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## HAWAII ADMINISTRATIVE RULES

### TITLE 17

#### DEPARTMENT OF HUMAN SERVICES

#### SUBTITLE 12 MED-QUEST DIVISION

#### CHAPTER 1739

#### AUTHORIZATION, PAYMENT, AND CLAIMS IN THE FEE-FOR-SERVICE MEDICAL ASSISTANCE PROGRAM

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Historical Note: This chapter is based substantially upon chapter 17-1322. [Eff 11/13/95 ]

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§§17-1739-1 to 17-1739-15 REPEALED [Eff 11/13/95;  
am 01/29/96; am 11/25/96; am 12/27/97; am 07/06/99; am  
06/19/00, R 10/26/01 ]

§17-1739-16 to §17-1739-20 (Reserved)

§§17-1739-21 to 17-1739-42 REPEALED [Eff  
11/13/95; am 11/25/96; R 09/01/03 ]

§17-1739-43 to §17-1739-52 (Reserved).

## SUBCHAPTER 3

### PROSPECTIVE PAYMENT FOR ACUTE CARE SERVICES

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

"Ancillary services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.

"Base year" means the state fiscal year used for initial calculation and recalculation of prospective payment rates. The base year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report. The 1983 state fiscal year shall be the base year for purposes of initial calculation of prospective payment rates.

"Break-even point" means the point at which a hypothetical special care percentage in the base year would not have resulted in the elimination of any costs due to the application of the ceiling factors in calculating the PPS rates.

"Capital related costs" means costs associated with the capital costs of the provider's facilities and equipment under Medicare principles of reimbursement.

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For purposes of the prospective payment methodology, capital related costs shall include depreciation, interest, property taxes, property insurance, capital leases and rentals, and costs and fees related to obtaining or maintaining capital related financing.

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

"Charity care" means, without limitation, care for which the provider never expected or sought payment. Charity care includes care provided pursuant to the Hill-Burton program, but excludes cash subsidies for patient services as defined above.

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

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

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

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

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

- (1) Divide indigent acute inpatient days by total acute inpatient days. Each percentage point or fraction thereof in excess of fifteen per cent shall be converted to a decimal and

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- added to 1.00 to obtain the disproportionate share adjustment;
- (2) Calculate the facility's medicaid utilization rate and subtract one standard deviation above the statewide mean medicaid utilization rate. Each percentage point in excess of this standard deviation shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment. A calculation resulting in a fraction of a percentage point shall be rounded up to the next percentage point. When the medicaid utilization rate equals the rate at one standard deviation point, it will be considered a fraction of a percentage point and rounded up; or
  - (3) Calculate the facility's low income utilization rate and subtract twenty-five per cent. Each percentage point or fraction thereof in excess of twenty-five per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment.

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

- (1) Either --
  - (A) Has at least two obstetricians with staff privileges at the facility who have agreed to provide obstetric services to individuals who are eligible for assistance under the medicaid program; or
  - (B) Did not offer nonemergency obstetric services as of December 21, 1987; and
- (2) Either --
  - (A) Has indigent inpatient days equal to or greater than fifteen per cent of total acute inpatient days;
  - (B) Has a medicaid utilization rate equal to or greater than one standard deviation above the statewide mean medicaid utilization rate; or
  - (C) Has a low income utilization rate equal to or greater than twenty-five per cent.

In applying the foregoing, the medicaid and total days and revenues shall be obtained from the facility's most recently filed cost report or related financial information for the period covered by that cost report. The Supplemental Security Income days shall be

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determined by the department based on the most recent information obtained from the Health Care Financing Administration. All other information shall be obtained from the most recent and reliable data available at the time the computation is made.

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

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

"Inpatient" means a patient who is admitted to an acute care facility on the recommendation of a physician or dentist and who is receiving room, board, and other inpatient services in the hospital at least overnight, and requires services that are determined by the State to be medically necessary. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight. Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

"Low income" means medicaid eligible and indigent patients.

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

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

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inpatient hospital services in the hospital in the period.

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

"Medicaid utilization rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan approved under Title XIX of the Social Security Act in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

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

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

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

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

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

"Outpatient" means a patient who receives outpatient services at a hospital which is not providing the patient with room and board and other inpatient services at least overnight. Outpatient includes a patient admitted as an inpatient whose inpatient stay is not overnight except in cases in which the patient expires.

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

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

"Special care percentage" means the result of dividing the medicaid special care days for a given cost reporting period by the total medicaid days for the same period. The days reported in the nursery cost

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center on the cost report shall be excluded from the calculation.

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

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

§17-1739-54 Provider participation requirements for acute care facilities. medicaid reimbursement for acute care services shall be limited to those facilities which have:

- (1) Applied to and been approved by the department of medicaid participation;
- (2) Received certification or recertification from the state department of health under federal standards in force;
- (3) Been licensed by the state department of health; and
- (4) Entered into a nontransferable provider agreement with the department for no more than twelve months coterminous with the state department of health's certification period. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-55 Payment for acute care services - general provisions. (a) The Hawaii medicaid program shall reimburse qualified providers for inpatient institutional services based solely on the prospective payment rates developed for each facility as determined in accordance with this subchapter. The estimated average proposed payment rate under this subchapter is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the department reasonably estimates would be paid for those services under Medicare principles of reimbursement.

(b) A hospital-specific retrospective settlement adjustment shall be made for those providers whose medicaid charges are less than medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.

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(c) Prospective rates shall be derived from historical facility costs, and facilities shall be classified based on discharge volume and participation in an approved intern and resident teaching program.

(d) Providers which average fewer than 250 medicaid discharges per year shall be classified as classification I facilities and shall receive payment based on either an all-inclusive psychiatric services per diem rate or an all-inclusive nonpsychiatric services per diem rate, which includes an adjustment for capital, disproportionate share, and medical education and, for proprietary facilities, return on equity and gross excise tax.

(e) Providers which average two hundred fifty medicaid discharges or more per year shall be separated into two facility classifications (classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid on the basis of an all-inclusive per diem rate. Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type. The per diem and per discharge rates shall include adjustments for capital, medical education, disproportionate share, and for proprietary facilities, return on equity and gross excise tax.

(f) The freestanding rehabilitation hospital shall be excluded from classifications I, II, and III and shall receive payment based on either an all-inclusive psychiatric services per diem rate or an all-inclusive nonpsychiatric services per diem rate, with the same adjustments noted above.

(g) Claims for payment shall be submitted following discharge of a patient, except as follows:

- (1) Claims for nonpsychiatric inpatient stays which exceed \$35,000 shall be submitted in accordance with section 17-1739-72;
- (2) If a patient is hospitalized in the freestanding rehabilitation hospital for more than thirty days, the facility may submit an interim claim for payment every thirty days until discharge. The final claim for payment shall cover services rendered on all those days not previously included in an interim claim.

(h) The prospective payment rates shall be paid in full for each medicaid discharge. Hospitals may not

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separately bill the patient or the medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in section 17-1739-56 below.

(i) At the point that a patient reaches outlier status, the facility is eligible for interim payments computed pursuant to section 17-1739-72.  
[Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-56 Services included in the prospective payment rate. The prospective payment rate shall include all services provided in an acute inpatient setting except:

- (1) Professional component including physician services or any other professional fees excluded under Part A Medicare;
- (2) Ambulance; and
- (3) Durable medical equipment that is a take home item except for implanted devices.  
[Eff 11/13/95 ] (Auth: HRS §346-59)  
(Imp: 42 C.F.R. §447.252)

§17-1739-57 Preparation of data for prospective payment rate calculation. (a) The calculation of prospective payment rates shall be based on facility-specific claims and cost data. Cost data shall be abstracted at the time the rate calculation begins from finally-settled uniform cost reports submitted to the department by each participating provider in accordance with federal medicaid requirements. Except for the disproportionate share adjustment, the cost report used for each facility shall be the facility's report which ended during the state fiscal year selected as the base year. For the first year of the prospective payment system, cost data shall be abstracted from the medicaid target amount computation (TAC) cost report. This cost report incorporates the adjustments made solely for the purpose of target amount determination in addition to adjustments made for final settlement. Supplemental cost reporting forms submitted by providers shall be used as necessary. Claims data shall be derived from claims submitted by participating providers for medicaid reimbursement. For the initial calculation of base year rates, claims from 1982 and 1983 facility fiscal years paid by December 31, 1984 shall be

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considered base year claim data. For subsequent calculation of rates by reference to a new base year, the latest available claims data for a two fiscal year period shall be used. Claims that are paid by December 31 of the year following the year in which the last fiscal year included in the data collection effort ends shall be considered as paid in the fiscal year when the service was rendered.

(b) Additional cost data supplied by participating providers shall be utilized to update cost data only as specified in this subchapter. For subsequent calculation of rates by reference to a new base year, providers will be given an opportunity to submit cost data similar in nature to that included in the TAC cost reports, excluding capital related costs.

(c) An inflation factor shall be based on the latest available actual (or estimated if actual is not available) national index for acute care facilities prepared by Data Resources, Inc. This factor shall project the change in the cost of delivering inpatient hospital services from one year to the next. The inflation factor shall be published annually by the department. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-58 Classification of acute inpatient facilities. (a) For purposes of establishing prospective payment rates, acute inpatient facilities shall be classified into the following four mutually exclusive groups:

- (1) Classification I - facilities averaging less than two hundred fifty medicaid discharges per year;
- (2) Classification II - facilities averaging two hundred fifty medicaid discharges per year or more, which do not participate in approved intern and resident teaching programs;
- (3) Classification III - facilities averaging two hundred fifty medicaid discharges per year or more, which participate in approved intern and resident teaching programs; and
- (4) Classification IV - The freestanding rehabilitation hospital.

(b) If a facility changes classification in accordance with the definitions in subsection (a), rates established under this subchapter shall continue to apply until the department recalculates the rates

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using new base year data. Facility classification changes shall only be recognized at the time of such rebasing. A facility that adds an approved intern and resident teaching program, however, may seek rate reconsideration under section 17-1739-78(a)(3). [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

## §17-1739-59 Service category designations.

Services provided by acute inpatient facilities shall be classified into four mutually exclusive service categories:

- (1) Maternity - an inpatient stay which results in a delivery with a maternity principal or secondary diagnosis code;
- (2) Surgical - an inpatient stay with the following characteristics:
  - (A) The claim has not been classified as a maternity claim;
  - (B) The claim includes a surgical code that is considered to be an operating room procedure in the latest and most current version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and
  - (C) The claim includes either:
    - (i) A surgical date; or
    - (ii) An operating room charge.
- (3) Psychiatric - an inpatient stay with a psychiatric primary diagnosis code and with no operating room charge; or
- (4) Medical - an inpatient stay not classified into one of the above three service categories. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

## §17-1739-60 Prospective payment rate.

Prospective payment rates to inpatient hospitals providing acute care services in accordance with sections 17-1737-3 and 17-1737-4 shall be established in accordance with the methodology set forth in this subchapter. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

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§17-1739-61 Preparation of data for calculation of base year prospective payment rates. (a) The department shall prepare data for the calculation of base year rates using the following general methodology.

(b) Base year claim charge data shall be prepared in order to establish charge ratios used in the payment calculation:

- (1) Claim charge data for all Medicare cross-over claims shall be considered based on dates of discharge which correspond to each facility's fiscal year end;
- (2) If more than one year of claim charge data is used, the charges reflected on the earlier year's claims data shall be inflated to the period covered by the most recent year's claims data in accordance with section 17-1739-57(c);
- (3) Claims shall be edited and properly classified;
- (4) Claim charge data including charge amounts, days of care, and number of discharges, shall be classified into the four service categories identified in section 17-1739-59. Combined claims for the delivery of a normal newborn shall be counted as one discharge in the calculation process. Claims for newborns described in section 17-1739-66(a)(5) shall be classified into the appropriate service category;
- (5) Claim charge data for surgical, maternity, and medical claims in classifications II and III facilities shall be segregated into routine, special care, and ancillary service charges. Nursery charges shall be included in the routine charges;
- (6) Claim charge data shall be adjusted in the case of classifications II and III facilities to delete nonpsychiatric ancillary claim charges associated with claims in excess of \$35,000; and
- (7) Claim charge data shall be adjusted to delete ancillary charges for wait listed patients.

(c) Cost report data including costs, days, and discharges, shall be extracted from base year cost reports and shall be prepared in order to determine medicaid allowable inpatient facility costs:

- (1) Costs of services excluded under section 17-1739-56 shall be deleted from costs for

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- purposes of the prospective rate calculation. This process shall involve identifying items pertaining to the excluded services and subtracting these costs from the cost report data;
- (2) Costs in excess of federal Medicare cost reimbursement limitations shall be deleted from costs for purposes of the prospective rate calculation. Costs which are not otherwise specifically addressed in this subchapter shall be included in a base year if they comply with HCFA publication number HIM 15 standards. Capital costs associated with the re-valuation of assets for any reason or due to a change in ownership, operator, or leaseholder where such re-valuation occurred after July 18, 1984 shall be identified and excluded. Costs in excess of charges shall not be deleted from costs for the purpose of the prospective rate calculation;
  - (3) Allowable medicaid inpatient facility costs shall be determined separately for routine and ancillary costs. Nursery costs shall be combined with other routine costs and reclassified into the routine service component;
  - (4) The medicaid inpatient portion of malpractice costs shall be determined by multiplying the ratio of medicaid inpatient costs to total costs by the facility's total malpractice costs. This amount shall be added to allowable medicaid inpatient facility costs;
  - (5) To recognize cost differences due to varying fiscal year ends and annual inflationary increases, allowable medicaid inpatient facility costs shall be standardized and inflated as described in section 17-1739-68;
  - (6) Capital, medical education, and for proprietary facilities, return on equity and gross excise tax amounts shall be deleted from allowable medicaid inpatient facility costs and shall be reimbursed in accordance with section 17-1739-65;
  - (7) Except as provided in section 17-1739-59, services provided to patients during an inpatient stay but billed by a provider other than the inpatient facility shall be added to allowable medicaid inpatient facility costs.

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- To obtain the estimated amount, the department shall survey facilities and accept reasonable estimates of such services; and
- (8) In computing the nonpsychiatric ancillary per discharge rates, the total ancillary costs and discharges associated with nonpsychiatric outlier claims and ancillary costs associated with wait listed patients shall be deleted from allowable medicaid inpatient facility costs and discharges based on the claim charge ratios identified in subsection (b) above. Routine costs and days related to the outlier claims shall be included in inpatient costs and days extracted from the cost reports and used in computation of the prospective payment rates. Routine costs and days related to wait listed patients shall not be extracted from the cost reports and shall be excluded from the computation of the inpatient rates. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-62 Calculation of base prospective rates for psychiatric services. (a) A base per diem rate for acute psychiatric inpatient services shall be established for all inpatient facilities using the following general methodology:

- (1) Deduct the capital related costs allocated to psychiatric services on the base year cost report;
- (2) Establish facility-specific ratios from claim charge data for psychiatric routine, special care, and ancillary charges and days to total routine, special care, and ancillary charges and days;
- (3) Multiply the ratios in paragraph (2) by total medicaid inpatient costs excluding capital related cost, and days for routine, special care, and ancillary services to achieve total psychiatric routine, special care, and ancillary medicaid inpatient costs and days as derived from the cost report; and
- (4) Total the resulting psychiatric costs and days for routine, special care, and ancillary services and achieve a facility-specific average medicaid psychiatric cost per day by dividing total psychiatric medicaid inpatient

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costs by total psychiatric inpatient medicaid days.

(b) A psychiatric per diem rate ceiling which applies to all facilities statewide shall be calculated in the following manner:

- (1) Total the costs, excluding capital related costs, and days for all psychiatric services for all facilities, as identified in subsection (a);
- (2) Divide the total psychiatric inpatient costs calculated in paragraph (1) by total psychiatric inpatient days; and
- (3) Multiply the result of paragraph (2) by the statewide psychiatric ceiling factor (one hundred fifteen per cent) published annually by the department. This result shall be the statewide base year per diem rate ceiling for psychiatric services.

(c) The prospective payment rate for psychiatric services for all facilities shall equal the lesser of either the facility-specific per diem rate or the per diem rate ceiling for inpatient psychiatric services. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

## §17-1739-63 Calculation of base year prospective rates for classification I - nonpsychiatric services.

(a) A base per diem rate for nonpsychiatric services for classification I facilities shall be established using the following general methodology:

- (1) Deduct the capital related costs allocated to non-psychiatric services on the base year cost report;
- (2) Calculate nonpsychiatric inpatient medicaid facility costs and days for all facilities in classification I by subtracting the facility's psychiatric costs and days for routine, special care, and ancillary services as specified in section 17-1739-62 from the facility's total allowable medicaid inpatient costs and days for routine, special care, and ancillary services as derived from the cost report and as calculated in section 17-1739-61; and
- (3) Total the resulting costs, excluding capital related costs, and days for routine, special care, and ancillary services and achieve a facility-specific medicaid inpatient

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nonpsychiatric cost per day by dividing total nonpsychiatric medicaid costs by total nonpsychiatric inpatient medicaid days.

(b) The classification I per diem rate ceiling for nonpsychiatric services shall be calculated as follows:

- (1) Total the costs, excluding capital related costs, and days for all nonpsychiatric services for all facilities in classification I, as identified in subsection (a);
- (2) Divide total nonpsychiatric inpatient costs calculated in paragraph (1) by total nonpsychiatric inpatient days for all facilities in classification I; and
- (3) Multiply the result of paragraph (2) by the nonpsychiatric classification I ceiling factor (one hundred twenty per cent) published annually by the department. This result shall be the classification I per diem rate ceiling for nonpsychiatric facilities.

(c) The prospective payment rate for classification I facilities shall equal the lesser of either the facility-specific per diem rates or the classification I per diem rate ceiling for nonpsychiatric inpatient services.

[Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-64 Calculation of base prospective rates for classifications II and III - nonpsychiatric services.

(a) The facility-specific prospective payment base rates for nonpsychiatric services rendered in facilities in classifications II and III shall be comprised of two separately established rate components, one per diem rate for routine services and one per discharge rate for ancillary services.

(b) The facility-specific base routine per diem and per discharge ancillary rate for nonpsychiatric services for each service category (maternity, surgical, and medical) shall be established using the following general methodology:

- (1) Deduct the capital related costs allocated to nonpsychiatric services and ancillaries on the base year cost report;
- (2) Determine separately for each service category the ratio of nonpsychiatric claim charges, days, and discharges to total claim charges, days, and discharges associated with

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- routine, special care, and ancillary components;
- (3) Multiply the ratios determined in paragraph (2) by total medicaid inpatient days, discharges and costs, excluding capital related costs;
  - (4) Determine the routine per diem costs for each service category by dividing the sum of routine and special care costs, excluding capital related costs, by the sum of routine and special care days as derived from the cost report; and
  - (5) Determine the facility ancillary cost per discharge for each service category by dividing the ancillary service costs, excluding capital related costs, by the discharges as derived from the cost report.
- (c) The base year per diem rate component ceiling shall be calculated for each nonpsychiatric service category for all facilities in classifications II and III as follows:
- (1) For all facilities within a classification, total for each service category the routine costs, excluding capital related costs, and days identified in subsection (b);
  - (2) Divide total costs calculated in paragraph (1) for each service category by total patient days;
  - (3) Multiply the result of paragraph (2) for each facility classification by the nonpsychiatric classification II and III ceiling factor (one hundred twenty per cent) published annually by the department; and
  - (4) The result shall be the per diem rate component ceiling for nonpsychiatric services for each service category within each facility classification.
- (d) A facility's prospective payment rate component for routine services for each nonpsychiatric service category shall equal the lesser of either the facility-specific base rate component or the per diem rate ceiling for the appropriate facility classification.
- (e) The ancillary services per discharge rate component ceiling shall be established separately for each service category in the following manner:
- (1) For all facilities within a classification, total the ancillary costs, excluding capital

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- related costs, and discharges within each nonpsychiatric service category;
- (2) Divide the total costs calculated in paragraph (1) by total discharges for each service category;
  - (3) Multiply the result of paragraph (2) for each facility classification by the nonpsychiatric classification II and III ceiling factor (one hundred twenty per cent) published annually by the department; and
  - (4) The result shall be the ancillary rate component ceiling for nonpsychiatric services for each nonpsychiatric service category within each facility classification.
- (f) A facility's prospective per discharge base payment rate component for ancillary services for each nonpsychiatric service category shall equal the lesser of either the facility-specific per discharge base rate or the per discharge rate ceiling for the appropriate facility classification. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-65 Addition of facility-specific factors. (a) A facility's payment rates as determined above shall be adjusted for facility-specific factors, including capital, medical education, disproportionate share, and for proprietary facilities, return on equity and gross excise tax. Adjustments shall be calculated using the following general methodology.

(b) The interim capital adjustments shall be determined according to the general procedures that are used to reimburse providers for capital costs under Medicare, except that capital related costs shall be reduced by ten per cent. At the option of the department, the following procedure may be utilized:

- (1) Each facility shall identify its capital related costs associated with providing acute care services. If a facility provides both acute and distinct part long term care services, then only the capital related costs associated with acute care shall be identified;
- (2) Each facility shall submit an estimate of its allowable capital related costs and projected medicaid utilization for each PPS rate year. The projected medicaid utilization shall be based upon the ratio of medicaid patient days to total patient days;

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- (3) The department shall review the estimates for reasonableness and determine an amount of projected allowable capital related costs for each facility;
  - (4) For FY June 30, 1988, the projected allowable capital related costs shall be reduced by seven per cent. For all subsequent PPS fiscal years, the projected amount shall be reduced by ten per cent;
  - (5) After the appropriate reduction, the projected allowable capital related costs shall be divided by twelve;
  - (6) The product of the foregoing computation shall, at the department's option, be multiplied either by the facility's projected medicaid utilization rate or by the facility's actual medicaid utilization (based upon the ratio of medicaid patient days to total patient days) reflected in the most recently filed cost report; and
  - (7) The net result shall constitute the interim capital component of the facility's PPS rate, which shall be paid on a monthly basis throughout the fiscal year.
- (c) The final capital adjustment shall be determined as follows:
- (1) After the end of the fiscal year, the department shall adjust and settle the capital related costs of each facility based upon information reflected in the finally settled cost reports that cover the fiscal year under review;
  - (2) Capital related costs shall follow the Medicare PPS capital pass through methodology in 42 C.F.R. Part 413, Subpart G, as of October 1, 1987 except the percentage reduction applied to actual costs shall be seven per cent for the fiscal year ending June 30, 1988, and ten per cent for every year thereafter; and
  - (3) A provider may appeal the department's final settlement of capital related costs in accordance with the procedural requirements of chapter 17-1736. The department may settle tentatively on the capital related costs.
- (d) For proprietary facilities, a return on equity factor, which represents a hospital's percentage of return on equity received in the base year under

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Medicare cost reimbursement principles, and gross excise tax factor, which represents gross excise tax paid on receipts in the base year, shall be determined as follows:

- (1) Divide the total allowed medicaid inpatient return on equity and gross excise tax amounts separately by allowed medicaid inpatient total costs; and
  - (2) The result shall be added to 1.00 to obtain the return on equity and gross excise tax adjustment factors, respectively.
- (e) For facilities which participate in an approved teaching program, a medical education factor shall be determined as follows:
- (1) Divide allowed medicaid inpatient medical education costs by total allowed medicaid inpatient total costs;
  - (2) The result shall be added to 1.00 to obtain the medical education adjustment factor; and
  - (3) For new providers, the medical education factor shall be determined as part of the rate reconsideration process as authorized in section 17-1739-78(a)(3).
- (f) Disproportionate share providers shall receive the disproportionate share adjustment factor. (Refer to section 17-1739-53, Definitions.)
- (g) The facility-specific adjustment factors for return on equity, gross excise tax, disproportionate share, and medical education shall be multiplied by the facility's base prospective per diem and per discharge rates. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-66 Final prospective payment calculation. (a) Based on the prospective payment rates as adjusted in section 17-1739-65, and inflated in section 17-1739-68, a facility's payment for each inpatient stay in each classification shall be calculated as follows:

- (1) For psychiatric discharges, multiply the per diem rate for a psychiatric discharge by the number of days of the psychiatric inpatient stay. The result shall be the payment for a psychiatric discharge;
- (2) For nonpsychiatric service discharges in classification I facilities, multiply the per diem rate for the discharge by the number of days of the inpatient stay. The result

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- shall be the payment for a nonpsychiatric service discharge;
- (3) For surgical, maternity, and medical service discharges in classification II and III facilities, calculate the prospective payment for each facility as follows:
    - (A) Multiply the per diem rate component for the appropriate nonpsychiatric inpatient service category by the number of days of care for each service category for the inpatient discharge;
    - (B) Add the ancillary rate per discharge for the appropriate service category; and
    - (C) The result shall be the payment for each nonpsychiatric service discharge.
  - (4) If a woman delivers a child, then payment for the mother and baby shall be made separately. A per diem payment shall be made separately for care delivered to a normal newborn based on the costs and days associated with nursery care; and
  - (5) The following situations shall not be considered as constituting care that is delivered to a normal newborn, and shall be reimbursed as indicated:
    - (A) If it is medically necessary for the baby to remain in the hospital more than six days following birth (including the birthday), then the payment shall be determined separately based on the same criteria as any other discharge;
    - (B) If the claim form for services delivered to the newborn indicates an intensive care unit revenue code, then the payment for a medical case shall be made; or
    - (C) If both of the following requirements are met:
      - (i) The claim form reflects information that would result in the claim being characterized as a surgical case under section 17-1739-59(2); and
      - (ii) The newborn remains in the hospital for more than three days; then the payment for a surgical case shall be made.
- (b) Payment shall be made under the prospective payment rate based on the date of discharge, except as provided in sections 17-1739-55(g) and 17-1739-71.

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(c) Capital related costs shall be reimbursed as defined in section 17-1739-65(b).  
[Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-67 Special prospective payment rate considerations. (a) For a facility with insufficient observations (less than five claims) in a given service category, the prospective payment rate shall be calculated using the weighted average for the applicable service category for the facility's classification.

(b) Prospective payment rates for classification IV, the freestanding rehabilitation hospital, shall be calculated in the following manner:

- (1) Facility-specific claim charge data shall be prepared in accordance with section 17-1739-61;
- (2) A facility-specific per diem base rate for psychiatric services shall be calculated in accordance with section 17-1739-62;
- (3) A facility-specific per diem base rate for nonpsychiatric services shall be calculated by dividing total nonpsychiatric costs, excluding capital related costs for the hospital by nonpsychiatric medicaid inpatient days; and
- (4) The facility-specific factors shall be computed or reimbursed as defined in section 17-1739-65. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-68 Adjustment to base year costs for inflation. (a) Cost increases due to varying fiscal year ends and inflation shall be recognized for purposes of establishing prospective payment rates in accordance with the following general methodology.

(b) Base year facility-specific costs shall be standardized to remove the effects caused by varying fiscal year ends of the facility. This shall be accomplished by dividing the inflation factor for the base year, as determined in accordance with section 17-1739-57 by twelve and multiplying this result by the number of months between the hospital's base year fiscal year end and June 30 of each year. This result shall be added to 1.00 to yield an inflation adjustment

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or which shall then be multiplied by the facility-specific costs.

(c) Cost increases due to inflation which occurred from the base year shall utilize the inflation factor specified in section 17-1739-57(c):

- (1) For years during which the department does not recalculate the rates by reference to a new base year, cost increases due to inflation for state fiscal years 1987 and beyond shall be recognized by multiplying the prospective payment rate (excluding rate reconsideration relief) in effect on June 30 of the fiscal year by one plus the inflation factor for the following fiscal year. To insure the prospective nature of the PPS, the inflation factor shall not be retroactively adjusted nor modified except as noted below;
- (2) For each year in which the department does recalculate the rates by reference to a new base year, cost increases due to inflation shall be recognized by multiplying the base year rates by one plus the inflation factor for each subsequent year, using the most current and accurate inflation data then available from Data Resources, Inc. (DRI). To insure the prospective nature of the PPS, that data shall not be retroactively adjusted nor modified; and
- (3) For years in which the department does not recalculate the rates by reference to a new base year and in which the inflation factor for the prior year was reduced pursuant to subsection (d), then the average rates for the prior fiscal year shall be deemed to be the rates in effect on June 30.

(d) Absent circumstances beyond the control of the department, before the expiration of six months in each fiscal year the department shall determine whether the aggregate amount of reimbursement for that state fiscal year is projected to exceed the amount that would be paid for the same services under Medicare principles of reimbursement. In making that determination, the department shall exclude sums paid pursuant to section 17-1739-77(c) or any exception to or exemption from the inpatient operating cost limits as defined pursuant to 42 C.F.R. Part 413. In making its determination, the department shall use the most current information available, including the most recent cost reports filed by the facilities. If the

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projected aggregate amount of reimbursement is reasonably anticipated to exceed the amount that would be paid under Medicare principles of reimbursement, then the department shall reduce the inflation factor used to calculate the rates for the remainder of the fiscal year so that the aggregate payments for the entire fiscal year (excluding the disproportionate share adjustments) are reasonably projected to be no more than that which would be paid under Medicare principles of reimbursement. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-69 Treatment of new facilities. (a) Rates for new providers shall be calculated by a separate method. A new provider shall receive the statewide weighted average payment rates for its classification times the following new provider adjustment factor:

- (1) First Operating Year - one hundred fifty per cent;
- (2) Second Operating Year - one hundred forty per cent;
- (3) Third Operating Year - one hundred thirty per cent; and
- (4) Fourth Operating Year and thereafter one hundred twenty five per cent;
- (5) If a facility's operating year does not coincide with the PPS fiscal year, then the new provider's rates shall be prorated based on the PPS fiscal year. For example, a new provider that begins its first operating year on January 1 would receive one hundred forty-five per cent of the statewide weighted average payment rates for its classification for the entire PPS fiscal year that begins on the immediately following July 1.

(b) Capital related costs shall be reimbursed as defined in section 17-1739-65(b) and (c).

(c) For new providers that are proprietary facilities, the PPS rates shall also be adjusted by return on equity and gross excise tax factors. Those factors shall be based on projected costs and receipts and calculated as defined in section 17-1739-65(d).

(d) A new provider may seek rate reconsideration under section 17-1739-78(a)(3) if it adds an approved intern and resident teaching program. A new provider is also eligible for the disproportionate share

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adjustment if it meets the qualifications defined in this subchapter.

(e) A new provider shall have its PPS rates determined under this section until it no longer meets the definition of a new provider. Thereafter, its PPS rates shall be based on its base year cost report like all other providers. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-70 Payment for transfers. (a) A hospital inpatient shall be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility.

(b) A hospital which receives a transfer and subsequently discharges that individual shall be considered the discharging hospital. All other hospitals which admitted and subsequently transferred the patient during a single spell of illness shall be considered transferring hospitals.

(c) The service category into which the patient falls at the time of transfer or discharge shall be considered the appropriate service category for purposes of payment to that facility.

(d) If a classification I facility or the freestanding rehabilitation hospital transfers an inpatient to another classification I facility or the freestanding rehabilitation hospital, both facilities shall receive the per diem rates calculated in section 17-1739-66.

(e) If a classification I facility or the freestanding rehabilitation hospital transfers an inpatient to a classification II or III facility, the classification I facility shall receive the per diem rate calculated in section 17-1739-66, and the classification II or III facility shall receive the full per diem and ancillary reimbursement rate to which it is entitled under section 17-1739-66.

(f) If a classification II or III facility transfers an inpatient to another acute inpatient facility, payment shall be as follows:

- (1) In nonpsychiatric cases where medical necessity requires that the patient remain in the transferring hospital three or more days or that the patient be cared for in the intensive care or coronary care units, the transferring classification II or III facility shall receive the full per diem rate

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for routine care and the full ancillary discharge rate for the appropriate service category, as calculated in accordance with section 17-1739-66;

- (2) For nonpsychiatric cases of less than three days and not involving intensive care, payment to a transferring classification II or III facility shall be the facility-specific per diem rate for routine care and thirty per cent of the ancillary discharge rate for the appropriate service category, as calculated in accordance with section 17-1739-66;
- (3) For nonpsychiatric services, payment to a discharging classification II or III facility shall be the full prospective payment rates calculated in section 17-1739-66;
- (4) For nonpsychiatric services, payment to a discharging classification I facility or the freestanding rehabilitation facility shall be determined by multiplying the number of days of stay in the discharging facility by the per diem calculated in section 17-1739-66; and
- (5) For psychiatric services, payment to any transferring or discharging facility shall be determined by multiplying the number of days of stay by the per diem calculated in section 17-1739-66.

(g) Transfers shall be subject to utilization review, and the department or its utilization review agent may deny full or partial payment to the transferring facility if it is determined that the transferring facility was able to provide all required care or that a patient was held three days or more or placed in intensive care when it was not medically necessary.

(h) For the purpose of determining capital related costs associated with transfers, all days and charges associated with services rendered by each facility to the transferred patient shall be included in that facility's computation. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-71 Payment for readmission. (a)  
Readmissions to the same facility within twenty four hours of discharge for the same spell of illness and

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for the same general diagnosis as the original admission shall be considered to be the same admission and shall be billed as a single stay. The department may deny full or partial payment for the original inpatient stay or the subsequent readmission if it is determined that the facility could have provided all required services during the original inpatient stay. This section shall not apply in cases where a patient leaves the hospital against medical advice.

(b) Readmission to the same facility within thirty days of a previous discharge for a similar diagnosis shall be subject to utilization review. The department may deny full or partial payment for the original stay or the subsequent readmission if it is determined that the facility could have provided all required services during the original stay. This section shall not apply in cases where a patient leaves the hospital against medical advice. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-72 Payment for nonpsychiatric cases which exceed \$35,000. If charges for nonpsychiatric services rendered to a patient during an inpatient stay are in excess of \$35,000, billing and payment for this stay shall be as follows:

- (1) For classification I facilities and the freestanding rehabilitation hospital, payment shall be made at applicable per diem rates for the full inpatient stay;
- (2) For classification II and III facilities:
  - (A) An initial interim bill shall be submitted covering the period from the admission date through the date the charge for the case reaches \$35,000. Payment for this interim bill shall be the classification per diem rate for the service category multiplied by the number of days covered by the bill plus the full appropriate ancillary rate as calculated in section 17-1739-68; and
  - (B) Sixty days after a patient reaches outlier status, monthly thereafter, and upon discharge, a facility shall bill the department for charges in excess of the outlier threshold. The facility shall also document to the department's reasonable satisfaction the medical

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necessity for the days of care and services rendered. The department shall pay such bills that are appropriately documented and properly within the scope of the acute care medicaid program no less than quarterly. The department shall pay for the full per diem and eighty per cent of the ancillary charges, excluding amounts included in computing the outlier threshold; and

- (3) For the purpose of determining capital related costs associated with outlier cases, the full amount of charges shall be included in the facility's computation.

[Eff 11/13/95 ] (Auth: HRS §346-59)  
(Imp: 42 C.F.R. §447.252)

## §17-1739-73 Wait listed reimbursements. (a)

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

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

(b) Wait listed rates shall be annually adjusted by the same inflation factors as the long-term care PPS rates.

(c) The rate for wait listed long-term care patients in acute care beds does not include ancillary services except for medical supplies and maintenance therapy. These excluded ancillary services must therefore be billed separately. Reimbursements will be consistent with the ancillary rates paid to long term

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care facilities. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-74 Payment for services rendered to patients with other health insurance. medicaid is a secondary payor. In no case shall medicaid pay a sum, when considered in conjunction with payments from all other sources (including the patient's cost share and Medicare), that exceeds the amount that would have been paid if no other source of reimbursement existed. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-75 Limitations on acute care facility payment. (a) Calculation of the prospective payment rate shall not be affected by a public provider's imposition of nominal charges in accordance with federal regulations. However, for providers whose charges are less than costs on the most recently filed cost report and who do not qualify as a nominal charge provider, the prospective rate shall be reduced during the interim until the applicable cost report is filed and a settlement adjustment is made. The interim reduction shall be in proportion to the ratio of costs to charges on the most recent filed cost report. Updated data and charge structures may be provided to the department's fiscal intermediary if the provider believes that its rate structure has changed significantly since the most recent filed cost report, but the department will be responsible for approving the final interim rate reduction necessary to approximate final settlement as closely as possible.

(b) Payment for out-of-state acute care facility services shall be the medicaid rate applicable in the facility's state. If an out of state medicaid rate is not available, the weighted average Hawaii medicaid rate applicable to services provided in comparable Hawaii facilities shall be used.

(c) The department or its utilization review agent may deny full or partial payment if it is determined that the admission or transfer was not medically necessary or the diagnosis or procedure code was not correctly assigned, or the patient was retained in the facility longer than necessary. The department shall recover amounts due using the most expedient methods possible which shall include but not be limited to offsetting amounts against current payments due

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providers. [Eff 11/13/95 ] (Auth: HRS §346-59)  
(Imp: 42 C.F.R. §447.252)

§17-1739-76 Adjustments for costs under appeal.  
A change in a facility's base year costs due to appeals to the base year cost report that occur subsequent to the effective date of these rules shall not result in changes to the rate ceilings for the classification group until the next recalculation of rates. The facility-specific prospective payment rate calculated under section 17-1739-66 shall be adjusted to reflect the appeal decision. Base year costs shall be adjusted to reflect the appeal decision, and the facility-specific prospective rate shall be recalculated, effective the first day of the rate year, based on the adjusted base year costs, as long as the rate ceilings are not exceeded. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-77 Future redetermination of prospective payment rates. (a) In future years, prospective payment rates for acute care facilities shall be established by trending forward the base year prospective payment rates by adjusting estimated to actuals and applying the projected inflation factor, as defined in section 17-1739-57, for the prospective payment year at the start of each fiscal year.

(b) Reimbursement for capital related costs shall be computed annually as defined in section 17-1739-65(b).

(c) The department shall recalculate the prospective payment rates periodically by reference to a new base year. This recalculation shall be performed at least once every five years, except under extraordinary circumstances. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-78 Requests for rate reconsideration.

(a) Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:

- (1) Extraordinary circumstances including but not limited to acts of God, changes in life and safety code requirements, changes in licensure law, rules or regulations, significant changes in case mix or the nature

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- of service, or addition of new services occurring subsequent to the base year. Mere inflation of costs, absent extraordinary circumstances, shall not be a ground for rate reconsideration;
- (2) Reduction in medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration relief provided under this section shall be the lesser of actual growth in the cost per day since the base year or seventy-five per cent of the reduction in the average cost per discharge (inflated) since the base year divided by the current average length of stay. In no case shall the add-on exceed the actual ancillary and room and board costs of the facility; and
  - (3) The addition of an approved intern and resident teaching program. This is the only circumstance that is eligible for a rate reconsideration request by a new provider.
- (b) A provider may also obtain a rate reconsideration if it provides an atypically high percentage of special care, determined as follows. In order to obtain the relief, the provider must meet each of the tests and follow each of the procedures defined below:
- (1) One or more of the facility's per diem rates is affected by the ceiling in its classification for that type of service;
  - (2) The percentage of the facility's base year medicaid special care days over total base year medicaid days (excluding days that are reported in the nursery cost center on the cost report) is greater than one hundred fifty per cent of the same average for all other facilities in its classification. The data to perform the comparison shall be obtained from the base year medicaid cost reports;
  - (3) The facility's average per diem costs for both general inpatient routine service and special care, excluding capital related costs and medical education costs, are no greater

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than one hundred twenty per cent of the weighted average for all other facilities in the same classification. The data to perform the comparison shall be obtained from the base year medicaid cost reports;

- (4) The provider must analyze its base year costs and vary its special care percentage to determine its break-even point. This analysis shall be performed for each PPS rate that was affected by a component ceiling;
- (5) The provider must compute its special care percentage based upon the most recent information available;
- (6) The provider must certify to the department in conjunction with its rate reconsideration request that, based upon its most recently filed cost report, the percentage defined in section 17-1739-78(b)(2) continues to exceed one hundred fifty per cent of the average for all other facilities in its classification during the base year. The certification shall be based upon a cost report classification method that is consistent with the method that the facility used in the base year medicaid cost report; and
- (7) The provider must submit the results of all of the foregoing analyses and calculations, along with its certification, to the department as part of its rate reconsideration request. For each rate category in which the most recent special care percentage exceeds the break-even point, the provider shall have the applicable PPS rate increased by the amount that it was reduced due to the application of the component ceilings. For each rate category in which the most recent special care percentage is equal to or less than the break-even point, the provider shall receive no increase in its PPS rates.

(c) 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 requests. Documentation shall include the data necessary to demonstrate that the circumstances for which reconsideration is requested meet the requirements noted above. Documentation shall include:

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- (1) A presentation of data to demonstrate reasons for the hospital's request for rate reconsideration; and
- (2) If the reconsideration request is based on changes in patient mix, then the facility must document the change using diagnosis related group case-mix index or other well-established case-mix measures, accompanied by a showing of cost implications.

(d) A request for reconsideration shall be submitted within sixty days after the prospective rate is provided to the facility by the department or at other times throughout the year if the department determines that extraordinary circumstances occurred. The addition of an approved intern and resident teaching program shall be one example of that type of extraordinary circumstance that justifies a mid-year rate reconsideration request.

(e) The provider shall be notified of the department's discretionary decision in writing within a reasonable time after receipt of the written request.

(f) Pending the department's discretionary decision on a request for rate reconsideration, the facility shall be paid the prospective payment rate initially determined by the department. If the reconsideration request is granted, the resultant new prospective payment rate shall be effective no earlier than the first date of the prospective rate year.

(g) A provider may appeal the department's decision on the rate reconsideration. The appeal shall be filed in accordance with the requirements of chapter 17-1736.

(h) Rate reconsiderations granted under this section shall be effective for the remainder of the prospective rate year. If the facility believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection (c) within sixty days of notice of the facility's rate for each subsequent rate year. The department shall review the documentation and notify the facility of its determination as described in subsection (e). The department may, at its discretion, grant a rate adjustment which is automatically renewable until the base year is recalculated. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

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§17-1739-79 Cost report requirements. (a) All participating acute care facilities shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

(b) Participating facilities shall submit the following on an annual basis no later than ninety days after the close of each facility's fiscal year:

- (1) Uniform cost report;
- (2) Working trial balance;
- (3) Provider cost report questionnaire;
- (4) Audited financial statements if available;  
and
- (5) Disclosure of appeal items included in the cost report.

(c) Payment for services shall be temporarily reduced by at least twenty per cent if the cost report is not received within one hundred twenty days, and one hundred per cent if the cost report is not received within one hundred fifty days. A thirty day maximum extension will be granted upon written request for good cause as provided in Medicare guidelines.

(d) Each provider shall keep financial and statistical records of the cost reporting year for at least five years after submitting the cost report to authorized state or federal representatives.

[Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-80 Audit requirements. (a) All costs reports shall be analyzed within six months after receipt to verify that each acute care provider has complied with medicaid cost reporting requirements.

(b) On-site audits of cost reports, including financial and statistical records of a sample of participating facilities in each facility classification, shall be conducted annually.

(c) Upon conclusion of each on-site audit, a report of the audit findings shall be retained by the medicaid agency for a period of not less than three years following the date of submission of the report.

(d) Facilities shall have the right to appeal audit findings. [Eff 11/13/95 ] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)

§17-1739-81 Effective date of amendments to subchapter 3. Unless otherwise stated, amendments to

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this subchapter shall be effective concurrent with the effective date of federal approval to a corresponding amendment to the Hawaii medicaid State Plan for inpatient hospital reimbursement. [Eff 11/13/95 ]  
(Auth: HRS §346-59) (Imp: 42 C.F.R. §447.252)