

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES:
HOSPITAL CARE**PART I. PAYMENT TO GENERAL HOSPITALS FOR INPATIENT
MEDICAL SERVICES****I. Methods and Standards for Payment of Inpatient Medical Hospital Services**

Effective for inpatient hospital discharges occurring on and after October 1, 2014, Medicaid payment for inpatient hospital services is based on All Patient Refined Diagnosis Related Groups (APR-DRGs) prospective payment system (PPS). The APR-DRG PPS algorithm classifies each hospital stay based on information on the inpatient Medicaid claim: diagnoses, procedures, patient age, patient gender, and discharge status. Inpatient hospital services subject to the APR-DRG PPS include inpatient hospital stays and services provided in Medicare-designated distinct-part psychiatric units and distinct-part rehabilitation units of acute care hospitals.

A. Definitions

For purposes of this part, the following terms have these ascribed meanings.

1. Acute care hospital: Hospital is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. § 1395x(e), as revised 1988); the term “acute care hospital” shall include those hospitals providing inpatient services as defined at 42 C.F.R. § 440.10.
2. APR-DRG Relative Weight: A numerical value which reflects the relative resource requirements for the DRG to which it is assigned.
3. Base year: The standardized year on which rates for all hospitals for inpatient hospital services are calculated to derive a prospective payment system.
4. Capital add-on: An add-on payment per discharge that contributes toward hospitals’ capital costs by adding supplemental monies to inpatient claim payments.
5. Diagnosis Related Group (DRG): A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources.

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6. Direct medical education (DME): An add-on payment to reimburse teaching hospitals for direct costs associated with graduate medical education (GME).
7. District-wide Base Rate: A standardized base amount used to reimburse hospitals reimbursed by DRG. The base rate is the basis of payment for DRG stays.
8. Fiscal Year: Unless otherwise noted, the accounting period for the Government of the District of Columbia beginning on October 1 and ending on September 30.
9. General Hospital: A hospital that has the facilities and provides the services that are necessary for the general medical and surgical care of patients, including the provision of emergency care by an Emergency Department.
10. High-cost outliers: Claims in which the computed loss to the hospital exceeds the outlier threshold to qualify for an additional payment.
11. Hospital-specific Base Rate: A standardized base amount used to reimburse hospitals reimbursed by DRG, as adjusted for Indirect Medical Education (IME).
12. Indirect medical education (IME): A component of the DRG base rate that is associated with indirect graduate medical education (GME) costs. It is included in the Hospital-specific base rate for each in-District general hospital paid under the APR-DRG PPS. The IME component of the District-wide Base Rate is Hospital-specific for each in-District general hospital with IME costs, as recognized on their cost report.
13. In-District hospitals: Any hospital located within the District of Columbia.

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14. Ineligible day: Any day that a patient was not eligible for District Medicaid on the day of service.
15. Low-cost outliers: Claims in which the computed gain to the hospital exceeds the outlier threshold to qualify for an adjustment to the DRG payment.
16. Marginal cost factor: A factor used to determine the additional payment for a high-cost outlier.
17. Medicaid Care Category (MCC) - A categorization accepted by DHCF to categorize DRGs into clinical care groupings. Each DRG is categorized into one MCC.
18. Normal Newborn: A liveborn neonate whose diagnosis is categorized by APR-DRG.
19. Outlier threshold: The annual minimum dollar amount that the hospital's loss or gain for a claim under APR-DRG PPS must meet in order for a high or low-cost outlier adjustment to DRG payment to be applied, *e.g.*, high cost outlier threshold (\$65,000) and low cost outlier threshold (\$30,000).
20. Out-of-District hospital: Any hospital that is not located within the District of Columbia. The term does not include hospitals located in the State of Maryland and specialty hospitals.
21. Pediatric (Children's) hospital: A hospital engaged in furnishing services to inpatients who are predominantly individuals under the age of twenty-one (21).
22. Specialty hospital: A hospital that consists of program of specialized services, such as obstetrics, mental health, orthopedics, long term acute care, rehabilitative services or pediatric services; (b) admits only patients

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with medical or surgical needs within the defined program; and (c) has the facilities for and provides those specialized services.

II. General Hospitals Providing Inpatient Services

Inpatient hospital services described herein include those services provided by general hospitals, including acute care and pediatric hospitals, located within the District of Columbia (District) and outside of the District.

A. District of Columbia General Hospitals

1. For discharges occurring on or after October 1, 2014, general hospitals shall be reimbursed by All Patient Refined-Diagnosis Related Group (APR-DRG) prospective payment.

B. APR-DRG Methodology

1. For discharges occurring on or after October 1, 2014, the Department of Health Care Finance (DHCF) adopted the APR-DRG classification system as contained in version 31 of the 3MTM APR-DRG Classification System Definitions Manual, for purposes of calculating reimbursement set forth in this chapter. DHCF may adopt subsequent versions of the 3MTM APR-DRG Classification System Definitions Manual when necessary.
2. New versions of the APR-DRG mapper are issued October 1 of each year, to coincide with the release of the new ICD diagnosis and ICD procedure codes, upon which the DRG logic relies. The District plans to update the APR-DRG grouper biennially.

C. Relative Weights

1. For discharges occurring on or after October 1, 2014, DHCF shall use Hospital-specific Relative Value (HSRV) version 31 national weights for

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APR-DRGs. National weights are calculated by 3M™ based on 15 million stays from the Nationwide Inpatient Sample from the Agency for Healthcare Research and Quality (AHRQ) and are developed and maintained annually by 3M™. The HSRV method adjusts for differences in cost-to-charge ratios (CCR) among hospitals nationwide.

2. Each DRG assignment has a severity of illness (SOI) that is reflected in its associated relative weight. Relative weights are updated biennially at the time the APR-DRG grouper version is updated. The annual APR-DRG documentation from 3M describes the changes made each year.

D. Policy Adjustor Functionality

1. The implementation of APR-DRG payment includes functionality to support policy adjustors. Policy adjustors are used to increase or decrease APR-DRG relative weights for certain Medicaid Care Categories (MCC) in order to meet policy goals.
2. The value of the policy adjustor(s) is reevaluated annually during review of hospital rates, and more often if determined necessary by DHCF. The type and amount of the policy adjustor(s) shall be determined by DHCF and published in the District of Columbia Municipal Regulations.

E. Casemix Index

1. The casemix index for each hospital is equal to the sum of the APR-DRG relative weight of each discharge, divided by the number of discharges in the base year.

F. Cost-to-Charge Ratio (CCR)

1. Hospital-specific cost-to-charge ratios (CCRs) are calculated annually. The CCR is developed based on each hospital's submitted cost reports for the hospital's fiscal year that ends prior to October 1 of the prior calendar year. The CCR used to calculate the cost of a claim is Hospital-specific for inpatient hospitals. A weighted average of in-District hospitals CCRs is used for out-of-District hospitals.

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G. Calculation of the Hospital-specific Cost per Discharge

1. The cost per discharge is equal to a hospital's Medicaid inpatient operating costs standardized for indirect medical education (IME) costs and variations in casemix, divided by the number of discharges in the base year and adjusted for outlier reserve.
2. Medicaid inpatient operating costs for the base year period are calculated by applying the Hospital-specific operating CCR to allowed charges from the base year claims data. The hospital CCR is based on reported costs on Form CMS 2552-10, Worksheet C Part I (Computation of ratio of cost to charges), or its successor, excluding inpatient capital costs. For the purposes of determining the overall hospital CCR, total costs reported on Worksheet C Part I are allocated to inpatient and outpatient costs based on the ratio of inpatient and outpatient charges reported in each cost center on Worksheet C Part I. For the purpose of excluding inpatient capital costs, capital costs associated with each ancillary cost center (as reported on Worksheet D Part II, column 1) are allocated to inpatient and outpatient capital costs based on the ratio of inpatient and outpatient charges reported in each cost center on Worksheet C Part I.
3. Medicaid inpatient operating costs calculated pursuant to paragraph G(2) are standardized for IME costs by removing IME costs to determine the District-wide component of the base rate. IME costs are removed by dividing Medicaid operating costs for each hospital with IME costs by the IME adjustment index for that hospital.
4. The IME adjustment index for each hospital is calculated using the Medicare algorithm for each hospital based on the hospital cost report for the base year period.
5. Medicaid inpatient operating costs calculated pursuant to paragraph G(2) are standardized for variations in casemix by dividing Medicaid operating costs standardized for IME pursuant to paragraph G(3) by the appropriate casemix adjustment index set forth in paragraph E.

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6. The Hospital-specific cost per discharge adjusted for IME and casemix is reduced by a net one percent (1%) to account for five percent (5%) of the cost reserved for payment of high-cost outlier claims and four percent (4%) of the cost restored to account for the reduction in payment for low-cost outlier claims.

H. APR-DRG PPS Payment

Payment for each APR-DRG claim, excluding transfer claims, low-outlier claims, or interim claims, is based on the following formula:

$$\begin{array}{r}
 \text{APR-DRG HSRV Relative Weight for each claim} \\
 \times \\
 \text{Policy Adjustor, if applicable} \\
 \times \\
 \text{District-wide Base Rate adjusted for IME, if applicable} \\
 = \\
 \text{DRG Base Payment}
 \end{array}$$

The final APR-DRG payment may include a high outlier adjustment, add-on payments, and subtraction of other health coverage and patient share of cost if applicable:

$$\begin{array}{r}
 \text{DRG Base Payment} \\
 + \\
 \text{High-Outlier Payment Adjustment} \\
 + \\
 \text{Add-on Payments for Capital and Direct Medical Education Costs} \\
 - \\
 \text{Other Health Coverage} \\
 - \\
 \text{Patient Share of Cost} \\
 = \\
 \text{APR-DRG PPS Payment}
 \end{array}$$

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I. District-wide Base Rate

1. For discharges occurring on or after October 1, 2014, DHCF shall use a single, District-wide Base Rate for all general hospitals.
2. Effective October 1, 2014, and annually thereafter, the base year is the District's fiscal year that ends prior to October 1 of the prior calendar year.
3. The District-wide Base Rate is based on aggregate costs for the base year. Aggregate cost is calculated using the hospital specific cost-to-charge ratio, as well as facility casemix data, and claims data from all in-District participating hospitals for the base year. Using aggregate cost data, the District-wide Base Rate is determined by solving for a base rate that represents 98% of total costs.
4. The Hospital-specific base rate for each hospital is equal to the District-wide Base Rate, plus the Hospital-specific cost per discharge of IME calculated pursuant to paragraphs K(2)(a)-(c).
5. Subject to federal upper payment limits, the District-wide Base Rate shall not exceed a rate that approximates an aggregate payment to cost ratio of ninety-eight percent (98%) for the base year for in-District general hospitals. The payment to cost ratio is determined by modeling payments to all hospitals using claims data relevant to the base year.

J. Special Consideration for Hospitals Located in Economic Development Zones

1. A factor that is two percent (2%) higher than the District-wide conversion factor for hospitals whose primary location is in an area identified as an Economic Development Zone and certified by the District's Department of Small and Local Business Development as a Developmental Zone Enterprise (DZE) pursuant to D.C. Code § 2-218.37.

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K. Indirect Medical Education (IME)

1. The Hospital-specific IME amount calculated pursuant to paragraphs K(2)(a)-(c) is added to the District-wide Base Rate for each in-District general hospital to determine the Hospital-specific base rate.
2. The Hospital-specific cost per discharge of IME is calculated annually as follows:
 - a. The Hospital-specific cost per discharge adjusted for casemix as determined in accordance with paragraph G(1), is divided by the IME factor set forth in paragraph G(4).
 - b. For discharges occurring on or after October 1, 2014, the amount calculated in paragraph K(2)(a) is multiplied by a factor of 0.75 to determine the IME payment per discharge for each hospital.
 - c. For discharges occurring on or after October 1, 2015, the amount calculated in paragraph K(2)(a) is multiplied by a factor of 0.50 to determine the IME payment per discharge for each hospital.
 - d. The amount established pursuant to paragraph K(2)(b) or (c) shall be subtracted from the average cost per discharge for each hospital before determining the District-wide Base Rate.

L. Direct Medical Education (DME)

1. DME is a per-discharge add-on payment for each in-District general hospital, that has DME costs on its cost report. The DME add-on is calculated annually by dividing the Medicaid DME costs by the number of Medicaid discharges for each hospital, in the base year, subject to the limits described in paragraphs L(3) and L(4).

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2. For discharges occurring on or after October 1, 2014, the DME add-on payment for each in-District general hospital is based on costs from each hospital's submitted or audited cost report for the fiscal year, subject to the limits described below in paragraphs L(3) and L(4).
3. For discharges occurring on or after October 1, 2014, the District limits DME to two hundred percent (200%) of the average District-wide cost of DME per Medicaid patient day. The District-wide average cost per Medicaid patient day is based on submitted cost reports for the base year. The average cost per patient day is calculated by dividing total Medicaid DME cost for all DME eligible hospitals by the total number of Medicaid days for those hospitals, as reported on the hospital cost reports. The per-day amount is translated to a per discharge amount for each hospital, based on Medicaid utilization information in the cost report.
4. For discharges occurring on or after October 1, 2015, DME costs for each hospital are limited to the per discharge equivalent of one-hundred fifty percent (150%) of the average District-wide cost of DME per Medicaid patient day. The average District-wide cost per Medicaid patient day is based on submitted cost reports for the base year.
5. If after an audit of the hospital's cost report for the base year period an adjustment is made to the hospital's reported costs which results in an increase or decrease of five percent (5%) or greater of the DME add-on payment, the add-on payment for DME add-on costs is adjusted prospectively to reflect the revised costs.

M. Capital Add-on Payments

1. Capital is a per-discharge add-on payment that applies to in-District general hospitals only. For discharges occurring on or after October 1, 2014, capital add-ons are limited to one hundred percent (100%) of the District average capital cost per Medicaid patient day. This is calculated

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based on submitted cost reports for in-District general hospitals for the base year as identified in paragraphs G(2)-G(5). The average cost per patient day is calculated by dividing total Medicaid capital cost for all eligible hospitals by the total number of Medicaid days for those hospitals, as reported on the hospital cost reports. The per-day amount is translated to a per discharge amount for each hospital, based on Medicaid utilization information in the cost report.

2. Effective October 1, 2014, and annually thereafter, subject to limits described in paragraph M(1), the capital cost add-on payment is calculated by dividing the sum of Medicaid capital costs applicable to inpatient routine services costs, as reported on cost report Form HCFA 2552-10, Worksheet D, Part I, Line 200, Columns 1 and 3, or its successor, and capital costs applicable to inpatient ancillary services, as determined pursuant to paragraph M(3), by the number of Medicaid discharges in the base year.
3. Capital costs applicable to inpatient ancillary services, as reported on Worksheet D, Part II, Column 2, are allocated to inpatient capital by applying the facility's ratio of ancillary inpatient charges to total ancillary charges for each ancillary line on the cost report.
4. For discharges occurring on or after October 1, 2014, and annually thereafter, the capital cost add-on payment for each in-District general hospital is based on costs from each hospital's cost report for the hospital's FY that ends prior to October 1 of the prior calendar year, subject to the limits described in paragraph M(1).
5. If after an audit of the hospital's cost report for the base year period an adjustment is made to the hospital's reported costs which results in an increase or decrease of five percent (5%) or greater of the capital cost add-on payment, the add-on payment for capital costs is adjusted, subject to the District-wide limits described above in paragraph M(1).

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N. Transfer and Abbreviated Stay Payment

1. Transfers

- a. For each claim involving a transfer to another general hospital, DHCF pays the transferring hospital the lesser of the DRG base payment amount as described in paragraph H or a prorated payment based on the ratio of covered days to the average length of stay associated with the APR-DRG. This prorated payment calculation is described in paragraph N(1)(b)-(c).
- b. The transfer calculation is applied to the transferring hospital according to the following calculation using the national average lengths of stay (ALOS) available with the APR-DRG grouper:

$$\begin{aligned} & \text{TRANSFER PAYMENT} \\ & = \\ & \text{(DRG BASE PAYMENT / NATIONAL ALOS)} \\ & \times \\ & \text{(LOS FOR ELIGIBLE DAYS OF THE STAY +1)} \end{aligned}$$

- c. If the transfer payment adjustment results in an amount greater than the DRG base payment amount without the adjustment, the transfer payment is disregarded and the APR-DRG PPS payment amount as described in paragraph H is used.
- d. The hospital receiving the patient receives the full DRG payment (unless the referring hospital also transfers the patient).
- e. All transfers, except for documented emergency cases are prior authorized and approved by DHCF, or its designee, as a condition of payment.

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O. Same-day Discharges

1. Claims representing same-day discharges are denied with instruction to bill the services as outpatient services. Same-day discharges occur when the patient is admitted and discharged on the same date. Same-day discharges are not allowed unless the patient status indicates death.

P. One-day Stays

1. A one-day stay occurs when the discharge date occurs on the day following the admission date. Under APR-DRG PPS, a claim reflecting a one-day stay is paid as a hospital stay, but may be subject to post-payment review of the medical necessity of the admission.
2. A one-day stay may qualify for a low-cost outlier adjustment pursuant to the low-cost outlier policy described at paragraph R(2).

Q. Eligible Days Less than Length of Stay

1. A claim for an inpatient stay that includes ineligible days shall be denied. A denied claim may be resubmitted for eligible days.

R. Outlier Payments

The APR-DRG PPS provides an additional payment for outliers, high and low cost, based on inpatient costs.

1. High-cost Outliers: For discharges occurring on or after October 1, 2014, DHCF shall provide an additional payment for inpatient stays when the cost of providing care results in a loss to the hospital that exceeds the high-cost outlier threshold (i.e., high-cost outlier). The goal for District-wide high-cost outlier payments is to identify an estimated maximum of five percent (5%) of inpatient payments as high-cost outliers.

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- a. The loss to the hospital is calculated pursuant to the following formula:

$$\begin{aligned} & \text{LOSS} \\ & = \\ & \text{COST (ALLOWED CHARGES X COST TO CHARGE RATIO (CCR))} \\ & - \\ & \text{THE DRG BASE PAYMENT} \end{aligned}$$

- b. The outlier payment is calculated if the loss exceeds the outlier threshold:

$$\begin{aligned} & \text{OUTLIER PAYMENT} \\ & = \\ & (\text{LOSS} - \text{OUTLIER THRESHOLD}) \\ & \times \\ & \text{THE MARGINAL COST FACTOR} \end{aligned}$$

- c. The DRG PPS payment for the stay is the sum of the DRG base payment as described in paragraph H and the outlier payment calculated pursuant to paragraphs R(1)(a)-(b) adjusted for transfer pricing if applicable.
- d. The CCR used to calculate the cost of a claim is Hospital-specific as described in paragraph F.
- e. The high-cost outlier threshold shall be reviewed annually and updated when necessary based upon a review of claims history from the District's previous fiscal year.

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2. Low-cost Outliers: For discharges occurring on or after October 1, 2014, DHCF shall adjust payments for extremely low-cost inpatient cases. Low-cost outliers are cases where the gain on the claim (claim cost minus DRG base payment) exceeds the low-cost outlier threshold. Each claim with a gain that exceeds the low-cost outlier threshold is paid at the lesser of the APR-DRG payment amount or a prorated payment as specified in paragraph R(2)(a). The low-cost outlier threshold is set by DHCF at a level that results in four percent (4%) or less of APR-DRG payments being associated with low-cost outlier cases.
 - a. The low-cost outlier calculation uses the national average lengths of stay (ALOS) available with the APR-DRG grouper as follows:

$$\begin{aligned}
 &\text{LOW-COST OUTLIER PAYMENT} \\
 &= \\
 &(\text{DRG BASE PAYMENT} / \text{NATIONAL ALOS}) \\
 &\quad \times \\
 &(\text{LOS FOR ELIGIBLE DAYS OF THE STAY} + 1)
 \end{aligned}$$

3. If the low-cost outlier payment results in an amount greater than the DRG base payment, the low-cost outlier payment is disregarded.
4. The low-cost outlier threshold is calculated annually and when necessary based upon a review of claims history from the District's previous fiscal year.

S. Third Party Liability and Patient Cost-Sharing

1. The Medicaid program calculates the allowed amount for a service and then subtracts third party liability (TPL) and patient cost-sharing in determining the actual payment to the provider. A beneficiary is considered to have TPL when the individual receives health care benefits from organizations such as commercial health insurance companies, prepaid health plans, health maintenance organizations, and other benefit plans. If a commercial payer or some other third party (except Medicare) is liable for some portion of the claim, then that portion is subtracted from the allowed amount.

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2. Patient cost-sharing relates to any portion that may be due from the patient such as coinsurance, deductibles, or spend-down amounts. The cost-sharing amount is subtracted from the allowed amount.

T. Provider Preventable Conditions, Including Health Care-Acquired Conditions

1. Medicaid payment adjustments for Provider Preventable Conditions, including Health Care-Acquired Conditions shall be processed and paid in accordance with the criteria for payment adjustment for provider preventable conditions, as described under Part IV of Attachment 4.19-A of the State Plan.

U. Prior Authorization

1. Prior authorization is required for all non-emergency, inpatient admissions.

V. Three-day Payment Window

1. For discharges occurring on or after October 1, 2014, outpatient diagnostic services provided by a hospital one (1) to three (3) days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay.
2. For discharges occurring on or after October 1, 2014, all hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are considered part of the inpatient stay and are not separately payable.
3. This policy applies to general hospitals, both in-District and out-of-District, with the exception of specialty hospitals (described in Part II of Attachment 4.19-A) and Maryland hospitals.

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W. Out-of-District Hospitals, With Exception

1. Out-of-District general hospitals are paid by DRG with the exception of hospitals located in Maryland and those hospitals identified in Part II of this Attachment, Payment to Specialty Hospitals for Inpatient Services.
2. The DRG base rate for out-of-District hospitals is the District-wide Base Rate, as defined in paragraphs I(1)-(7), without IME.

X. Maryland

1. Except for specialty hospitals identified in Part II of this Attachment, hospitals located in Maryland shall be reimbursed in accordance with Health Services Cost Review Commission (HSCRC's) All-Payer Model Contract with Center for Medicare and Medicaid Innovation, or its successor.

Y. Claims

1. All claims for inpatient services in general hospitals shall be reimbursed in accordance with the State Plan for Medical Assistance and applicable federal and District laws and regulations.

Z. Payment under Certain Extenuating Circumstances within the District's Hospital System

1. The Director of DHCF may determine that extenuating circumstances exist within the District's specialty hospital system, including but not limited to closure or bankruptcy.
2. In such circumstances, a general hospital may receive reimbursement determined under Part II (Inpatient Services Provided in Specialty Hospitals) for services provided to a patient who would have been transferred from the general hospital to a Long Term Care Hospital, if a bed were available.

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3. To ensure appropriate payment, reimbursement under these circumstances may be adjusted based on the acuity of the patient.

AA. Cost Reports and Audits

1. All in-District general hospitals shall be required to submit cost reports and shall comply with audits in accordance with the requirements described under Part V, Attachment 4.19-A of the State Plan.

BB. Record Maintenance and Access to Records

1. All general hospitals that provide inpatient services shall maintain records in accordance with the requirements described under Part V, Attachment 4.19-A of the State Plan.

CC. Appeals

1. All general hospitals that provide inpatient services shall be subject to the appeal and administrative review requirements described under Part V, Attachment 4.19-A of the State Plan.