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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 09-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

APR - 7 2010

Lillian B. Koller, Esq.
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

RE: Hawaii State Plan Amendment 09-002

Dear Ms. Koller:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 09-002. This amendment provides for disproportionate share hospital payments for the State fiscal year ending June 30, 2009.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-002 is approved effective June 29, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

cc: Kenny Fink, Administrator, MEDQUEST
Ann Kinningham, Finance Officer, MEDQUEST
Aileen Befitel, State Plan Coordinator, MEDQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-002	2. STATE HAWAII
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) MEDICAL ASSISTANCE	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE June 29, 2009	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.253 42 CFR 447 Subpart D Section 1923 of the Act	a. FFY 2009: ~~$Annual payment - $10,250,000~~ $7.5 million
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-A, pages 42 and 43 43a, 43b, 43c, 43d	ATTACHMENT 4.19-A, pages 42 and 43

10. SUBJECT OF AMENDMENT:
DISPROPORTIONATE SHARE PAYMENTS

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: LILLIAN B. KOLLER	
14. TITLE: DIRECTOR	
15. DATE SUBMITTED: 06/29/09	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 4-7-10
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 29 2009	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMSO

23. REMARKS:

CMS RO made pen-and-ink changes to Box6, 7, 8, with concurrence by State per emails in March 2010 and response to Request for Additional Information on January 28, 2010.

FORM HCFA-179 (07-92)

specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(4) "Uncompensated care costs" means the costs of providing care to the uninsured, shortfall in reimbursement of the cost of providing inpatient and outpatient services under the QUEST managed care program, and any shortfall in reimbursement of the cost of providing inpatient or outpatient services on a fee-for-service basis to Medicaid eligible patients. The State will adhere to the OBRA'93 hospital specific DSH limits (42 USC 1396r-4(g)) and is net of any profit earned on fee-for-service or managed care reimbursement. "Shortfall" means the cost of providing service less the payment received for the service, either pursuant to the state plan or pursuant to the section 1115 waiver and is net of any profit earned on fee-for-service or managed care reimbursement.

(5) "Governmental DSH Provider" means a hospital meeting the tests in Paragraph 2 (above) that is owned and operated by the Hawaii Health Systems Corporation.

B. PAYMENT ADJUSTMENT

1. With respect to state fiscal year 2009, all DSH providers (which do not include Governmental DSH providers) will receive payments as follows:

a. For the first quarter, payments will be made from a pool of funds in the amount of $4,536,382. The payment for each DSH provider shall be determined by a distribution formula that is based on the following four factors:

(i) Medicaid inpatient fee-for-service uncovered cost (30%);

(ii) Medicaid outpatient fee-for-service uncovered cost (10%);

(iii) Bad debt and charity (20%); and

(iv) Case mix adjusted days (40%).

The percentages applicable to each factor represent the portion of the pool to be distributed in accordance with the listed factor. For each portion of the pool, each hospital's share will be based on its share of the total for portions for each hospital and shall constitute its payment amount.

b. For the second, third and fourth quarters, payments will be made from a pool of funds in the amount of $3,582,804. The payment for each DSH provider shall be determined by the distribution formula set forth in paragraph 1.a. above.

c. In no event shall the total payments to a DSH provider under this paragraph 1 for state fiscal year 2009 exceed the uncompensated care costs of the provider. If the provider has uncompensated care costs (as defined in paragraph A.4 above) attributable to state fiscal year 2009 that are less than the amount of the payments that would be made to that provider pursuant to the formula set forth above (or to the redistribution described in this sentence), the payments to that provider shall be reduced to the amount of its uncompensated care costs attributable to state fiscal year 2009 and the difference shall be distributed to the remaining DSH providers in accordance with the formula set forth above.

2. With respect to state fiscal year 2009, governmental DSH providers will receive DSH payments as follows:

a. For the first quarter, payments will be made from a pool of funds in the amount of $25.00. The pool shall be distributed to each qualifying governmental DSH hospital in proportion to its share of uncompensated care cost (as defined in paragraph A.4 above).

b. For the second, third and fourth quarters, payments will be made based on each qualifying government DSH hospital's uncompensated care cost (as defined in paragraph A.4 above) for those quarters.

The federal share of the DSH payments to government hospitals under this paragraph 2, when combined with the federal share of the DSH payments made to DSH hospitals under paragraph 1 of Section B., shall not exceed $10 million.

3. No payment will be made to any hospital in excess of its total inpatient and outpatient hospital uncompensated care costs.

C. PAYMENT METHOD

Payments for state fiscal year 2009 will be made in a single installment within thirty (30) days after approval of this state plan amendment.

DSH payments for government DSH providers will be reconciled in accordance with the methodology set forth in the Protocol referred to in Section E.

D. SOURCE OF DATA

The calculations to be made in determining the payment amounts in accordance with Section B.1. above shall be based on hospital reported data for each hospital's current fiscal year concluded by June 30, 2009. The calculations to be made in determining the payment amounts in accordance with Section B.2. above shall be based on hospital reported data for the current year.

E. COST PROTOCOL

Uncompensated cost of government DSH providers will be determined in accordance with the following Cost Protocol:

Government-Owned Hospital
Uncompensated Care Cost (UCC) Protocol

Introduction

This protocol directs the method that will be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by this Section VIII (Disproportionate Share Payments).

Summary of Medicare Cost Report Worksheets

Expenditures will be determined according to costs reported on the hospitals' 2552 Medicare cost reports as follows:

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B

Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C

Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The governmentally-operated hospitals (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost-to-charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any DSH payments to hospitals by the State related to this DSH computation will not be reflected in the payment received to determine hospitals' uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g., state-only, local-only, or state-local health programs).

Notes:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due five months after the end of the hospitals' fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services cost from the Medicaid Fee For Service (Medicaid FFS), Medicaid QUEST Expanded (QEx), and Uninsured population, less payments received from Medicaid FFS, QEx, and uninsured patients.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

Determination of Allowable Payments to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospitals' (hospital) allowable UCC, the following steps must be taken to ensure Federal financial participation (FFP):

Annual Payment

Each hospital's annual DSH payments will be based on its filed Medicare cost reports for the spending year in which payments were made.

The annual payment is based on the calculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges, and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total cost of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private room differential cost from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center's per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets.

For outpatient UCC cost computation, each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the cost are included in the program costs described above, including payments from managed care entities, for serving QEx enrollees, will be included in the total program payments under this annual initial

reconciliation process. Non-Medicaid payments, funding and subsidies made by a state or unit of local government will not be included in the total program payment offset.

Final Reconciliation Payment

Each hospital's annual DSH payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported under the final reconciliation payment. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center's per diem and cost-to-charge ratios from the finalized Medicare cost report for the service period. The hospital will update the program charges to include only paid claims from Medicaid FFS and QEx in computing program costs for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured. Days, charges, and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payment will originate from the provider's auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for Federal financial participation for the uncompensated care costs under this DSH process.

The inpatient and outpatient costs computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim DSH payments.

Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset. Federal matching funds may be claimed for UCCs up to the hospitals' eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within six months after the issuance of all of the finalized government-owned hospital Medicare cost reports from each respective fiscal year. The State is responsible to ensure the accuracy of the DSH amounts used for federal claiming.

If a hospital's financial and cost reporting period does not coincide with the Medicaid State plan period for which the DSH UCC cost is being computed, the hospital's cost will be computed based on its full cost reporting period, as prescribed above, and then allocated pro rata to a State plan period based on the number of months covered by the financial or cost reporting period that are included in the Medicaid State plan period.

OS Notification

State/Title/Plan Number: Hawaii State Plan Amendment 09-002

Type of Action: SPA Approval

Effective Date of SPA: June 29, 2009

Required Date for State Notification: May 3, 2010

Fiscal Impact: $7.5M federal for FFY 2009

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification:

Provider Payment Increase or Decrease: Increase

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This State Plan Amendment, effective June 29, 2009, provides disproportionate share hospital payments to qualifying hospitals for state fiscal year ending June 30, 2009, using $7.5 million of Hawaii's FY 2009 federal DSH allotment. DSH payment to each DSH hospital does not exceed the hospital's OBRA 1993 uncompensated care cost limit. DSH payments to private hospitals will be funded by State Legislature appropriation from the State General Fund, while DSH payments to governmental hospitals will be funded by certified public expenditures. Appropriate cost protocol to support the governmental hospitals' certified public expenditure funding has been incorporated into the State plan.

Other Considerations: We do not recommend the Secretary contact the Governor.

Recovery Act Impact: We are not aware at this time of any violations of the Recovery Act requirements, including political subdivision contribution percentage, eligibility maintenance of effort, prompt payment, and rainy day funds. The governmental hospitals that are funding the non-federal share of DSH payments with their certified public expenditures are state-owned and -operated hospitals and are therefore not considered political subdivisions.

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