. Due to the limited number of ICF/MRs, those facilities shall not be eligible to receive either the Capital Incentive or G&A Incentive Adjustments.

D. Beginning with PPS rate year July 1, 1995 to June 30, 1996, qualifying NFs shall receive the "G & A Small Facility Adjustment".

E. All ICF/MR facilities will have a per diem dental allowance added to the basic PPS rate. This amount will be the same for all ICF/MR facilities. The dental benefits and expenditures by State Medicaid Agencies survey taken by the American Dental Association was used to determine the dental allowance add-on. The survey allowed a comparison of the cost of State dental Medicaid payments and provided the average median cost per patient per year. The average and median cost were updated by inflation factors used for the annual updating of long term care rates. The average annual cost was divided by 365 days to determine a cost per day and rounded to the nearest dollar.

F. DRR add-on applies to nursing facilities (SNF/ICF) without pharmacy staffing. The basic PPS rate for a facility without pharmacy staff will include a per diem add-on to reimburse for the completion of monthly drug regiment reviews. The drug regiment review per diem add-on equals the sum of the quotients of (monthly payment per review x 12 months)/365 days + (monthly facility payment X 12 months)/Medicaid days and rounded up to the nearest whole cents.

G. The Total PPS Rates

1. A Provider's Basic PPS Rate shall equal the sum of its direct nursing, G&A and capital per diem components for each Acuity Level as calculated under this Plan. A New Provider's Basic PPS Rate shall be the per diem rate calculated under the provisions of Section VI.A. The Basic PPS Rate for a Provider with New Beds shall be the per diem rate calculated under the provisions of Section VI.B.

2. A Provider's Adjusted PPS Rate shall be the product of the following formula:

Basic PPS Rate
+ Capital Incentive Adjustment [if applicable]
+ G&A Incentive Adjustment [if applicable]
+ ROE Adjustment [if applicable]
+ G&A Small Facility Adjustment [if applicable]
+ Dental allowance add-on (applicableto ICF/MR facilities only)
+ DRR add-on (if applicable)
Subtotal

x GET Adjustment [if applicable])

= Adjusted PPS Rate

3. A Provider's Total PPS Rate shall be the Adjusted PPS Rate.

**Citation:** 42 CFR 434, 438 and 447; and Social Security Act 1902(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.

**Other Provider-Preventable Conditions.**

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

☒ 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 nursing facility reimbursement to account for non-payment of 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 for 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.

The Med-QUEST Division will utilize medical review to identify potential OPPCs on claims. For claims with identified OPPCs that were not previously existing, reimbursement associated with the OPPC will be recovered. For per diem payments, the number of covered days shall be reduced by the number of days associated solely due to any OPPC not previously existing.

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.

## IX. ADMINISTRATIVE REVIEW - RATE RECONSIDERATION

A. Providers shall have the right to request a rate reconsideration for the following conditions:

1. A change in ownership, leaseholder, or operator, without a change in licensure and certification, which shall be grounds for rate reconsideration only to the extent authorized in Section II.C.6.

2. Providers who receive no rate increase or a reduced rate due to implementation of the acuity based reimbursement system will not be able to file for a rate reconsideration under this section for adjustments or damages.

3. Extraordinary circumstances including, but not limited to, the following: acts of God; changes in life and safety code requirements; changes in licensure law, rules, or regulations; significant changes in patient mix or nature of service occurring subsequent to the Base Year; errors by the Department in data extraction or calculation of the per diem rates; subject to Section VII.C, inaccuracies or errors in the Base Year Cost Report; or additional capital costs resulting from renovation of a facility that does not result in additional beds but otherwise are attributable to extraordinary circumstances. Mere inflation of costs, absent extraordinary circumstances, shall not be a basis for rate reconsideration.

4. To determine in advance the amount of rate reconsideration relief, if any, that will be granted to the Provider for an anticipated future cost in excess of $50,000, or $1,000 per bed, whichever is less. The Provider must be otherwise ready to incur the cost, and it must be attributable to a proposed capital expenditure, change in service or licensure or extraordinary circumstance. Any determination by the Department is subject to the Provider actually incurring the anticipated cost. If the actual cost is greater or lesser than the anticipated future cost submitted by the Provider, then the Department may adjust its rate reconsideration relief determination either on its own initiative or by supplemental request of the Provider. A Provider that fails to request an advance rate reconsideration from the Department assumes the risk that no rate reconsideration relief may ultimately be available.

5. If the Department reduces the Grandfathered Capital Component of a New Provider or a Provider with New Beds due to an inaccurate or unreasonable projection of capital costs by the Provider.

B. 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 data necessary to demonstrate that the circumstances for which reconsideration is requested meet one or more of the conditions specified in Section IX.A. The requests shall include the following:

1. A presentation of data to demonstrate the reasons for the Provider's request for rate reconsideration.

2. If the reconsideration request is based on changes in patient mix, the Provider must document the change using well established case mix measures, accompanied by a showing of cost impact.

3. A demonstration that the Provider's costs exceed the payments under this Plan.

C. Except as otherwise provided in this Plan, a request for reconsideration shall be submitted within 60 days after the annual PPS Rate is provided to the Provider by the Department, or at other times throughout the year if the Department determines that extraordinary circumstances occurred or if the circumstances defined in Section IX.A.1 occur.

D. Pending the Department's decision on a request for rate reconsideration, the Provider shall be paid the PPS Rate initially determined by the Department. If the reconsideration request is granted, the resulting new PPS Rate will be effective no earlier than the first day of the PPS rate year.

E. A Provider may appeal the Department's decision on the rate reconsideration request. The appeal shall be filed in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii

Administrative Rules. A copy of the Hawaii Administrative Rules is appended to this Plan as Exhibit 17-1736.

Except as noted below, rate increases granted pursuant to the rate reconsideration process shall not exceed an amount equal to the sum of the component ceilings for a particular Provider's classification minus the Provider's Basic PPS Rate.

1. If a Provider is either New or has added New Beds and its Basic PPS Rate is calculated under Section VI, then a rate increase shall not exceed the difference between the sum of the ceilings for the direct nursing and general and administrative components and the sum of the Provider's facility-specific components for those categories.

2. If a Provider is receiving the Grandfathered Capital Component, then the increase shall not exceed the difference between the sum of the direct nursing and G&A component ceilings and sum of the Provider's direct nursing and G&A components.

3. For Providers that qualify for the " G & A Small Facility Adjustment", the sum of the component ceilings is to reflect the increase to the G & A component ceiling as described in Section I.V.

F. Rate reconsideration granted under this Section shall be effective for the remainder of the PPS rate year. If the Provider believes its experience justifies continuation of the reconsidered rate in subsequent fiscal years, then it shall submit information to update the documentation specified in Section IX.B within 60 days after receiving notice of the Provider's rate for each subsequent PPS rate year. The Department shall review the documentation and notify the Provider of its determination as described in Section IX.D. The Department may, at its discretion, grant a rate adjustment that will be incorporated into the Provider's rate for one or more of the following PPS rate years.

G. The decision to grant a rate reconsideration request is subject to the Department's discretion. In exercising that discretion, the Department may consider that a Provider's Adjusted PPS Rate includes a Grandfathered component or Incentive Adjustment.

## X. COST REPORT REQUIREMENTS

A. All Providers shall maintain an accounting system that identifies costs in conformance with generally accepted accounting principles.

B. Beginning with cost reporting periods ending on or after January 1, 1996, participating Providers shall submit the following on an annual basis no later than five months after the close of each Provider's fiscal year:

1. Uniform cost report;

2. Working trial balance;

3. Provider cost report questionnaire;

4. If the Provider has its financial statement audited, then a copy of that audited financial statement;

5. Disclosure of appeal items included in the cost report;

6. 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.

7. Such other cost reporting and financial information as the Department shall request. This information may include segregation of certain costs of delivering services to Acuity Level C Residents as opposed to Acuity Level A Residents.

C. In subsequent years, the Department may require Providers to classify their costs according to the components defined in Section V.B.1 and interpretive guidelines provided by the Department and submit that classification with its cost report. Final classification of costs into appropriate components shall be at the discretion of the Department.

D. Claims payment for services will be suspended 100 percent until an acceptable cost report is received. A 30 day maximum extension will be granted upon written request for 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.

E. Each Provider shall keep financial and statistical records of the cost reporting year for at least six years after submitting the cost report form to the Department and shall make such records available upon request to authorized state or federal representatives.

## XI. ACUITY BASED REIMBURSEMENT SYSTEM

A. Beginning with the effective date of these rules, the Department will implement a transition from PPS to an acuity based reimbursement system. The phased approach was implemented on July 1, 2008.

B. The rate methodology uses a price-based system with the following parameters:

1. For the direct care rate component, the component price is set at one hundred ten per cent of the day-weighted median. The rate that is calculated is subject to a case mix adjustment based upon the change on each facility's overall case mix.

2. For the administrative and general rate component, the component price is set at one hundred three per cent of the day-weighted median. The rate is not subject to a case mix adjustment.

3. For the capital rate component, the component price is at the day-weighted median. The rate is not subject to a case mix adjustment.

4. The gross excise taxes paid to the State of Hawaii (Hawaii general excise tax) is treated as a pass-through.

5. The Medicaid share of the NF Sustainability Fee is treated as a pass-through.

The rate setting parameters will remain constant for all future rate setting periods. The prices calculated for direct care, administrative and general, and capital will reflect prices that relate to the rate period beginning July 1, 2002 and ending June 30, 2003. The component prices will be updated for each subsequent rate period by the inflation adjustment for each period, provided that no inflation adjustment shall be applied in determining component prices for the 4th quarter of FFY 2012 and the 1st, 2nd and 3rd quarter of FFY 2013.

C. Effective for rate periods starting September 1, 2003 and July 1, 2004, the annual cost increases shall be determined as follows:

1. Calculate the blended Acuity A and Acuity C rates for all eligible NF facilities using the inflation adjustment.

2. For each NF, compare the blended rates with the inflation adjustment to the rates that would have been reimbursed under the acuity based reimbursement system.

3. Apply the inflation adjustment only to the NFs that would have received an increase under the acuity based reimbursement system. The rate as increased by the inflation adjustment for the NF shall not exceed the rate the provider would have been entitled to under the acuity based reimbursement system. Any NF not entitled to the inflation adjustment shall receive no rate increase or decrease.

4. For all NFs that are not entitled to an inflation adjustment, or whose rate is limited by the rate determined by the acuity based reimbursement system, calculate by facility the annual amount associated with the inflation adjustment based on the Medicaid bed days from the latest available cost report.

5. The total amount of inflation adjustments calculated in paragraph (4) shall be distributed to NFs whose rates with inflation adjustments are below the rate calculated under the acuity based reimbursement system. The total amount shall be divided by the number of Medicaid bed days for the NFs with rates below those calculated by the acuity based reimbursement system. A SNF and ICF bed day rate shall be calculated.

6. Each NF with rates below that calculated by the acuity based reimbursement system shall receive an additional adjustment to its rate. The adjustment shall be applied to each SNF and ICF bed day, provided the new bed day rate does not exceed the rate that would have been paid under the acuity based reimbursement system.

D. Effective for rate periods starting September 1, 2003, and July 1, 2004, all NFs that do not receive an inflation adjustment under paragraph C above shall receive an additional transition payment equal to the difference between the rate as calculated under paragraph C above and the allowable cost of serving Medicaid eligible patients (based on the most recently approved cost report trended forward).

(E) Effective for rate periods starting with July 1, 2005, the reimbursement rate for all facilities will be calculated under the acuity based reimbursement system.

(F) Effective for rate periods starting with July 1, 2005, and ending on June 30, 2008, all hospital-based nursing facilities shall receive an additional transition payment equal to a specified percentage of the difference between their acuity-based rate and their rate as calculated under the PPS methodology. Refer to paragraph (K) below. The specified percentages are as follows:

| | |
|---|---|
| July 1, 2005-June 30, 2006- | 75 percent |
| July 1, 2006-June 30, 2007- | 50 percent |
| July 1, 2007-June 30, 2008- | 25 percent |

(G) Public hospital-based nursing facilities shall determine their costs during each transition year of serving Medicaid-eligible patients, which shall be the basis for claiming federal financial participation in additional transition payments to those facilities pursuant to paragraphs D and E above.

(H) Any free-standing nursing facility whose acuity-based rate for the rate period July 1, 2005-June 30, 2008 is less than what its rate would have been if calculated under the PPS methodology shall receive an additional transition payment equal to a specified percentage of the difference (referred to as "rate shortfall"). Refer to paragraph (K) below. The specified percentages of the rate shortfall are as follows:

| | |
|---|---|
| July 1, 2005-June 30, 2006- | 75 percent |
| July 1, 2006-June 30, 2007- | 50 percent |
| July 1, 2007-June 30, 2008- | 25 percent |

(I) If any hospital-based nursing facility is sold to, or the operation of such facility is assumed by a non-hospital entity the additional transition payment shall continue to be made to the new operator as if it was a hospital-based facility.

(J) In the event that additional transition payments cause overall payments to a class of privately owned or operated nursing facilities or publicly (non-state) owned or operated nursing facilities to exceed the Department's reasonable estimate of the upper payment limit under 42 C.F.R. §447.272, additional transition payments to all nursing facilities in the affected class shall be reduced pro rata in order that overall payments to that class not exceed the upper payment limit.

(K) Effective March 22, 2008 and ending on June 30, 2008, public hospital-based or freestanding nursing facilities shall receive a further payment equal to the difference between their Medicaid fee-for-service payment amounts and their allowable routine cost of serving Medicaid eligible fee-for-service patients.

(L) Effective for rate periods starting with July 1, 2008, public hospital-based or freestanding nursing facilities shall receive an additional payment equal to the difference between their Medicaid fee-for-service payment amounts and their allowable routine cost of serving Medicaid eligible fee-for-service patients.

(M) Public hospital-based or freestanding nursing facilities shall determine their allowable routine fee-for-service costs each year, which shall be the basis for claiming federal financial participation in additional payments to those facilities pursuant to paragraph (K) and (L) above.

(N) To determine a public hospital-based or freestanding nursing facility's allowable Medicaid costs eligible for supplemental payment under paragraphs (K) and (L), the following steps must be taken to ensure Federal financial participation (FFP):

(1) *Interim Medicaid Supplemental Payment*

The State will make interim quarterly Medicaid supplemental payments to approximate actual net Medicaid loss for the expenditure period. The net Medicaid loss is the difference between the Medicaid fee-for-service payment amount and the nursing facility's allowable Medicaid routine cost.

For the period of March 22, 2008 to June 30, 2008, the State will make one interim Medicaid supplemental payment. For the period beginning on or after July 1, 2008, the State will make quarterly interim Medicaid supplemental payments.

(a) The process of determining allowable Medicaid nursing facility routine costs eligible for FFP begins with the use of each public nursing facility's most recently filed cost report (the

last cost report filed to the Medicare fiscal intermediary). For hospital-based nursing facilities, such costs are reported on the CMS-2552-96. For freestanding nursing facilities, such costs are reported on the CMS-2540-96.

(b) On the latest as-filed Medicare cost report, the allowable hospital-based nursing facility routine per diem cost is identified on the CMS-2552-96, worksheet D-1, Part III, line 67. This amount represents the allowable NF cost from worksheet B, Part I, line 34 and/or 35, column 27; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part I; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 15 and/or 16, column 6.

On the latest as-filed Medicare cost report, the allowable freestanding nursing facility routine per diem cost is identified on the CMS-2540-96, worksheet D-1, Part I, line 16. This amount represents the allowable NF cost from worksheet B, Part I, line 16 and/or 18, column 18; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part 1; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 1 and/or 3, column 7.

The routine per diems above are computed in accordance with Medicare cost principles and trended forward by the CMS Nursing Home without Capital Market Basket inflation factor as necessary.

The above computation is performed separately for the NF component and, if applicable, the SNF component to arrive at separate NF and SNF per diems.

(c) The routine per diem from step b) above is multiplied by the number of Medicaid FFS NF routine days during the current period for which the interim supplemental payment is being computed. For example, to compute the interim supplemental payments to be made for the period of March 22, 2008 to June 30, 2008, the routine per diem from the latest available as-filed cost reporting period is multiplied by the number of Medicaid FFS NF routine days for the

period from March 22, 2008 to June 30, 2008 to arrive at the estimated allowable Medicaid NF routine costs. The source of the number of Medicaid FFS NF routine days is the Provider's claims information, as validated by the State's MMIS. The State can make adjustments to the Provider's claims data based on State MMIS with adjustments to account for claims lag.

If applicable, this step is also performed for the SNF component, by multiplying the SNF per diem from step (b) by the number of Medicaid FFS SNF days for the period.

(d) The allowable Medicaid NF routine costs, including any applicable Medicaid SNF component costs, computed from step c above is offset by the Medicaid NF fee-for-service payments made by the State. If the State made adjustments to the paid days from MMIS to account for claims lag, the revenue offset should also be adjusted to account for the expected Medicaid NF FFS payments. The allowable Medicaid NF routine costs are further offset by all other revenues received by the facility for the Medicaid NF routine services, including patient copayments and third party payments. The result is the net Medicaid NF routine loss reimbursable as interim Medicaid NF supplemental payment.

2) *Interim Reconciliation to As-Filed Cost Report*

Each public nursing facility's interim supplemental payments will be reconciled to actual cost based on its as-filed CMS-2552-96 or 2540-96 for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The interim reconciliation is based on each public nursing facility's allowable routine cost from its as-filed cost report (filed to the Medicare fiscal intermediary) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-96. For freestanding nursing facilities, such costs are reported on the CMS-2540-96.

The same methodology detailed in the interim Medicaid supplemental payment section above will be used for the interim reconciliation. The per diems computed

using the as-filed cost report covering the expenditure period will be applied to Medicaid FFS NF days (or SNF days if applicable) furnished during the expenditure period, and all applicable revenues for the period will be applied as offsets. The State will perform this interim reconciliation within twelve months from the filing of the cost report for the expenditure period.

3) *Final Reconciliation to Finalized Cost Report*

Each public nursing facility's interim supplemental payments will also be reconciled to actual cost based on its finalized CMS-2552-96 or 2540-96 for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation is based on each public nursing facility's allowable routine cost from its finalized cost report (finalized/settled by the Medicare fiscal intermediary with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-96. For freestanding nursing facilities, such costs are reported on the CMS-2540-96.

The same methodology detailed in the interim Medicaid supplemental payment section above will be used for the final reconciliation. The per diems computed using the finalized cost report covering the expenditure period will be applied to Medicaid FFS NF days (or SNF days if applicable) furnished during the expenditure period. For the final reconciliation, such Medicaid FFS NF or SNF days must be tied to State MMIS paid claims reports, with no further claim lag adjustments. All applicable revenues for the period will be applied as offsets. The State will perform this final reconciliation within twelve months from the finalization of the cost report for the expenditure period.

(O) If any public nursing facility has received FFS reimbursement that exceeded its costs, the supplemental payments provided under paragraphs (K) and (L) to other public nursing facilities would be reduced pro rata so that the total of all regular and supplemental payments to public nursing facilities would not exceed the public nursing facilities would not exceed the public nursing facilities' aggregate cost of serving of Medicaid FFS patients.

## XII. AUDIT REQUIREMENTS

A. 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.

B. Reports of the on-site or desk audit findings shall be retained by the Department or its fiscal agent for a period of not less than three years following the date of submission of the report.

C. 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.

## XIII. 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.

## Acuity Based Long Term Care Reimbursement Rates

A new price based reimbursement system with three components (direct care, administrative and capital) will determine the rates paid to nursing facilities. The direct care component will be acuity based (adjusted for the average acuity of all of the patients in each facility).

The case mix system is based on the thirty-four III classification methodology similar to that which will be employed to calculate the acuity based portion of the long term care reimbursement rates. The system is price-based, with periodic evaluation of the price level of the rate components. An adjustment for case mix will be applied periodically to the direct care price component.

The acuity based portion of the reimbursement system applies the average case mix of all of the patients in each provider's facility to the direct care price to arrive at an acuity adjusted direct care component for each provider. The resulting acuity adjusted direct care component will be combined with the other price components to establish the rate for that provider. This rate will be adjusted periodically when the acuity scores are compiled. The rate established will be used for all patient days billed to Medicaid for that period. After the initial phase in period there will no longer be a distinction between level A and level C acuity as the new thirty-four group RUG-III system will replace the old classification system. The standard price components for direct care, general and administrative, and capital were derived from the most current Medicare cost reports available on June 30, 2001 and inflated using from the midpoint of the cost report period to the midpoint of the FY 03 rate year using DRI. A statewide standard price for the direct care component is calculated using the cost reports for all facilities and their respective case mix indices.

Calculation of the facility specific case mix index is based on data from the Minimum Data Set (MDS), a component of the federally mandated Resident Assessment Instrument, to classify residents into one of thirty-four mutually exclusive groups representing the residents' relative direct care resource requirements. The average case mix index of all of the residents of the facility at various points in time ("snapshots") is then applied to the direct care component for each facility. The facility's Medicaid acuity based reimbursement rate is the direct care component adjusted by the facility's case mix index for all residents, to which is added the general and administrative component, and the capital component.

**Parameters of the New Rate Setting Methodology**

The new rate setting methodology uses a price based system with the following parameters:

| Rate Component | Component Price set at | Myers & Stauffer calculated amount for rate period ending 6/30/2003 | Case - Mix Adjusted |
|---|---|---|---|
| Direct care | 110% of Median | $102.19 | Yes |
| Administrative & General | 103% of Median | $61.83 | No |
| Capital | Median | $13.04 | No |

The price parameters listed above (110% of median for direct care, 103% of the median for administrative and general and the median for capital) will remain

Constant for all future rates setting periods. The prices listed above ($102.19 for direct care, $61.83 for administrative and general and $13.04 for capital) reflect prices that relate to the rate period beginning July 1, 2002 and ending June 30, 2003. Therefore, those prices will need to be updated for each subsequent rate period before they can be used in the rate setting process for those periods. They will be updated by the full inflation factor for each period, as determined by the inflation adjustment provided that no inflation adjustment shall be applied in determining rates for the 4th quarter of FFY 2012 and the 1st, 2nd and 3rd quarters of FFY 2013.

For all services covered by the Hawaii Medical Assistance Program:

"Claim" means a bill for services rendered by a provider.

TRANSMITTAL # 83-1 EFFECTIVE 1-1-83
REC'D RO 3-25-83 SUPERSEDED BY TRANS. #
APPROVED 5-13-83 EFFECTIVE

STATE PLAN UNDER TITLE XIX FOR THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Requirements for Third Party Liability -
Identifying Liable Resources

1) The frequency of data exchanges are as follows: State wage information collection agency (SWICA) - Monthly; SSA wage and earnings files - semi-annual; State Title IV-A agency - weekly; State workers' Compensation - quarterly; state motor vehicle accident report files - N/A (see 42 CFR 433.138 (d)(5)). Diagnosis and trauma code edits are conducted simultaneously as claims are processed.

2) Within 30 days, follow-up (when appropriate) on data exchange is made in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base so the agency may process claims under the third party liability payment procedures specified in Section 433.139(b) through (f). The method is by personal contact with the applicant/recipient by the eligibility worker to investigate eligibility under the third party resource.

Health insurance information and workers' compensation data exchange information follow-up (when appropriate) will be conducted within sixty (60) days in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base so the agency and QUEST Health Plans may process claims under the third party liability payment procedures specified in Section 433.139 (b) through (f).

3) See item 1 above.

4) With the exception of code 994.6, action is taken to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 and "e" prefix codes (ICDCM) International Classification of Disease, 9th Revision Clinical Modification (Volume 1), inclusive for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability procedures specified in Section 433.139 (b) through (f).

Diagnosis codes that yield the highest third party collections are identified yearly and given highest priority for follow-up.

When a recipient who is receiving medical assistance is involved in an accident and medical treatment is necessary, the recipient is required to notify the Caseworker within ten (10) days. The DHS Forms 1125 (Assignment of Payment) and 1125A (Accident Report)are completed by the Caseworker and sent to the State Agency's Third Party Liability (TPL) Medical Recovery Unit for review. If a liable third party is identified , a medical lien is developed and notarized by the TPL Medical Recovery Unit and sent to the liable third party by certified mail. For Medicaid recipients, the medical expenses incurred information is obtained from the MMIS. For Quest Health Plan recipients, the medical expense incurred information is obtained from the Quest Health Plan.

If a recipient receives medical treatment for an accident and fails to report the accident to the Caseworker, an accident letter is generated and sent to the recipient when a $500 or more of medical expenses are paid. The accident letter instructs the recipient to report the accident to the Caseworker. The recipient who is injured in the accident is identified by the diagnosis code(s) on the claim. (See item 4 above). Accident letters are generated on a quarterly basis.

A TPL subrogation code 41 is entered in the recipient's eligibility file by the Caseworker when the accident is reported by the recipient.

To ensure that medical expenses are recovered, Attorneys representing a claimant, by statute, must make a reasonable inquiry with the Department as to whether the claimant has received medical assistance or is receiving medical assistance related to the incident. Before the release of any award or settlement proceeds, the claimant, attorney, or representative must notify the Department immediately. If notification is received, the TPL Medical Recovery Unit takes immediate action to obtain the medical expense incurred information from the Quest Health Plan or Medicaid Program (MMIS) and pursues recovery.

State/Territory: Hawaii

Requirements for Third Party Liability -
Payment of Claims

(d)(1) Claims for services covered the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D Agency are paid if the provider certifies that before billing Medicaid , the provider has waited 30 days from the date of service and has not received payment from the third party. The methods used to determine the providers' compliance with the above billing requirements are:

(a) The claim received date must be more than 30 days from the date of service;

(b) Provider must certify in writing that the TPL was billed and more than 30 days have elapsed; and

(c) Confirmation is made with the TPL on a sample basis to monitor that the provider filed a claim and payment has yet to be made.

(2) All third party resources available to a recipient are ascertained and this TPL data is entered in the recipient's eligibility file. A provider must seek all reimburements from the liable third party prior to Medicaid payments. Claims must be filed within a year from the date of service and only the amount remaining after third party coverage is reimbursable.

Post payment recovery is initiated when a previously unknown third party resource becomes known. A refund is requested and if after two (2) notices, no refund is received, pending claims by a provider may be reduced by the amount of liability.

(3) A threshold amount of $500 is used in determining whether to seek reimbursement from a liable third party for accident or accident related cases involving liens or court action. Any liability below this amount is not pursued as non-cost effecive. No specific time limits are applicable The Attorney General determines at which point in time to discontinue efforts to seek reimbursements.

For recipients' under managed care (Hawaii QUEST), the State assumes responsibility for recovery.

(e) The Medicaid agency ensures that in the case of individuals who are eligible for medical assistance under the plan for service(s) which a third party or parties are liable for payment, if the total amount of the established liability of the third party or parties for the service is:

(1) Equal to or greater than the amount payable under the State Plan (which includes, when applicable, cost -sharing payments), the provider furnishing the services to the individual may not seek to collect from the individual(or any financially responsible relative or representative of that individual) any payment amount for that service; or

(2) Less than the amount payable under the State Plan (including cost sharing payments) the provider furnishing the service to that individual may collect from the individual (or any financially responsible relative or representative of the individual) an amount wqhich is the lesser of:

(a) Any cost-sharing payment amount imposed upon the individual ; or

(b) An amount which represents the difference between the amount payable under the State Plan (which includes, when applicable, cost-sharing payments) and the total of the established third party liability for the services (s). This claim payment function is accomplished on a claim by claim basis when reported by the caseworker, client, or provider.

The Medicaid agency also ensures that providers do not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s). The methods used to ensure compliance are:

(1) By written notification in Medicaid Newsletter; and

(2) By pursuing enforcement when refusal to furnish services are reported by individuals to the State Agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

## STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

State/Territory: STATE OF HAWAII

| Citation | Sanctions for Psychiatric Hospitals |
|---|---|
| 1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)) | (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(A) of the Act | (b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(B) of the Act | (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:<br>1. terminate the hospital's participation under the State plan; or<br>2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or<br>3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding. |
| 1902(y)(2)(A) of the Act | (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period. |

State: HAWAII

Citation:

1932(e)
42 CFR 428.726

Sanctions for MCOs and PCCMs

(a). The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

The State of Hawaii's contracted EQRO and Med-QUEST Staff will perform annual reviews and evaluations in regards to compliance with State guidelines that may be imposed on the organization when the contractor fails to act or meet compliance with Medicaid guidelines included in 1903 (m) 1932 (e) (1) 42 CRF. The EQRO and the State have developed an extensive quality review tool that will be used to monitor and evaluate compliance with Medicaid rules and regulations.

The evaluations will be based on the following: on-site meetings with the contracted organization, review of appeals and grievances, provider complaints, recipient encounter data, and provider network submission, review of recipient and provider surveys, quality improvement projects,. financial audits, State BBA Quality Strategies, etc.

Contracts include a description of the State's plan to monitor performance and if the contracted organization is not in compliance, the State will require a corrective action plan that will be closely monitored by the EQRO and the State Med-QUEST staff. If the contractor is not compliant with the corrective action plan, the State will move to more severe penalties.

Civil monetary penalties may be implemented, the contract may be terminated, or the State may impose temporary management upon the contracted organization if it finds that a contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Act.

State: HAWAII

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Optional Imposition of Sanction:

The State may impose temporary management only if it finds (through on-site survey, enrollee complaints, financial audits, or any other means) that:

- There is continued egregious behavior by the contractor, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of section 1903(m) and 1932 of the Act;
- There is substantial risk to recipient's health; or
- The sanction is necessary to ensure the health of the contractor's recipients while improvements are made to remedy violations under 42 CFR 438.700.

The temporary management will remain in place until improvements are made to remedy violations or until there is an orderly termination or reorganization of the organization.

Required Imposition of Sanction

The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that the contracted organization repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Act, or Subpart 42 CFR 438.706.

The required imposition of the Sanction will remain until the State determines that the contracted provider can ensure that the sanctioned behavior will not recur.

State: HAWAII

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Any additional income, resource, or eligibility information concerning STATE applicants and recipients is routinely requested and verified from agencies within STATE and other States administering the programs described in 42 C.F.R. 435.948(a)(6).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

1. Arrangement may be made to have the individual report to the district office to pick up the card.

2. The card may be mailed "General Delivery" to the individual to the post office designated by the individual.

3. The card may be mailed to the individual at an address in care of whomever the individual may designate.

4. The card may be mailed to a facility for homeless individuals where the person may call for his mail.

ATTACHMENT 4.34

State/Territory: HAWAII

Waiver granted accordance with section 121(c)(4)(B) of the Immigration Reform and Control Act of 1986. This waiver does not apply to the Citizen/Alien declaration required by IRCA. Waiver was granted in 11/93.

The State will continue to verify alien status through the Citizen/Alien declaration and verification of alien documents. Alien status will be verified as a condition of eligibility.

# *SUMMARY OF HAWAII STATE LAW REGARDING AN INDIVIDUAL'S RIGHT TO MAKE MEDICAL TREATMENT DECISIONS*

(Hawaii Revised Statutes, Section 327D)
(As amended by Act 321, effective July 1, 1991)

November 1, 1991

1. **Hawaii has adopted a strong public policy in favor of the person's right to accept or refuse treatment.** Hawaii law provides that "all competent persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, continued, withheld or withdrawn. The artificial prolongation of life for persons with a terminal condition or a permanent loss of the ability to communicate concerning medical treatment decisions, may secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the person."

2. **A competent adult may make their own health care decisions.** Hawaii law permits a competent adult (age 18 or over) to make a written declaration in advance (often called a living

*Summary of Hawaii Law Regarding*
*Medical Treatment Decisions/Living Wills*
*Executive Office on Aging/Department of Human Services*
*November 1, 1991*

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will or advance directive), instructing his or her physician to provide, withhold or withdraw life-sustaining procedures under certain conditions, such as a terminal condition or where the patient has a permanent loss of ability to communicate with others due to irreversible brain injury or coma. In other words, the person has a right to choose: the person can request all available treatment in order to stay alive as long as possible, or the person can refuse some or all treatment -- even if the treatment might keep the person alive or prolong their life.

3. **How is the advance directive/living will executed?** The person's written instructions must be signed by them or by someone else in the person's presence and at their instruction. It must be witnessed by two witnesses not related to the person and not currently involved with the person's medical care. The signature's of the person and the two witnesses must be notarized (all at the same time).

4. **The person's instructions do not have to be in writing, but it is strongly preferred.** Although written advance directives are preferable, they are not required. Hawaii law also recognizes a "verbal statement or statements if they are consistent, made by the patient to either a physician or to the patient's friend or relative." Such statement(s) "may be considered by the physician

*Summary of Hawaii Law Regarding*
*Medical Treatment Decisions/Living Wills*
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*November 1, 1991*

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in deciding whether the patient would want the physician to withdraw or to withhold life-sustaining procedures." However, as a general proposition, there is less doubt and potential confusion with written directives. It is sound policy to encourage written advance directives instead of verbal ones if the person has any interest in making their health care wishes known in advance.

5. **The person's medical record**. The living will or advance directive is to be made a part of the person's medical record, and all inpatient health care facilities must develop a system to visibly identify when a patient's chart contains an advance directive. A copy of the person's living will or advance directive should normally be sufficient (at least for filing purposes). The Hawaii law does not require that an original be in each of the patient's various medical files.

6. **What the physician has to do**. An attending physician who is aware and in possession of the patient's advance directive shall immediately take steps to certify that the patient is now in the condition described in the person's living will. Thereafter, the attending physician must a) follow as closely as possible the terms of the patient's directive, or b) if the physician is not willing to comply with the patient's advance directive, the physician must arrange for transfer of the patient to another physician's care

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without unreasonable delay.

7. Revocation. Hawaii law makes it easy for the patient to revoke his or her advance directive, and the patient may revoke it at any time after it was executed, by various methods (both written and verbal), including:

* the declarant's causing it to be torn, defaced, or otherwise destroyed, or
* by executing a written revocation, or
* by the declarant's unambiguous verbal statement, in front of two adult witnesses, of the declarant's intent to revoke, or
* by the declarant's unambiguous verbal expression to an attending physician.

8. Euthanasia. Nothing in the Hawaii law is intended to condone, authorize, or approve mercy killings or euthanasia.

9. Effect upon life insurance/suicide. Compliance with the terms of a person's advance directive does not constitute suicide nor modify the terms of an existing policy of life insurance.

10. If there is no valid advance directive. Hawaii law also has a "catch-all" provision. In the absence of a valid advance directive, "ordinary standards of current medical practice will be followed."

11. Other states. Hawaii law recognizes living wills executed

in other states if the out-of-state document substantially complies with Hawaii law.

12. Durable Power-of-Attorney for Health Care. This is a document where the person appoints someone else (usually called a proxy, attorney-in-fact, or substitute decision-maker) to make some, many, or all medical treatment decisions for them, often including the right to make decisions to withhold or withdraw life-sustaining medical treatment. Hawaii law does not expressly authorize such a document, nor does Hawaii law expressly prohibit such a document; therefore, the law is not yet clear in Hawaii on whether such a document is legally enforceable. (Note: accordingly, until Hawaii law is more clear on this issue, the individual health care provider will set their own policies on whether or not to honor a Durable Power-of-Attorney for Health Care, including those executed in other states or countries. Consumers may wish to check with their own health care provider regarding their policy on this issue.)

13. Living Wills Executed Before July 1, 1991. If the person's living will is an "old" one (signed before the new Hawaii law went into effect on July 1, 1991), the old living will may seriously restrict the person's wishes and rights. (Note: therefore, it is good policy for any person with an "old" living

will to carefully review it. Then the person can take advantage of the new law -- if they want to -- by executing a new living will.)

14. Without reliable evidence of the patient's intentions or wishes, such as where there is no living will, no verbal statements, the patient is a minor, and where the patient is a now-incompetent person whose wishes were not made known while they were competent, a guardianship proceeding in court may be necessary.

15. This is merely a summary of the new Hawaii law. It does not address all possibilities or describe all of the law. For individual situations, your health care provider or other expert should be consulted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

**Not Applicable**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

x Specified Remedy *

(Will use the criteria and notice requirements specified in the regulation.)

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

| | | | |
|---|---|---|---|
| X | Specified Remedy * | _ | Alternative Remedy |
| (Will use the criteria and notice requirements specified in the regulation.) | | (Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) | |

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy *

(Will use the criteria and notice requirements specified in the regulation.)

_ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

**Enforcement of Compliance for Nursing Facilities**

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

| | | | |
|---|---|---|---|
| X | Specified Remedy * | _ | Alternative Remedy |
| | (Will use the criteria and notice requirements specified in the regulation.) | | (Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

| | | | |
|---|---|---|---|
| X | Specified Remedy * | _ | Alternative Remedy |
| | (Will use the criteria and notice requirements specified in the regulation.) | | (Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

| | | | |
|---|---|---|---|
| X | Specified Remedy * | _ | Alternative Remedy |
| (Will use the criteria and notice requirements specified in the regulation.) | | (Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) | |

* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

**Not Applicable**

§17-1737-40 Remedies for nursing facilities that do not meet the requirements for participation. (a) The department shall impose one or more of the following remedies when a nursing facility does not meet one or more of the requirements of participation and its deficiencies constitute immediate jeopardy or widespread actual harm that does not constitute immediate jeopardy to the health and safety of its residents:

(1) Remove the jeopardy and appoint temporary management to oversee correction of the deficiencies and assure the health and safety of the facility's residents while corrections are being made to bring the facility into compliance with all of the requirements of participation, or to oversee orderly closure of a facility.

(A) Temporary management shall be state personnel, private individuals, or a team with education and requisite work experience in nursing home administration that qualifies the individual(s) to correct the deficiencies in the facility to be managed; and be licensed in accordance with state law. The following individuals are not eligible to serve as temporary managers:

(i) Any individual who has been found guilty of misconduct by any licensing board or professional society in any state;

(ii) Has or whose immediate family members have any financial interest in the facility managed; or

(iii) Currently serves or, within the past two years, has served as a member of the staff of the facility;

(B) Facility management must agree to relinquish control to the temporary manager and to pay his or her salary before the temporary manager can be installed in the facility. The facility cannot retain final authority to approve changes of personnel or expenditures of facility funds and be considered to have

relinquished control to the temporary manager;

(C) If the facility refuses to relinquish control to the temporary manager, the facility shall be terminated;

(D) A temporary manager has the authority to hire, terminate, or reassign staff, obligate facility funds, alter facility procedures, and otherwise manage a facility to correct deficiencies identified in the facility operation. The temporary manager must be given access to facility bank accounts that include receipts;

(E) A temporary manager may be imposed fifteen days after the facility receives notice, in non-immediate jeopardy situations; and two days after the facility receives notice, in immediate jeopardy situations; and

(F) Temporary management shall continue until a facility is terminated, achieves substantial compliance and is capable of remaining in substantial compliance, or decides to discontinue the remedy and reassumes management control before it has achieved substantial compliance, in which case the facility faces termination;

(2) Assess civil money penalty, with interest, and impose civil money penalty for the number of days that a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy and for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

(A) Civil money penalties may be imposed as a remedy for past noncompliance that is corrected at the time of the current survey. Situations for consideration of a civil money penalty may include, but may not be limited to, facilities that cannot consistently sustain substantial compliance with the requirements as noted in the facility-specified reports,

substantiated complaints, or situations which indicate that the facility did not act to prevent a situation of noncompliance from occurring;

(B) The amount of the civil money penalty shall be on the lower range of $50 to $3,000 per day or on the upper range of $3,050 to $10,000 per day. A civil money penalty shall not be less than $50;

(C) Factors to be considered in determining the amount of the civil money penalty are:

(i) The facility's history of noncompliance, including repeated deficiencies;

(ii) The facility's financial condition;

(iii) Seriousness and scope of the deficiencies;

(iv) Likelihood that the civil money penalty will achieve correction and continued compliance;

(v) The facility's degree of culpability; and

(vi) Any other remedies being imposed in addition to the civil money penalty;

(D) All funds collected as a result of these civil money penalties shall be applied to the protection of the health and property of the residents of the facility;

(E) The funds shall be used for:

(i) Payment for the cost of relocating residents to other facilities;

(ii) State costs related to the maintenance or operation of a facility pending correction of deficiencies or closure;

(iii) Reimbursement of residents for personal funds or property lost as a result of actions by the facility or by individuals used by the facility to provide services to residents; and

(iv) Other costs related to the health and property of the residents, such as, the cost of having resident

medical records sealed, secured, and stored; the cost of picking up and transferring or delivering resident medications or drugs; the cost of using ambulance service; and etc.;

(F) The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by HCFA or the State. A civil money penalty cannot be collected until a provider requests a hearing. When no hearing is requested, payment of a civil money penalty will be due fifteen days after the time period for requesting a hearing has expired and a hearing request was not received or after the final administrative decision which includes a hearing and review; and

(G) A notice of imposition of civil money penalty shall be sent to the facility and shall include the following information:

(i) Nature of the noncompliance (regulatory requirements not met);

(ii) Statutory basis for the penalty;

(iii) Amount of penalty per day of noncompliance;

(iv) Factors that were considered in determining the amount of the penalty;

(v) Date on which the penalty begins to accrue;

(vi) Statement that the penalty will stop accruing on the date on which that facility comes into substantial compliance or is terminated from participation in the program;

(vii) When the penalty shall be collected; and

(viii) Statement of the facility's right to a hearing and information regarding how to request a hearing, implications of waiving the right to a hearing, and information regarding how to waive the right to a hearing;

(3) Close the nursing facility or transfer the residents to other facilities or both, to minimize the period of time during which residents are receiving less than adequate care.
   (A) A finding of immediate jeopardy will not require the State to close a facility and transfer residents. It may result in the immediate termination of provider agreement and the subsequent transfer of residents;
   (B) During an emergency which relates to the facility's gross inability to provide care and related services because of fire, natural disaster, epidemic, or other conditions endangering the health and safety of the residents, the State may permanently or temporarily transfer residents to another facility until the original facility is again able to care for its residents; and
   (C) Transfer requirements shall apply to only Medicare and Medicaid residents and not to private pay residents;

(4) Terminate the nursing facility's Medicaid participation.
   (A) When there is immediate jeopardy to residents' health and safety, termination procedures shall be completed within twenty-three days from the last day of the survey which found the immediate jeopardy, if the jeopardy is not removed before then;
   (B) When there is no immediate jeopardy, HCFA or the State may terminate a facility if the facility does not come into substantial compliance within six months of the date of the survey that found it to be out of substantial compliance; and
   (C) Termination may be imposed by the State at any time when appropriate for any noncompliance. The facility's compliance history shall be taken into account when considering whether or not to terminate a facility's provider agreement;

(5) Impose denial of payment for new admissions when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies imposed.

(A) Deny payment for all new admissions within the third month from the last day of the third consecutive survey.

(B) Facility shall be given written notice at least two days before the effective date in immediate jeopardy cases and at least fifteen days before the effective date in all others;

(C) Optional denial of payment for all new admissions shall be imposed only when the facility makes little or no effort to come into substantial compliance, e.g., when it fails to adhere to its plan of correction;

(D) Mandatory denial of payment for all new admissions shall be imposed when the facility is not in substantial compliance by the third month after the last day of the survey identifying the deficiency or when a provider has been found to have furnished substandard care on the last three consecutive standard surveys;

(E) The denial of payment remedy may be imposed at other times singly or in conjunction with other remedies, when a facility is not in substantial compliance;

(F) The denial of payments shall continue until the State has verified that the facility has achieved substantial compliance. Payment resumes prospectively from the date the State has determined that substantial compliance is achieved.

(i) When payment is denied for repeated instances of substandard quality of care, the remedy shall not be lifted until the facility is in substantial compliance and the State or HCFA believes that the facility will remain in substantial compliance; and

(ii) If payment is denied for any other reason and, if a survey team finds written credible evidence that the facility corrected deficiencies or was in substantial compliance before the date the survey agency received the credible evidence, the remedy shall be lifted as of that date;

(G) No payments shall be made for the period between the date the remedy was imposed and the date that substantial compliance was achieved; and

(H) Residents admitted before and discharged before the effective date of the denial of payment are considered new admissions, if readmitted, and are subject to the denial of payment; and

(6) State monitoring shall be imposed when a facility has been found on three consecutive standard surveys to have provided substandard quality of care.

(A) State monitoring shall oversee the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring shall include:

(i) Providing special consultative services to a facility for obtaining the type of training and basic knowledge needed to achieve and remain in compliance with federal regulations or to attend an in-service training program likely to correct the deficiencies; and

(ii) Assisting in the development of an acceptable plan of correction;

(B) Situations when state monitoring may be appropriate include, but are not limited to, the following:

(i) Poor facility history, i.e., a pattern of poor quality of care, many complaints, etc.;

(ii) State agency concern that the situation in the facility has the potential to worsen;

(iii) Immediate jeopardy exists and no temporary manager can be appointed or the facility refuses to relinquish control to a temporary manager. A monitor shall be imposed to oversee termination procedures and transfer of residents; or

(iv) The facility seems unable or unwilling to take corrective action for cited substandard quality of care;

(C) Monitoring may occur anytime in a facility, i.e., twenty-four hours a day, seven days a week, if necessary. In all instances, monitors shall have complete access to all areas of the facility as necessary for performance of the monitoring task; and

(D) State monitoring shall be discontinued when:

(i) The facility's provider agreement is terminated; or

(ii) The facility is terminated; or the facility has demonstrated to the satisfaction of HCFA or the State Agency, that the facility is in substantial compliance with the requirements and (if imposed for repeated substandard quality of care) that the facility will remain in substantial compliance.

(b) The appeal and hearing provisions of chapter 17-1736 shall be available to providers subject to state imposed remedies. [Eff 08/01/94; am 01/29/96; am 11/25/96; am 09/14/98] (Auth: HRS §346-14; 42 C.F.R. §§442.118, 442.119; Pub. L. No. 100-203) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§431.152, 431.202, 442.118, 442.119)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

N/A



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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

DEFINITION OF SPECIALIZED SERVICES

## SPECIALIZED SERVICES FOR SMI

For individuals with SMI, it is the continuous and aggressive implementation of an individualized plan of care that:

Is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals;

Prescribes specific therapies and activities for the treatment of individuals experiencing an acute episode of severe mental illness, which necessitates twenty-four (24) hour supervision by trained mental health personnel in an institution; and

Is directed toward diagnosing and reducing the individual's psychotic symptoms that necessitated institutionalization, improving his/her level of independent functioning and achieving a functioning level that permits reduction in the intensity of mental health services below the level of specialized services at the earliest possible time.

## SPECIALIZED SERVICES FOR MENTAL RETARDATION

For individuals with MR/DD it is a continuous treatment program which includes aggressive, consistent implementation of a program of specialized services and generic training, treatment, and health related services that is directed toward:

The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible;

The prevention or deceleration of regression or loss of current optimal functional status; and

Does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program.

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State/Territory:** HAWAII

## CATEGORICAL DETERMINATION

### PASRR Level II Preadmission Screening by Categorical Determination

The following categories developed by the State mental health or mental retardation authorities may be made applicable to individuals identified by Level I as possibly having serious mental illness / mental retardation when existing data about the individual appear to be current and accurate and are sufficient to allow the reviewer readily to determine that the individual fits into the category. The data available includes physical, mental, and functional assessments as required by 42 CFR 483.132(c). An adequate inspection of records for a categorical determination takes the place of the NF or the Specialized Services individualized Level II evaluation. The State mental health or mental retardation authority produces categorical evaluation and determination reports as required by 42 CFR 483.128 and .130, prior to admission. When existing data is not adequate, or any judgment is required about the presence of serious mental illness / mental retardation, the individual is referred for individualized Level II evaluation. Individuals are either discharged from the NF or evaluated by Level II Resident Review within the specified time limits (if any). *(Check each that applies, and supply definitions and time limits as required.)*

(1) **Categorical Determination that NF placement is appropriate.** Specialized Services evaluation and determination by the SMH/MRA is individualized

[X] (a) Convalescent care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempt hospital discharge, (which, as specified in 42 CFR 483.106(b)(2) is not subject to preadmission screening). *(Define, with time limit.) Not to exceed 120 days.*

[X] (b) Terminal illness, as defined for hospice purposes in 42 CFR 418.3.

[X] (c) Severe physical illness such as coma, ventilator dependence, functioning At a brain stem level, or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

[ ] (d) Other category(s) defined by the State. *(Define, with time limit if applicable.)*

(2) **Categorical Determination that NF placement is appropriate.** Option to also categorically determine by the SMH/MRA that Specialized Services (SS) are not needed. No categorical determinations are made that Specialized Services are needed.

[X] (a) Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.

Time limit: seven days

[X] May also categorically determine that SS are not needed

[X] (b) Provisional admission pending further assessment in emergency situations requiring protective services.

Time limit: seven days *(not to exceed 7)*

[X] May also categorically determine that SS are not needed

[X] (c) Very brief and finite stays to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

Time limit: Thirty days

[X] May also categorically determine that SS are not needed

(3) **Categorical determination that Specialized Services are not needed.** No categorical determinations are made that Specialized Services are needed. Determination by the SMH/MRA that NF placement is appropriate is individualized.

[ ] (a) Dementia and MR. The State mental retardation authority (not Level I screeners) may make categorical determinations that individuals with dementia, which exists in combination with mental retardation or a related condition, do not need specialized services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

The State will assure compliance with the requirements of Section 1902(a)(68) through the distribution of a Provider Memorandum which will inform providers statewide of the requirements in July 2007. The State will identify entities which have received or paid $5 million of Title XIX dollars or more in the Federal Fiscal Year 2006 as those providers needing to submit attestations. Affected entities will be required to submit an attestation to the State of their compliance with the required provisions by September 30, 2007.

After the initial round of compliance attestations, beginning with the calendar year (CY) 2008, compliance assurance will be delegated to the Health Coverage Management Branch (HCMB) within the Med-QUEST Division which administers the Provider Agreements and provider contracts. In the first quarter of the CY 2008, no later than March 31st and each subsequent year thereafter, the State will identify those providers having been reimbursed $5 million or more (Medicaid dollars) in a fiscal year and request an attestation from those entities annually to demonstrate compliance with this Section. A sampling of the providers identified as affected "entities" will be selected for verification of required policies/procedures and a copy of the employee handbook, if one exists, which contains the rights of the employees to be protected as whistleblowers and the procedures for preventing fraud, waste, and abuse. This information will be reviewed by the State annually beginning April 2008, in order to verify the attestation. Providers will be selected from provider categories including, but not limited to hospitals, FQHC'S, nursing facilities, DME's, individual practitioners, etc for annual review.