(3) The Department shall review the estimates for reasonableness and determine an amount of projected allowable Capital Related Costs for each facility.

(4) The projected allowable Capital Related Costs (less 10%) shall be divided by 12.

(5) The product of the foregoing computation shall, at the Department's option, be multiplied either by the facility's projected Medicaid utilization rate or by the facility's actual Medicaid utilization (based upon the ratio of Medicaid patient days to total patient days) reflected in the most recently filed cost report.

(6) The net result shall constitute the interim Capital Payment, which shall be paid on a monthly basis throughout the fiscal year.

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

(1) After the end of the fiscal year, the Department shall adjust and settle the Capital Related Costs of each facility based upon information reflected in the finally settled cost reports that cover the fiscal year under review.

(2) Capital Related Costs shall follow the Medicare PPS capital pass through methodology in 42 C.F.R. Part 413, Subpart G, as of 10/1/87 .

(3) A provider may appeal the Department's final settlement of Capital Related Costs in accordance with the procedural requirements of Chapter 17-1321 of the Hawaii Administrative Rules (see appendix to state plan). The Department

may settle tentatively on the Capital Related Costs.

3. For Proprietary Providers, the ROE Adjustment, which represents a hospital's percentage of return on equity received in the Base Year under Medicare cost reimbursement principles, shall be determined as follows:

   a. Divide the total allowed Medicaid inpatient return on equity amounts by allowed Medicaid inpatient total costs; and

   b. The results shall be added to 1.00 to obtain the return on equity adjustment factor.

4. All Providers that participate in an approved teaching program shall receive the Medical Education Adjustment, calculated as follows:

   a. Divide allowed Medicaid inpatient medical education costs by total allowed Medicaid inpatient total costs; and

   b. The result shall be added to 1.00 to obtain the medical education adjustment factor.

   c. For New Providers, the medical education factor shall be determined as part of the rate reconsideration process as authorized in Section V.C.1.c.

E. FINAL PROSPECTIVE PAYMENT CALCULATIONS

1. Based on the PPS rates as adjusted in Section III.D. above and inflated in Section III.G. below, a facility's payment for each inpatient stay in each classification shall be calculated as follows:

   a. For psychiatric discharges, multiply the Total All-Inclusive Rate for a psychiatric discharge by the number of days of the psychiatric inpatient stay. The result shall be the payment for a psychiatric discharge;

b. For nonpsychiatric service discharges in Classification I facilities, multiply the Total All-Inclusive Rate for the discharge by the number of days of the inpatient stay. The result shall be the payment for a nonpsychiatric service discharge.

c. For surgical, maternity, and medical service discharges in Classification II and III facilities, calculate the prospective payment for each facility as follows:

(1) Multiply the Total Per Diem Rate component for the appropriate nonpsychiatric inpatient service category by the number of days of care for each service category for the inpatient discharge;

(2) Add the Total Per Discharge Rate for the appropriate service category; and

(3) The result shall be the payment for each nonpsychiatric service discharge.

d. If a woman delivers a child, then payment for the mother and baby shall be made separately. A per diem payment shall be made separately for care delivered to a normal newborn based on the costs and days associated with nursery care.

e. The following situations shall not be considered as constituting care that is delivered to a normal newborn, and shall be reimbursed as indicated:

(1) If it is medically necessary for the baby to remain in the hospital more than six days following birth (including the birthday), then the payment shall be determined separately based on the same criteria as any other discharge;

(2) If the claim form for services delivered to the newborn indicates an intensive

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

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

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

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

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

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

F. FACILITIES WITH SPECIAL PROSPECTIVE PAYMENT RATE CONSIDERATIONS

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

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

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

b. A facility-specific per diem base rate for psychiatric services shall be calculated in accordance with Section III.A.

c. A facility-specific per diem base rate for nonpsychiatric services shall be calculated

by dividing total nonpsychiatric costs, excluding Capital Related Costs, for the hospital by nonpsychiatric Medicaid patient days.

d. The facility specific factors shall be computed or reimbursed as defined in Section III. D.

G. ADJUSTMENT TO BASE YEAR COSTS FOR INFLATION

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

1. Base year facility-specific costs shall be standardized to remove the effects caused by varing fiscal year ends of the facility. This shall be accomplished by dividing the Inflation Factor for the Base Year, as determined in accordance with Section II.A.3. by 12 and multiplying this result by the number of months between the hospital's Base Year fiscal year end and June 30 of each year. This result shall be added to 1.00 to yield an inflation adjustment factor which shall then be multiplied by the facility-specific costs.

2. Cost increases due to inflation which occurred from the Base Year shall utilize the inflation factor specified in Section II.A.3.

3. For years in which the Department does not Rebase the PPS rates, cost increases due to inflation shall be recognized by multiplying the Total All-Inclusive, Total Per Diem and Total Per Discharge Rates in effect for the fiscal year by one plus the Inflation Factor for the following fiscal year. To insure the prospective nature of the PPS, the inflation factor shall not be retroactively adjusted nor modified, except as noted below.

4. For years in which the Department does not Rebase and in which the Inflation Factor for the prior year was reduced prusuant to Section III.G.6.,

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

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

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

IV. SPECIAL PAYMENT PROVISIONS

A. TREATMENT OF NEW FACILITIES

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

its classification times the following New provider adjustment factor:

a. First Operating Year 150%;

b. Second Operating Year 140%;

c. Third Operating Year 130%; and

d. Fourth Operating Year and thereafter 125%.

e. If a facility's Operating Year does not coincide with the PPS fiscal year, then the New Provider's rates shall be prorated based on the PPS fiscal year. For example, a New Provider that begins its First Operating Year on January 1 would receive 145% of the statewide weighted average payment rates for its classification for the entire PPS fiscal year that begins on the immediately following July 1.

2. Capital Related Costs shall be reimbursed as defined in Section III.D.2 and 3.

3. For New Providers that are also Proprietary Providers, the PPS rates shall also be adjusted by ROE and GET Adjustments, (Section III.D.3.). Those factors shall be based on projected costs and receipts and calculated as defined in this Plan.

4. A New Provider may seek rate reconsideration under Section V.C.1.c if it adds an approved intern and resident teaching program.

5. Notwithstanding the foregoing, a Provider that begins operations after January 1, 1993, shall receive the statewide weighted average per diem and per discharge rates for its classification.

6. A New Provider shall have its PPS rates determined under this section until a Rebasing occurs that identifies a Base Year in which the New Provider has a cost report that reflects a full twelve months of operations. Thereafter, its PPS rates

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

B. PAYMENT FOR TRANSFERS

1. A hospital inpatient shall be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility.

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

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

4. If a Classification I or IV facility transfers an inpatient to another Classification I or IV facility, then both facilities shall receive their All-Inclusive Rates.

5. If a Classification I or IV facility transfers an inpatient to a Classification II or III facility, the Classification I or IV facility shall receive its All-Inclusive Rate, and the Classification II or III facility shall receive the full per diem and ancillary reimbursement rates defined in Section III.E.

6. If a Classification II or III facility transfers an inpatient to another acute inpatient facility:

   a. In the nonpsychiatric cases, where medical necessity requires that the patient remain in the transferring hospital three or more days or that the patient be cared for in the intensive care or coronary care units, the transferring Classification II or III facility shall receive the full per diem rate for routine care and the full ancillary

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

b. For nonpsychiatric cases of less than three days and not involving intensive care, payment to a transferring Classification II or III facility shall be the facility-specific per diem rate for routine care and 30 percent of the ancillary discharge rate for the appropriate service category, as calculated in accordance with Section III.E.

c. For nonpsychiatric services, payment to a discharging Classification II or III facility shall be the full prospective payment rates calculated in Section III.E. of these rules.

d. For nonpsychiatric services, payment to a discharging Classification I facility or, Classification IV facility, shall be determined by multiplying the number of days of stay in the discharging facility by the per diem calculated in Section III.E or F.2, respectively.

e. For psychiatric services, payment to any transferring or discharging facility shall be determined by multiplying the number of days of stay by the per diem calculated in Section III.E.

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

8. For the purposes of determining Capital Related Costs associated with transfers, all days and charges associated with services rendered by each facility to the transferred patient shall be included in that facility's computation.

C. PAYMENT FOR READMISSION

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

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

D. PAYMENT FOR NONPSYCHIATRIC CASES WHICH EXCEED THE OUTLIER THRESHOLD

1. If charges for nonpsychiatric services rendered to a patient during an inpatient stay are in excess of the Outlier Threshold, then billing and payment for this stay shall be as follows:

   a. For Classification I facilities, and Classification IV facilities, payment will be made at applicable per diem rates for the full inpatient stay.

   b. For Classifications II and III facilities:

      (1) An initial interim bill shall be submitted covering the period from the admission date through the date that the charge for the case reaches the Outlier Threshold. Payment for this interim bill shall be the classification per