

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

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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

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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.

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- 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.

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- 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.

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- 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.

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- 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 a new 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:

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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 Regimen 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 regimen 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

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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.

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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;

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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)

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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

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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;

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- 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:

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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.

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- 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

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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.

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- 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.

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- 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.

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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

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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.

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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:

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- (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.

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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

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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

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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.

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- (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:

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- 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

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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 lower 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 (including 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 2013, FFY 2014 and the 1st, 2nd, and 3rd quarters of FFY 2015 except for Acuity Level B facilities. For Acuity Level B facilities, the Inflation Adjustment shall be applied to rates for the 4th quarter of FFY 2014 and 1st, 2nd, and 3rd quarters of FFY 2015.

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/IIDs) 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/IIDs) 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.

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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.

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ATTACHMENT 4.19-D

- 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 (applicable to 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.

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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.

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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.

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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

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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.

TN No. 97-002

Supersedes

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9/25/98

Effective Date 7/01/97

TN No. 95-012

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.

TN No. 03-002

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TN No. 97-002

- 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 2013, FFY 2014 and the 1st, 2nd and 3rd quarters of FFY 2015 except for Acuity Level B facilities. For Acuity Level B facilities, the Inflation Adjustment shall be applied to rates for the 4th quarter of FFY 2014 and 1st, 2nd, and 3rd quarters of FFY 2015.

- 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.

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TN No. 12-005

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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).

TN No. 03-002

Supersedes Approval Date: JUN - 9 2004 Effective Date: 07/01/03

TN No. 98-004

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- (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.

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Supersedes 03-002 Approval Date: MAR - 5 2009 Effective Date: 03/22/2008

- (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

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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 I; 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

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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

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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.

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(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.

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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.

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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.

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SUPPLEMENT TO ATTACHMENT 4.19-D

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

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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 2013, FFY 2014 and the 1st, 2nd and 3rd quarters of FFY 2015 except for Acuity Level B facilities. For Acuity Level B facilities, the Inflation Adjustment shall be applied to rates for the 4th quarter of FFY 2014 and 1st, 2nd, and 3rd quarters of FFY 2015.

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State of Hawaii

For all services covered by the Hawaii Medical Assistance Program:

"Claim" means a bill for services rendered by a provider.

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REC'D RO	<u>3-25-83</u>	SUPERSEDED BY TRANS
APPROVED	<u>5-13-83</u>	EFFECTIVE