STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES - HOSPITAL CARE

1. Fee structures are established and designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can have reasonable access, taking into account geographic locations and reasonable travel time, to inpatient hospital services of adequate quality.

2. Participation in the program by providers of hospital services is limited to those who:

   a. give signatory agreement to conform with the applicable "Conditions of Participation" which are established by the State Agency for all non-State operated services included in the plan;

   b. are accepted by the State Agency as being qualified and authorized to provide such services;

   c. evidence, to the continuing satisfaction of the State Agency, their compliance with all terms of these conditions; and

   d. accept, as payment in full, the amounts paid in accordance with the reimbursement policy set forth below.

3A. Hospitals are placed into the following groups for purposes of reimbursement:

   a. Private hospitals that provide inpatient hospital services as defined in 42 CFR 440.10. This group consists of: Children's Hospital National Medical Center, Columbia Hospital for Women, Georgetown University Hospital, George Washington University Medical Center, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, National Rehabilitation Hospital, Providence Hospital, Sibley Memorial Hospital, Hospital for Sick Children, and Washington Hospital Center. Public Hospitals that provide inpatient hospital services as defined in 42 CFR 440.10 shall be defined as hospitals owned and operated by the District of Columbia. This group consists of D.C. General Hospital.

b. The upper limits for payment will not exceed the payment excluding payment for Medicare residuals, which is determined as reasonable cost using the Title XVIII standards and principles described in 42 CFR 405 Subpart D.

c. Payments are based on a reasonable cost of service or the customary charge to the general public for such services, whichever is less, in accordance with the provisions of 42 CFR 447.271.

3B. Reimbursement for inpatient services, except organ transplant services as provided in Subsection c of this section, rendered on and after October 1, 1984, and before November 17, 1990, by Capitol Hill Hospital, Children's Hospital National Medical Center, Columbia Hospital for Women, D.C. General Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, Providence Hospital, and the Washington Hospital Center, is made on a cost per discharge basis as follows:

a. The total allowable base year costs for each hospital are established in accordance with the standards outlined in Title SVIII of the Social Security Act for reimbursing hospitals which are excluded from the Prospective Payment System. Discharges are calculated for each hospital, and equal to the sum of Medicaid adult, pediatric, and nursery discharges, plus one sixth of the number of Medicaid in and out surgeries which were reimbursed on an inpatient basis.

b. Medicaid payment inpatient hospital services is based on each hospital's audited reimbursable cost per discharge for a based year period defined as the hospital fiscal year ending September 30, 1982, December 31, 1982, and June 30, 1983. The base year cost per discharge, including capital and direct medical education expense, is then inflated forward:

- For the first covered year, by 8.3%
- For the second covered year, by 6.9%
- For the third covered year, by 6.6%
- For the fourth covered year, by 4.5%
- For the fifth covered year, by 3%
- For the sixth covered year through November 16, 1990 by 3%

c. Public hospitals that provide inpatient hospital services as defined in 42 CFR 440.140: this group consists of: St. Elizabeth's Hospital.

4A. Reimbursement for inpatient services provided before November 17, 1990, by The Hospital for Sick Children, National Rehabilitation Hospital, St. Elizabeth's Hospital, and Sibley Hospital is based on reasonable costs of providing care or service.

a. National Rehabilitation Hospital and St. Elizabeth's Hospital are reimbursed on a per diem basis for inpatient services. The rates are established as allowable under Title XVIII of the Social Security Act, and are calculated in accordance with that Title's provisions for reimbursing hospitals which are excluded from the Prospective Payment System (PPS).

b. The Hospital for Sick Children is reimbursed on a Periodic Interim Payment (PIP) basis developed from its estimated utilization and per diem rates. There are two rates: one for regular chronic care and another for respiratory care. The chronic care rate is a prospective rate, established as follows:

1. for 10/1/84-12/31/84, on the calendar 1983 audited allowable cost per day plus 6.9%;

2. for 1/1/85-9/30/85, on the calendar 1984 audited allowable cost per day plus 6.6%;

3. for 10/1/85, on the rate in effect on 9/30/85 plus 4.5%;

4. for 1/1/87-12/31/87, on the rate in effect on 12/31/86 plus 3%;

5. for 1/1/88-11/16/90, on the rate in effect on 12/31/87 plus 3%.

The respiratory care rate is established as follows:

1. for 10/1/84-12/31/84, on the audited allowable cost per day;

2. for 1/1/85-9/10/85, a prospective rate based on the audited allowable cost per day from the opening of the unit through 12/31/84 plus 6.6%;

3. for 10/1/85-12/31/86, on the rate in effect on 9/30/85 plus 4.5%;

4. for 1/1/87-12/31/87, on the rate in effect on 12/31/86 plus 3%;

5. for 1/1/88-11/16/90, on the rate in effect on 12/31/87 plus 3%.

The standards used to determine allowable costs are those established for reimbursement of PPS exempt hospitals under Title XVIII of the Social Security Act.

c. Sibley Hospital is reimbursed on a per diem basis, calculated in the same manner and using the same time frames, percentages and standards as are used for the chronic care rate for the Hospital for Sick Children, described in (b) above.

d. The upper limits for payment will not exceed the payment excluding payment for Medicare residuals, which is determined as reasonable cost using the Title XVIII standards and principles described in 42 CFR 405 Subpart D.

e. Payments are based on a reasonable cost of service or the customary charge to the general public for such services, whichever is less, in accordance with the provisions of 42 CFR 447.271.

4B. Reimbursement for inpatient services, except organ transplant services as provided in Subsection c of this section, rendered on or after October 1, 1984, and before November 17, 1990, by Capitol Hill Hospital, Children's Hospital National Medical Center, Columbia Hospital for Women, D.C. General Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, Providence Hospital, and the Washington Hospital Center, is made on a cost per discharge basis as follows:

a. The total allowable base year costs for each hospital are established in accordance with the standards outlined in Title XVIII of the Social Security Act for reimbursing hospitals which are excluded from the Prospective Payment System. Discharges are calculated for each hospital, and equal to the sum of Medicaid adult, pediatric, and nursery discharges, plus one sixth of the number of Medicaid in and out surgeries which were reimbursed on an inpatient basis.

b. Medicaid payment inpatient hospital services is based on each hospital's audited reimbursable cost per discharge for a based year period defined as the hospital fiscal year ending September 30, 1982, December 31, 1982, and June 30, 1983. The base year cost per discharge, including capital and direct medical education expense, is then inflated forward:

- For the first covered year, by 8.3%
- For the second covered year, by 6.9%
- For the third covered year, by 6.6%
- For the fourth covered year, by 4.5%
- For the fifth covered year, by 3%
- For the sixth covered year through November 16, 1990, by 3%.

c. Each hospital is paid on a periodic interim payment (PIP) basis during the government fiscal year (October 1 through September 30). The PIP for each hospital is based on the estimated total earnings for services rendered that hospital year. At the end of each hospital's fiscal year, the hospital files a cost report for that year. Final settlement of each fiscal year's claims is made once all relevant cost reports are filed, audited, and any audit adjustments are settled.

Reimbursement for discharges when the treatment is heart transplant surgery and the services are rendered by a hospital member of the Washington Regional Transplant Consortium (Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Fairfax Hospital, or the Washington Hospital Center), shall be in accordance with Title XVIII principles of reimbursement for heart transplant surgery performed by a hospital covered under the Prospective Payment System (PPS).

Reimbursement for discharges when the treatment is liver transplant surgery and the services are rendered by Children's Hospital National Medical Center, Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Fairfax Hospital, or the Washington Hospital Center, shall be made on the basis of a fixed percentage of actual charges or 100% of hospital charges, whichever is less. The percentage will be specific to the hospital, and will represent the ratio of total charges for Medicaid inpatients to total Medicaid

allowable costs for those patients as shown in the hospital's Medicaid audited cost report for its Fiscal Year ending in 1984. Should any of the six participating hospitals qualify as a Medicaid disproportionate share hospital under Section 4112 of the Omnibus Budget Reconciliation Act of 1987, (P.L. 100-203), the same adjustment factor shall be applied to the total payment for either a liver or a heart transplant patient as is applied to the hospital's usual Medicaid reimbursement per discharge.

Reimbursement for discharges when the treatment is pediatric heart transplant surgery and the services are rendered by Children's National Medical Center shall be made on the basis of a fixed percentage of actual charges or 100% of hospital charges, whichever is less.

The percentage will be specific to the hospital, and will represent the ratio of total charges for Medicaid inpatients as shown in the hospital's Medicaid allowable costs for those patients as shown in the hospital's Medicaid audited cost report for its fiscal year ending in 1984. Should Children's Hospital National Medical Center qualify as a Medicaid disproportionate share hospital under Section 4112 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), the same adjustment factor shall be applied to the total payment for a pediatric heart transplant patient as is applied to the hospital's usual Medicaid reimbursement per discharge.

An additional payment of $14,500 shall be made to the hospital to cover the cost of organ procurement within the metropolitan area. If the procurement requires special services, including air transport, because it is not available within the metropolitan area, these costs may be added to the procurement claim.

The transplant discharges will be paid outside the District's Periodic Interim Payment (PIP) Program.

d. To determine the government fiscal year allowable costs for those hospitals for which the District's fiscal year covers portions of two different hospital covered years, proportional amounts from each covered year are used. For example, a hospital whose second covered year ended December 31, 1984, would have 25% of its second year allowable costs combined with 75% of its third covered year allowable costs to determine the government's 1985 fiscal year costs.

5. Medicaid reimbursement for hospital inpatient services rendered during the first cost reporting period beginning on or after November 17, 1990 shall be on a per discharge basis for Children's Hospital National Medical Center, Columbia Hospital for Women, D.C. General Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center. The Hospital for Sick Children, The Psychiatric Institute, Sibley Memorial Hospital, National Rehabilitation Hospital and St. Elizabeth's Hospital shall be reimbursed based upon a per diem, rather than a per discharge basis.

   Effective July 1, 2012, the Hospital for Sick Children's Medicaid payment for inpatient hospital services is based upon the Hospital's audited allowable costs per diem for the base year period defined as the Hospital's fiscal year ending December 31, 2009.

   a. Medicare principles of reimbursement for hospitals not included in the Medicare Prospective Payment system, which stipulates that reimbursement will be based upon reasonable cost limited by an operating cost per discharge amount (TEFRA Target Rate). The TEFRA Target Rate is calculated by dividing reasonable operating costs by the discharges during the base periods beginning on or after October 1, 1981 and before September 30, 1982. A hospital's rate per discharge or per diem shall be based on the reasonable cost of providing care, as determined in accordance with the Title XVIII (Medicare) principles of reimbursement applicable to hospitals not included in the Prospective Payment System, and set forth in Part 413 of Title 42 of the Code of Federal Regulations, with the following exceptions:

      1. Operating costs shall be reimbursed at actual audited allowable cost, subject to the TEFRA Target Rate Ceiling. The TEFRA Target Rate Ceiling is determined by calculating a "base year" cost per discharge which is updated for inflation utilizing the update factors adopted by Medicare, except that the target rate percentage update factor for private hospitals for the hospital fiscal year that began on or after October 1, 1989 and before October 1, 1990 shall be 2.5%. The "base year" is defined as cost reporting periods beginning on or after October 1, 1981 and before September 30, 1982.

      2. If a hospital's operating costs are less than, or equal to, its target amount, the hospital shall be entitled to an incentive payment calculated pursuant to 42 CFR 413.40 (d) (2), but no costs in excess of the target amount will be allowable.

3. In calculating the base year operating cost per discharge, the number of discharges for a hospital shall be the sum of its Medicaid adult, pediatric, and nursery discharges, plus one sixth of the number of Medicaid in and out surgeries which were reimbursed on an inpatient basis.

4. Payment for discharges when the treatment is organ transplant surgery shall be made in accordance with Section 9.

5. Medicaid Target Rates will be recalculated for Providence Hospital, Columbia Hospital for Women, and Washington Hospital Center based upon the cost reporting period encompassing September 1, 1991. The revised Medicaid Target Rates for these hospitals will become effective April 1, 1993.

b. D.C. General, and those hospitals that in the TEFRA base year, included in and out surgery cases in their inpatient costs, shall continue to be reimbursed for those cases at a rate equal to 1/6 of their rate per discharge.

c. No hospital shall be paid more for inpatient and in and out surgery services to Medicaid patients in any hospital fiscal year than the sum of its charges for those patients.

d. Each hospital except Sibley Memorial Hospital, The Psychiatric Institute, and those hospitals located out-of-state, is paid on a periodic interim payment (PIP) basis during the government fiscal year (October 1 through September 30). The PIP for each hospital is based on the estimated total earnings for services to be rendered that year. At the end of each hospital's fiscal year, the hospital files a cost report for that year. Final settlement of each fiscal year's claim is made once all relevant cost reports are filed, audited, and any audit adjustments are settled.

For Sibley Memorial Hospital, The Psychiatric Institute, and those hospitals located out of state, interim reimbursement will be made as claims are submitted for payment.

e. Reimbursement for discharges when the treatment is heart transplant surgery and the services are rendered by a hospital member of the Washington Regional Transplant Consortium (Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Fairfax Hospital, and the Washington Hospital Center), shall be in accordance with the Title XVIII principles of reimbursement for heart transplant surgery performed by a hospital covered under the Prospective Payment System (PPS).

Reimbursement for discharges when the treatment is liver transplant surgery and the services are rendered by Children's Hospital National Medical Center, Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Fairfax Hospital, or the Washington Hospital Center, shall be made on the basis of a fixed percentage of actual charges or 100% of hospital charges, whichever is less. The percentage will be specific to the hospital, and will represent the ratio of total charges for Medicaid inpatients to total Medicaid allowable costs for those patients as shown in the hospital's Medicaid audited cost report for its fiscal year ending in 1984. Should any of the six participating hospitals qualify as a Medicaid disproportionate share hospital under Section 1923 of the Social Security Act, the same adjustment factor shall be applied to the total payment for either a liver or a heart patient as is applied to the hospital's usual Medicaid reimbursement per discharge.

Reimbursement for discharges when the treatment is pediatric heart transplant surgery and the services are rendered by Children's Hospital National Medical Center, shall be made on the basis of a fixed percentage of actual charges or 100% of hospital charges, whichever is less.

The percentage will be specific to the hospital, and will represent the ratio of total charges for Medicaid inpatients to total Medicaid allowable costs for those patients as shown in the hospital's Medicaid audited cost report for its fiscal year ended in 1984. Should Children's Hospital National Medical Center qualify as a Medicaid disproportionate share hospital under Section 1923 of the Social Security Act, the same adjustment factor shall be applied to the total payment for a pediatric heart transplant patient as is applied to the hospital's usual Medicaid reimbursement per discharge.

An additional payment of $14,500 shall be made to the hospital to cover the cost of organ procurement within the metropolitan area. If the procurement requires special services, including air transport, because it is not available within the metropolitan area, these costs may be added to the procurement claim.

The transplant discharges will be paid outside the District's Periodic Interim Payment (PIP) System.

f. Beginning on September 21, 2002, as set forth in sections 4800.1 and 4809.1 of Title 29 DCMR, Hadley Memorial Hospital will no longer be reimbursed for its inpatient services on an APDRG basis, but will instead be reimbursed on a per diem basis as are the other specialty hospitals in the District (Hospital for Sick Children, The Psychiatric Institute, National Rehabilitation Hospital, St. Elizabeth's Hospital, Medlink Hospital, and Riverside Hospital.) The reimbursement methodology for this group of specialty hospitals is detailed in section 5a. of this Attachment. All previous references in the state Medicaid Plan to Hadley Hospital as an APDRG Hospital shall not apply after September 21, 2002.

6. Reimbursement for public hospitals that provide inpatient hospital services as defined in 42 CFR 440.10 will be as follows effective with services provided on or after August 9, 1993:

a. Reimbursement for inpatient services provided by D.C. General Hospital, except organ transplant services as described in Section 5e, is at one hundred percent (100%) of D.C. General Hospital's audited allowable costs as described below:

1. D.C. General Hospital will receive on an interim basis a prospective rate in accordance with the principles contained in 42 CFR 413.13(c)(ii), based on the audited allowable cost per day in the base year. Per Diem rates for subsequent periods shall be inflated by the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for the District of Columbia, as developed by Data Resources, Inc., determined in the quarter in which the provider's new fiscal year begins. Allowable costs are established in accordance with the requirements of 42 CFR Part 413, except for Section 413.30 (Limitations on reimbursable

for Section 413.30 (Limitations on reimbursable costs), Section 413.35 (Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services) and Section 413.40 (Ceiling on rate of hospital cost increases).

2. The program shall determine the rate for each year and shall notify D.C. General Hospital of the new interim rate thirty (30) days prior to the beginning of the hospital's next fiscal year. The base year used for the initial interim rate calculation shall be the hospital's fiscal year ended in 1992.

3. D.C. General shall receive a Periodic Interim Payment (PIP) which shall be based upon the estimated costs calculated as described in A above. D.C. General Hospital shall file a cost report with the program within ninety (90) days of the close of its fiscal year. Final settlement of all cost reports will be made on a biennial basis beginning with the hospital's fiscal year ended 1995 once all relevant cost reports are filed, audited, and all audit adjustments are completed.

7. Medicaid reimbursement for hospital inpatient services rendered on or after April 1, 1995, shall be on an APDRG (All Patient Diagnosis-Related Group) Prospective Payment System discharge basis for Children's Hospital National Medical Center, Columbia Hospital for Women, Howard University Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Providence Hospital and Washington Hospital Center.

   The hospitals participating in the APDRG Prospective Payment System will be separated into four (4) peer groups as follows:

   - Children's Hospitals
     - Children's National Medical Center
   - Women's Hospitals
     - Columbia Hospital for Women
   - Major Teaching Hospitals
     - Howard University Hospital
     - Georgetown University Hospital
     - George Washington University Hospital
     - Washington Hospital Center
   - Other Hospitals
     - Greater Southeast Community Hospital
     - Hadley Memorial Hospital
     - Providence Hospital

   Exempt hospitals include: The Hospital for Sick Children, The Psychiatric Institute, National Rehabilitation Hospital, D.C. General Hospital, Sibley Memorial Hospital and St. Elizabeth's Hospital. These hospitals will not be included in the District APDRG Prospective Payment System and will be reimbursed based upon a methodology specified elsewhere in the State Plan. (See Attachment 4.19A, Sections 4A, 5, and 6.)

Exempt units are those units within general acute care hospitals which are Medicare psychiatric and rehabilitation exempt units, certified by the Joint Commission on Accreditation of Healthcare Organizations and meet all State regulations and requirements for certification as a rehabilitation or psychiatric unit. These units will be reimbursed at a rate established by the State Agency.

All facilities operated by the District of Columbia shall be exempt from the APDRG Prospective Payment System.

The following describes the APDRG Prospective Payment System payment methodology for inpatient services provided by participating providers:

a. PEER GROUP SPECIFIC BASE RATE

Each participating hospital will have a peer group specific base rate which will be multiplied times the APDRG relative weight to determine the amount of payment due for inpatient hospital services provided. The peer group specific base rate will be calculated based upon the audited fiscal year 1990 Medicaid cost report. This rate will include operating costs, capital costs, and direct medical education costs.

b. INFLATION ADJUSTMENT AND REBASING

Subject to limitations described in paragraph 7(i), inflation factors shall be periodically applied to each facility's base rate to arrive at an updated rate for payment purposes in periods subsequent to the base period. Also, after two years of operations of the APDRG system, the Medicaid agency will evaluate the need for rebasing and adjustment of the APDRG weights. Inflation factors applied shall be based on the DRI McGraw Hill National Market Basket Index.

c. SERVICE INTENSITY WEIGHTS

The service intensity weights to be used are based upon calendar year 1991 charge data for participating District of Columbia hospitals. Weights for the District's Medicaid payment system will be calculated by identifying the average charge for cases within each discharge category, excluding outliers. An average charge per discharge will be determined. The

ratio of average charge per discharge for each APDRG to the overall average charge per discharge will become the intensity weight used in the payment formula. In those instances where there are no cases billed, or where there are too few to arrive at a statistically valid weight, the weight developed by the New York APDRG system will be implemented.

Modification to the relative weights will be made periodically. Relative weights are intended to be cost effective and based upon the District of Columbia data as available. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, and other changes in hospital costs that may impact specific DRG relative weights.

d. PAYMENT CALCULATIONS

Payment for inpatient hospital services will be made by multiplying the updated peer group specific rate as described in paragraphs 7(a) and 7(b) above by the service intensity weight as described in 7(c).

e. OUTLIER CASES

The APDRG Prospective Payment System will provide for an additional payment for high cost outliers. Cost outliers are defined as cases with costs exceeding 2.95 times the standard deviation from the mean cost for each APDRG classification. Cost outlier payments will be based upon the average ratio of Medicaid cost to charges as indicated on the most recent final settled Medicaid cost report.

When a case exceeds the outlier threshold, the payment for the case will be the base rate as described in paragraph 7(d) plus an outlier payment. The outlier payment is calculated by multiplying the difference between total claim charges and the outlier threshold times the hospital-specific Medicaid cost-to-charge ratio as described in paragraph 7(i).

f. TRANSFER CASES AND ABBREVIATED STAYS

In cases involving transfers, the program will pay the transferring hospital the lesser of the APDRG amount

and a percentage of the DRG based upon the established cost to charge ratio for the transferring hospital. The hospital from which the patient is ultimately discharged will receive a payment equal to the total APDRG payment. Prior authorization and approval by the review agency will be required for each transfer before payment can be made. Documented emergency cases are exempt from the prior authorization requirement.

g. CAPITAL COSTS

In order to provide an additional incentive for hospitals to contain capital costs and to allocate resources efficiently, capital costs will be included in the peer group specific base rate.

h. MEDICAL EDUCATION COSTS

Direct medical education costs will be included in the peer group specific base rate. Direct medical education costs include salaries of interns and residents as well as salaries and related costs for members of hospital staffs who are involved in medical education activities. Additional payments for indirect medical education costs will not be required as the peer group specific base rates will reflect the total cost of all education activities.

i. RISK CORRIDOR UPPER AND LOWER PAYMENT LIMITS

Effective with admissions on or after August 15, 1996 and prior to July 1, 1997, total claims payment for APDRG cases will be subject to upper and lower total payment limitations as described in this paragraph. If total claim payment including outlier payment under the APDRG methodology as described in paragraphs 7(d) and 7(e) above is neither below ninety percent (90%) of claim costs nor above one hundred and ten percent (110%) of claim cost, final payment will be the calculated APDRG payment. In instances where this calculated payment exceeds 110% of claim cost, then payment is capped at 110% of claim cost. In instances where this calculated payment is below 90% of claim cost, payment is made at 90% of claim cost.

Effective with admissions on or after July 1, 1997, total payment for an APDRG case will be 100 percent of claim cost.

The cost-to-charge ratios used to calculate claim cost are hospital specific and are extracted from each hospital FY 1995 cost report as desk audited by the Medicaid agency. The cost component of this ratio includes Medicaid inpatient operating cost including indirect medical education cost, Medicaid's portion of total Medicare approved graduate medical education cost, and Medicaid capital cost.

j. REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES: APDRG REVISION

Medicaid reimbursement for inpatient hospital services rendered on or after July 1, 1998 shall be on an All-Payer Diagnosis-Related Group (APDRG) Prospective Payment System discharge basis for the following hospitals: Children's Hospital National Medical Center, Columbia Hospital for Women, George Washington University Medical Center, Georgetown University Hospital, Howard University Hospital, Hadley Hospital, Greater Southeast Community Hospital, Providence Hospital, Sibley Hopsital, and Washington Hospital Center. Inpatient hospital services provided in Medicare-designated distinct-part psychiatric units, inpatient hospital stays that last only one day, and inpatient services provided by Sibley Hospital, all previously exempt from the APDRG system, are subject to the APDRG methodology. Inpatient hospital services that have been reimbursed pursuant to APDRG methodology since April 1, 1995 will continue to be reimbursed pursuant to APDRGs.

The Hospital for Sick Children, Medlink Hospital, National Rehabilitation Hospital, St. Elizabeth's Hospital, Psychiatric Institute, and Riverside Hospital shall be reimbursed on a per diem basis. D.C. General Hospital shall be reimbursed for inpatient services at one hundred percent (100%) of audited, allowable costs.

See Supplement 1, Attachment 4.19A for a detailed description of the reimbursement methodology.

j.00 MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

j.00.1 Medicaid reimbursement for hospital inpatient services shall be on an All Patient Diagnosis-Related Group (APDRG) Prospective Payment System discharge basis for Children's Hospital National Medical Center, Columbia Hospital for Women, Howard University Hospital, George Washington University Hospital, Georgetown University Hospital, Greater Southeast Community Hospital, Hadley Memorial Hospital, Providence Hospital, Washington Hospital Center and Sibley Hospital.

j.00.2 Hospital inpatient services shall include inpatient hospital stays that last only one day, and services provided in Medicare-designated distinct-part psychiatric units.

j.00.3 Services provided in Medicare-designated distinct-part rehabilitation units as described in 42 CFR 412.23 shall be reimbursed on a per diem basis.

j.00.4 Payment for each APDRG claim, excluding transfer claims as described in subsection j.08.1, shall be based on the following formula:

APDRG Relative Weight for each Claim
X
Final Base Payment Rate
+
Add-on Payments for Capital and Graduate Medical Education and Indirect Medical Education
+
Outlier Payment

j.00.5 The APDRG Prospective Payment System shall be based on a base year payment rate for each hospital. The base year payment rate for each hospital shall be based on costs from each hospital's submitted Medicaid Cost reports as follows:

(a) Adjusted, reported costs for hospital discharges on or after April 15, 1995, but before January 1, 1996, for each hospital with a fiscal year ending December 31, 1995; or

(b) Adjusted, reported costs for hospital discharges on or after July 1, 1995, but before July 1, 1996, for each hospital with a fiscal year ending June 30, 1996 that filed a Medicaid cost report for Fiscal Year 1996 by September 1, 1997.

j.00.6 The Fiscal Year 1995 Medicaid cost report for each hospital with a fiscal year that ended June 30, 1996, that failed to file a cost report for Fiscal Year 1996 by September 1, 1997, shall be used solely for the purpose of calculating add-ons to the base year payment rate.

j.00.7 The Medicaid cost report for Sibley Hospital for the base year shall be used solely for the purpose of calculating add-ons to the base year payment rate.

j.00.8 The base year payment rate for each hospital that is reimbursed pursuant to APDRG methodology as of July 1, 1997, and that has filed its Fiscal Year 1996 Medicaid cost report by September 1, 1997, shall equal the Blended Average Cost Per Discharge ("Blended ACD").

j.00.9 The Blended ACD shall be equal to the average of the Hospital Specific Average Cost Per Discharge (Hospital Specific ACD), determined in accordance with section j.01, and the District-wide Average Cost Per Discharge ("District-wide ACP") determined in accordance with section j.02.

j.00.10 The base year payment rate for each hospital that failed to file their Fiscal year 1996 cost report by September 1, 1997, shall equal 100% of the District-wide ACD.

j.00.11 The base year payment rate for Sibley Hospital shall equal 100% of the District-wide ACD.

j.00.12 Beginning October 1, 1999, the base year payment rate for all hospitals subject to APDRG reimbursement methodology shall equal 100% of the District-wide ACD.

j.01 CALCULATION OF THE HOSPITAL-SPECIFIC AVERAGE COST PER DISCHARGE (Hospital-Specific ACD)

j.01.1 The Hospital-Specific ACD shall be equal to each hospital's Medicaid inpatient operating costs standardized for indirect medical education costs and variations in case mix, as set forth in j.01.4 and j.01.6, divided by the number of Medicaid discharges during the base year.

j.01.2 Medicaid inpatient operating costs for the base year period shall be calculated in accordance with 42 CFR 413.53 (Determination of cost of services to beneficiaries) and 42 CFR 412.1 through 412.125 (Prospective payment systems for inpatient hospital services), as reported in cost reporting Form HCFA 2552-92, Worksheet D-1 (computation of Inpatient Operating Cost), Part II, Line 53.

j.01.3 Cost classification and allocation methods shall be made in accordance with the Department of Health and Human Services, Health Care Finance Administration Guidelines for Form HCFA 2552-92 and the Medicare Provider Reimbursement Manual (PRM) 15.

j.01.4 Medicaid inpatient operating costs, calculated pursuant to j.01.2, shall be standardized for indirect medical education costs by removing indirect medical education costs. Indirect medical education costs shall be removed by dividing Medicaid operating costs by the indirect medical education factor set forth in section j.01.5.

j.01.5 The indirect medical education adjustment factor for each hospital shall equal 1 + (1.72*(e raised to the power of (ln(1+IR/B))*.405) minus 1) where e is the natural log of 1.0 and ln is the natural log of 1 plus the intern and resident-to-bed ratio. IR represents the number of interns and residents in approved graduate medical education programs and B represents the number of licensed hospital beds as reported in cost reporting Form HCFA 2552-92, Worksheet S-3, Part 1, Line 8, Column 1.

j.01.6 Medicaid inpatient operating costs calculated pursuant to j.01.2 shall be standardized for variations in case mix by dividing Medicaid operating costs standardized for indirect medical education pursuant to j.01.4, by the appropriate case mix adjustment factor set forth in either section j.01.7 or j.01.8.

j.01.7 The case mix adjustment factor for each hospital shall be equal to the sum of the relative weights of each discharge in the base year divided by the number of discharges in the base year.

j.01.8 A case mix value of 1.00 shall be used for each hospital new to the APDRG system for which there is not a historical database to calculate the hospital's case mix adjustment factor.

j.01.9 The hospital-specific ACD shall be adjusted to June 30, 1996, using an inflation factor obtained from the Medicare Hospital Market-Basket Index (Hospital Index). The inflation factor for each hospital with a base year ending on December 30, 1995, shall be 1.018, which is the actual 1996 Hospital Index.

j.01.10 If after an audit of the hospital's cost report for the base year, 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 Hospital-Specific ACD, the Hospital-Specific ACD calculated pursuant to this section shall be adjusted for services rendered beginning one day after the effective date of these rules. The District-wide ACD shall not be adjusted if an adjustment is made to the Hospital Specific ACD pursuant to this subsection.

j.02 CALCULATION OF THE DISTRICT-WIDE AVERAGE COST PER DISCHARGE (District-wide ACD)

j.02.1 The District-wide ACD shall be calculated by multiplying the Hospital-Specific ACD for each hospital listed in j.02.2, by the number of discharges for each hospital listed in j.02.2, adding the products for each hospital and dividing the sum of the products by the total number of discharges for the hospital listed in j.02.2.

j.02.2 The calculation for the District-wide ACD set forth in j.02.1 shall be based on cost reports from the following hospitals:

(a) Children's National Medical Center;
(b) Howard University Hospital;
(c) Georgetown University Hospital;
(d) Greater Southeast Community Hospital;
(e) Hadley Memorial Hospital;
(f) Providence Hospital; and
(g) Washington Hospital Center.

j.03 ADJUSTMENT FOR INFLATION

j.03.1 The Blended ACD, calculated in accordance with subsection j.00.9 and the District-wide ACD, calculated in accordance with section j.02, shall be adjusted for inflation from the base year, which ended June 30, 1996, to the effective date of these rules by the most recently published projected Hospital Index applicable to 1998.

j.03.2 From October 1, 1999 to March 21, 2003, or the date of publication of the Notice of Final Rulemaking, whichever is later, all base year payment rates shall be adjusted for inflation pursuant to the most recently published projected Hospital Index for the applicable Fiscal Year. Beginning March 22, 2003, or one day after the publication of the Notice of Final Rulemaking, whichever is later, each hospital shall be paid based on the rates in effect on September 30, 2002.

j.04 ADJUSTMENT FOR OUTLIER PAYMENTS

j.04.1 The Blended ACD rates and District-wide ACD rates, adjusted for inflation pursuant to section j.03, shall be adjusted to account for anticipated additional payments for unusually expensive claims, which shall be referred to as outlier claims. The inflation adjusted rates adjusted for outlier claims shall equal the final base payment rate for each discharge.

j.04.2 To establish the final base payment rate for each discharge for the District-wide ACD, the District-wide ACD adjusted for inflation pursuant to section j.03 shall be divided by the outlier set-aside adjustment factor, set forth in subsection j.04.4.

j.04.3 To establish the final base payment rate for each discharge for the Blended-ACD, the Blended-ACD adjusted for inflation in accordance with section j.03 shall be divided by the outlier set-aside adjustment factor, set forth in subsection j.04.4.

j.04.4 The outlier set-aside adjustment factor shall be as follows:

$$\frac{\text{Total Outlier Payments} + \text{Total Claim Payments}}{\text{Total Claim Payments}}$$

j.05 CALCULATION OF ADD-ONS TO THE FINAL BASE PAYMENT RATE

j.05.1 The final base payment rate, calculated pursuant to j.04.2 or j.04.3, shall be supplemented by additional payments for capital costs, graduate medical education or indirect medical education, as appropriate.

j.05.2 The capital cost add-on shall be calculated by dividing Medicaid capital costs applicable to hospital inpatient routine service costs, as reported on cost report Form HCFA 2552-92, Worksheet D, Part 1, Line 101, Columns 4 and 6; and capital costs applicable to hospital inpatient ancillary services as reported on Worksheet D, Part II, Line 101, Columns 6 and 8, by the number of Medicaid discharges in the base year. If after an audit of the hospital's cost report for the base year 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 capital cost add-on payment calculated pursuant to this subsection shall be adjusted for services rendered beginning one day after the effective date of these rules.

j.05.3 Graduate medical education add-on shall be calculated by dividing Medicaid graduate medical education costs by the number of Medicaid discharges in the base year.

j.05.4 Medicaid graduate medical education costs shall be established by multiplying the ratio of Medicaid patient days to total patient days, by the Medicare approved graduate medical education cost for interns and residents in approved teaching programs, as determined pursuant to 42 CFR 413.86, and as reported on cost report Form HCFA 2552-92, Worksheet E-3, Part IV, Line 3.

j.05.5 Beginning October 1, 1999 to March 21, 2003, or the date of publication of the Notice of Final Rulemaking, whichever is later, the add-on payment for graduate medical education shall be indexed for inflation by a factor obtained from the most recently published projected Hospital Index for the applicable Fiscal Year. Beginning March 21, 2003, or one day after the publication of the Notice of Final Rulemaking, whichever is later, graduate medical education shall be reimbursed based on the rates in effect on September 30, 2002.

j.05.6 The final base payment rate for each discharge shall be supplemented by an add-on for the indirect medical education costs.

j.05.7 The indirect medical education cost is the difference between the Medicaid operating cost standardized for indirect medical education costs calculated pursuant to subsection j.01.4 and Medicaid inpatient operating costs calculated pursuant to subsection j.01.2.

j.05.8 The indirect medical education cost add-on is calculated as follows:

(a) The indirect medical education cost shall be divided by the amount [i.e., number] of Medicaid discharges in the base year period.

(b) The amount [i.e., number] established in subsection j.05.8(a) shall be divided by the hospital's case mix adjustment factor as determined pursuant to subsection j.01.7 or j.02.8, as appropriate.

(c) Beginning October 1, 1999 to March 21, 2003, or the date of publication of the Notice of Final Rulemaking, whichever is later, the amount [i.e., number] established in subsection j.05.8(b) shall be indexed for inflation by the most recently published projected Hospital Index for the applicable Fiscal Year to determine the add-on payment for indirect medical education costs. Beginning March 21, 2003, or one day after the publication of the Notice of Final Rulemaking, whichever is later, the amount [i.e., number] established in subsection j.05.8(b) shall not be indexed for inflation.

j.06 CALCULATION OF ALL PATIENTS DIAGNOSIS-RELATED GROUPS (APDRG) RELATIVE WEIGHTS

j.06.1 Each inpatient hospital discharge shall be classified by APDEZG, the relative weights of which shall be calculated by dividing the mean Medicaid operating costs for each APDRG by the mean Medicaid operating costs of all claims in the relative weight data file. Outliers shall be excluded from the calculation of the final APDRG mean cost.

j.06.2 For each APDRG for which no historical claims exist, the relative weight shall be 1.00 and the outlier threshold shall be equal to the District-wide mean Medicaid cost for all claims in the relative weight data file.

j.06.3 Inpatient claims for all services, except those provided in distinct-part rehabilitation units with admission dates on or after April 1, 1995, and prior to January 1, 1997, from the following hospitals, shall be used for purposes of establishing the relative weight data file:

(a) Children's National Medical Center
(b) Columbia Hospital for Women
(c) Howard University Hospital
(d) George Washington University Hospital
(e) Georgetown University Hospital
(f) Greater Southeast Community Hospital
(g) Hadley Memorial Hospital
(h) Providence Hospital
(i) Washington Hospital Center.

j.06.4 The operating cost of each claim in the relative weight file shall be determined by multiplying the amount of the claim by an operating cost-to-charge ratio. The operating cost-to-charge ratio shall be determined by dividing the hospital's Medicaid operating cost (excluding capital, graduate medical education and indirect medical education costs) by Medicaid charges during the base year reporting period.

j.06.5 The Medicaid operating cost of each claim shall be multiplied by 1.5 to calculate the total Medicaid cost used for the purpose of outlier determination. All claims in the relative weight data file with costs exceeding one standard deviation from the mean Medicaid cost for each APDRG classification shall be identified as a cost outlier and shall be excluded in the calculation of the final APDRG mean cost. For each APDRG with less than five claims, the mean Medicaid cost shall be the outlier threshold.

j.07 CALCULATION OF OUTLIER PAYMENT

j.07.1 Each claim with a Medicaid cost exceeding the outlier threshold, determined pursuant to section j.06, shall be subject to an outlier payment. The amount of the outlier payment shall be calculated pursuant to the following formula:

(Medicaid claim cost minus the outlier threshold) X .5

j.08 TRANSFER CLAIMS PAYMENT FOR INPATIENT HOSPITAL SERVICES

j.08.1 For each APDRG claim where the patient was transferred from a hospital subject to APDRG payment to a hospital subject to APDRG payment, the final claim payment shall be the product of claim charges times the Medicaid cost-to-charge ratio of the hospital where the patient was transferred.

j.09 PAYMENT TO OTHER HOSPITALS FOR INPATIENT HOSPITAL SERVICES

j.09.1 The Hospital for Sick Children, the Psychiatric Institute, National Rehabilitation Hospital, St. Elizabeth's Hospital, Medlink Hospital and Riverside Hospital shall be reimbursed on a per diem basis and shall not be paid more for inpatient and in-and-out surgery services to Medicaid patients in any hospital fiscal year than the sum of its charges.

j.09.2 D.C. General Hospital shall be reimbursed for inpatient services at one hundred percent (100%) of D.C. General's audited, allowable costs.

j.10 COST REPORTING AND RECORD MAINTENANCE

j.10.1 Each hospital shall submit an annual cost report to the Medicaid Program within 150 days of the

close of the hospital's cost reporting period. Each cost report shall cover a twelve(12) month cost reporting period, which shall be the same as the hospital's fiscal year, unless the Medicaid Program has approved an exception.

j.10.2 Each hospital shall complete its cost report in accordance with Medicaid Program instructions and forms and shall include any supporting documentation required by the Medicaid Program. The Medicaid Program shall review the cost report for completeness, accuracy, compliance and reasonableness through a desk audit.

j.10.3 The submission of an incomplete cost report shall be treated as a failure to file a cost report as required by subsection j.10.1, and the hospital shall be so notified.

j.10.4 The Medicaid Program shall issue a delinquency notice to the hospital if the hospital does not submit its cost report on time or when the hospital is notified, pursuant to j.10.3, that its submitted cost report is incomplete.

j.10.5 If the hospital does not submit a complete cost report within thirty (30) days of the date of the notice of delinquency, twenty percent (20%) of the hospital's regular monthly payment shall be withheld each month until the cost report is received. If a complete cost report is not filed within ninety (90) days of the notice of delinquency, one hundred percent (100%) of the hospital's regular monthly payment shall be withheld each month until a complete report is filed.

j.10.6 The Medicaid Program shall pay the withheld funds promptly after receipt of the complete cost report and documentation that meets the requirements of this section.

j.10.7 Each hospital shall maintain sufficient financial records and statistical data for proper determination of allowable costs.

j.10.8 Each hospital's accounting and related records, including the general ledger and books of original entry, and all transaction documents and statistical data, are permanent records and shall be retained for a period of not less than five (5) years after the filing of a cost report or until the Notice of Final Program Reimbursement is received, whichever is later.

j.10.9 If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

j.10.10 Payments made to related organizations and the reason for each payment to related organizations shall be disclosed by the hospital.

j.10.11 Each hospital shall:

(a) Use the accrual method of accounting; and

(b) Prepare the cost report according to generally accepted accounting principles and all Medicaid Program instructions.

j.11 AUDITING AND ACCESS TO RECORDS

j.11.1 On-site audits shall be conducted not less than once every three (3) years.

j.11.2 During an on-site audit or review, each hospital shall allow appropriate Department of Health auditors and authorized agents of the District of Columbia government and the United States Department of Health and Human Services access to financial records and statistical data necessary to verify costs reported to the Medicaid Program.

j.12 APPEALS FOR HOSPITALS THAT ARE NOT COMPENSATED ON AN APDRG BASIS

j.12.1 Hospitals that are not compensated on an APDRG discharge basis shall receive a Notice of Program Reimbursement (NPR) at the end of its fiscal year after a site audit.

j.12.2 Within sixty (60) days of the date of the NPR, any hospital that disagrees with the NPR shall submit a written request for administrative review of the NPR to the Financial Manager, Audit and Finance Office, Medical Assistance Administration, Department of Health, 2100 Martin Luther King, Jr. Ave., SE, Suite 401, Washington, D.C. 20020-5719.

j.12.3 The written request for administrative review shall include a specific description of the audit adjustment or estimated budget item to be reviewed, the reason for the request for review of the adjustment or item, the relief requested, and documentation in support of the relief requested.

j.12.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days from the date of receipt of the hospital's written request for administrative review under subsection j.12.2.

j.12.5 Within 45 days of receipt of the Medicaid Program's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Board of Appeals and Review, 441 4th Street, N.W., 5th Floor South-Suite 540, Washington, D.C. 20001.

j.12.6 Filing an appeal with the Board of Appeals and Review shall not stay any action to recover any overpayment to the hospital. The hospital shall be liable immediately to the Medicaid Program for any overpayment set forth in the Medicaid Program's determination.

j.13 APPEALS FOR HOSPITALS THAT ARE COMPENSATED ON AN APDRG BASIS

j.13.1 Hospitals that are compensated on an APDRG discharge basis shall receive a Remittance Advice each payment cycle.

j.13.2 Within sixty (60) days of the date of the Remittance Advice, any hospital that disagrees with the payment rate calculation for the amounts listed in subsection j.13.3 or the APDRG assignment shall submit a written request for administrative review to the Financial Manager, Audit and Finance Office, Medical Assistance Administration, Department of Health, 2100 Martin Luther King, Jr. Avenue, S.E., Suite 401, Washington, D.C. 20020-5719.

j.13.3 The amounts subject to an administrative review are as follows:

(a) Add-on payment for capital costs, graduate medical education costs or indirect medical education costs, or

(b) Outlier payment.

j.13.4 The written request for administrative review shall include a specific description of the payment rate calculation or the APDRG assignment for each claim the hospital believes to be in error, the reason for review of each claim, the relief requested, and documentation in support of the relief request.

j.13.5 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days from the date of receipt of the hospital's written request for administrative review under subsection j.13.2.

j.13.6 Filing an appeal with the Board of Appeals and Review shall not stay any action to recover any overpayment to the hospital. The hospital shall be liable immediately to the Medicaid Program for any overpayment set forth in the Medicaid Program's determination.

j.13.7 Within 45 days of receipt of the Medicaid Program's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Board of Appeals and Review, 441 4th Street, N.W., 5th Floor South-Suite 540, Washington, D.C. 20001.

j.14 APPEAL OF ADJUSTMENT TO THE HOSPITAL SPECIFIC BASE YEAR PAYMENT RATE, GRADUATE MEDICAL EDUCATION COST PAYMENT RATE OR CAPITAL COST PAYMENT RATE FOR HOSPITALS COMPENSATED ON AN APDRG BASIS PURSUANT TO SUBSECTION j.00.8

j.14.1 After completion of an audit of the hospital's cost report for the base year, the Medical Assistance Administration shall provide the hospital a written notice of its determination of any adjustment to the Hospital Specific ACD, graduate medical education cost add-on payment, or capital cost add-on payment for the base year. The notice shall include the following:

(1) A description of the rate adjustment, including the amount of the old payment rate and the revised payment rate;
(2) The effective date of the change in the payment rate;
(3) A summary of all audit adjustments made to the hospital's reported costs, including an explanation, by appropriate reference to law, rules, or program manual of the reason in support of the adjustment; and
(4) A statement informing the hospital of the right to request an administrative review within sixty days of the date of the determination.

j.14.2 Any hospital that disagrees with any audit adjustment or payment rate calculation for the Hospital-Specific ACD, capital add-on cost, or graduate medical education add-on cost shall submit a written request for administrative review to the Financial Manager, Audit and Finance Office, Medical Assistance Administration, Department of Health.

j.14.3 The written request for the administrative review shall include a specific description of the audit adjustment or payment rate calculation to be reviewed, the reason for review of each item, the relief requested, and documentation to support the relief requested.

j.14.4 The Medicaid Program shall mail a formal response of its determination to the hospital not later than one hundred and twenty (120) days from the date of receipt of the hospital's written request for administrative review pursuant to subsection j.14.2.

j.14.5 Within 45 days of receipt of the Medicaid Program's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Board of Appeals and Review.

j.14.6 Filing an appeal with the Board of Appeals and Review shall not stay any action to adjust the hospital's payment rate.

j.15 CONVERSION OF HADLEY MEMORIAL HOSPITAL

j.15.1 Beginning on September 21, 2002, Hadley Memorial Hospital will no longer be reimbursed as an APDRG hospital. All previous references in the State Medicaid Plan to Hadley Hospital as an APDRG hospital shall not apply after the effective date of these rules.

j.15.2 Hadley Memorial Hospital shall be reimbursed using the methodology for specialty hospitals detailed in section 5a. of this Attachment.

j.16 RESERVED

j. 17 **RESERVED**

j. 18 **RESERVED**

j. 19 **RESERVED**

K. **MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES**

k.00.1 Effective for inpatient hospital discharges occurring on or after April 1, 2010, Medicaid reimbursement for inpatient hospital services shall be on an All Patient- Diagnosis Related Group (APDRG) prospective payment system discharge basis for all of the hospitals in the District of Columbia, except:

(a) Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill Hospital, Hospital for Sick Children and National Rehabilitation Hospital as set forth in section k.10;

(b) Psychiatric hospitals as set forth in section k. 10; and

(c) Hospitals located in Maryland as set forth in section k.00.5.

(d) Other out-of-state hospitals as set forth in section k.00.6.

k.00.2 Hospital inpatient services subject to the APDRG prospective payment system shall include inpatient hospital stays that last only one (1) day and services provided in Medicare-designated distinct-part psychiatric units and distinct-part rehabilitation units.

k.00.3 Payment for each APDRG claim, excluding transfer claims as described in section k.09, shall be based on the following formula:

APDRG Service Intensity Weight for each claim

X

Final Base Payment Rate

+

Add-on Payments for Capital and Direct Medical

Education Costs

+

Outlier Payment

k.00.4 The Department of Health Care Finance (DHCF) has adopted the APDRG classification system as contained in the 2009 APDRGs Definition Manual, Version 26 for purposes of calculating the rates set forth in this Chapter. Subsequent versions may be adopted after publication, if DHCF determines a substantial change has occurred.

k.00.5 Effective for Medicaid inpatient discharges occurring on or after October 1, 2012, hospitals located within the State of Maryland shall be reimbursed 94 percent of covered charged as allowed by the Maryland Health Services Cost Review Commission (MHSCRC), except that:

(a) Adventist Behavioral Health (Potomac Ridge), Sheppard Pratt and any other specialty psychiatric hospital located within the State of Maryland shall be paid the lessor of the hospital's submitted charges or the rate paid to hospitals in k.00.1(b); and

(b) Adventist Rehabilitation Hospital and any other specialty rehabilitation hospital shall be paid the lessor of the hospital's submitted charges or the TEFRA Target Rate for National Rehabilitation Hospital as set forth in k.10.1.

(c) Kennedy Krieger shall be paid a per diem consistent with Maryland's reimbursement methodology.

k.00.6 Out of state hospitals in states other than Maryland shall be reimbursed a DRG payment. The DRG base rate for out of state hospitals is the weighted average of the base rates for hospitals in the Community Hospital peer group, as defined in k.01.1(b).

k.01 **CALCULATION OF BASE PAYMENT RATES**

k.01.1 For purposes of establishing the base payment rates, the participating hospitals located in the District of Columbia shall be separated into three (3) peer groups as follows:

(a) Children's Hospitals: Children's National Medical Center;

(b) Community Hospitals: Providence Hospital, Sibley Hospital, United Medical Center; and

(c) Major Teaching Hospitals: Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Washington Hospital Center

k.01.2 Effective October 1, 2012, the base year period shall be each hospital's fiscal year that ends prior to October 1, 2011.

k.01.3 Effective October 1, 2012, the payment rate for each participating hospital shall be based on costs from each hospital's submitted cost report for the fiscal year that ends prior to October 1, 2011, as well as facility case mix data, claims data, and discharge data from all participating hospitals for the District's fiscal year ending September 30, 2011.

k.01.4 Effective October 1, 2013 and annually thereafter, the base payment rate for each hospital shall be based on costs from each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior year, as well as facility case mix data, claims data, and discharge data from all participating hospitals for the District's most recently completed fiscal year.

k.01.5 Effective October 1, 2012 and annually thereafter, the costs set forth in section k.01.3 shall be updated annually by applying the cost-to-charge ratio determined by each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior calendar year.

k.01.6 The final base year payment rate for each hospital shall be equal to the peer group average cost per discharge calculated pursuant to section k.03.1, plus the hospital specific cost per discharge of indirect medical education calculated pursuant to section k.04.1, subject to a gain/loss corridor as set forth in section k.01.7 and adjusted for inflation pursuant to section k.01.8.

k.01.7 Subject to federal upper payment limits, each hospital's base year payment rate shall not exceed a rate that approximates an overall payment to cost ratio of ninety-eight percent (98%) for the base year. The payment to cost ratio is determined by modeling payments to each facility using claims data from the District's most recently completed fiscal year.

k.02 **CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE**

k.02.1 The hospital-specific cost per discharge shall be equal to each hospital's Medicaid inpatient operating costs standardized for indirect medical education costs and variations in case mix, divided by the number of Medicaid discharges in the base year data set and adjusted for outlier reserve.

k.02.2 Medicaid inpatient operating costs for the base year period shall be

calculated by applying the hospital specific operating cost-to-charge ratio to allowed charges from the base year claims data. The cost-to-charge ratio shall be calculated in accordance with 42 CFR 413.53 (Determination of cost of services to beneficiaries) and 42 CFR 412.1 through 412.125 (Prospective payment systems for inpatient hospital services), as reported on cost reporting Form HCFA 2552-10, Worksheet C Part I, (Computation of ratio of cost to charges), or its successor, except that organ acquisition costs shall be excluded.

k.02.3 Cost classifications and allocation methods shall be made in accordance with the Department of Health and Human Services, Health Care Finance Administration Guidelines for Form HCFA 2552-10 and the Medicare Provider Reimbursement Manual 15 or any subsequent guidance issued by the federal Department of Health and Human Services.

k.02.4 Medicaid inpatient operating costs calculated pursuant to section k.02.2 shall be standardized for indirect medical education costs by removing indirect medical education costs. Indirect medical education costs shall be removed by dividing Medicaid operating costs by the indirect medical education factor set forth in section k.02.5.

k.02.5 The indirect medical education adjustment factor for each hospital shall be the factor calculated by Medicare for each hospital based on the hospital cost report for the base year period as defined in k.01.2.

k.02.6 Medicaid inpatient operating costs calculated pursuant to k.02.2 shall be standardized for variations in case mix by dividing Medicaid operating costs standardized for indirect medical education pursuant to k.02.4 by the appropriate case mix adjustment factor set forth in k.02.7.

k.02.7 The case mix adjustment factor for each hospital shall be equal to the sum of the relative weights of each discharge in the base year, divided by the number of discharges in the base year. The case mix adjustment factor calculated pursuant to this section shall be adjusted by 2.5%, which accounts for an expected change in case mix related to improved coding of claims.

k.02.8 The hospital specific cost per discharge adjusted for indirect medical education and case mix shall be reduced by a net one percent (1%), which takes into account five percent (5%) of the cost reserved for payment of high cost claims and four percent (4%) of the cost restored to account for the reduction in payment for low cost claims.

k.03 **CALCULATION OF THE PEER GROUP AVERAGE COST PER DISCHARGE**

k.03.1 The peer group average cost per discharge shall be equal to the weighted average of the hospital specific cost per discharge calculated pursuant to section k.02 for each hospital in the peer group.

k.04 **CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE OF INDIRECT MEDICAL EDUCATION**

k.04.1 The hospital specific cost per discharge of indirect medical education shall be calculated as follows:

(a) The cost per discharge adjusted for case mix shall be divided by the indirect medical education factor set forth in section k.02.5.

(b) The amount established pursuant to section k.04.1 (a) shall be subtracted from the average cost per discharge adjusted for case mix.

k.05 **REBASING**

k.05.1 Effective October 1, 2012, DHCF shall evaluate the need for rebasing and adjustment of the APDRG service intensity weights subsequent to hospital audits.

k.06 **CALCULATION OF APDRG SERVICE INTENSITY WEIGHTS**

k.06.1 The service intensity weights shall be based upon the discharge data base supplied by 3M with the version 26 APDRG grouper and centered for participating District of Columbia hospitals.

k.06.2 The average charge per discharge shall be determined by identifying the average charge for cases within each discharge category, excluding outliers.

k.06.3 The service intensity weight for each claim shall be equal to the ratio of the average charge per discharge for each APDRG to the aggregate average charge per discharge.

k.06.4 The amount calculated in section k.06.3 shall be adjusted by a common factor to achieve a District wide case mix of 1.00 for the base year.

k.06.5 The service intensity weights shall be modified periodically as the 3M APDRG weights are updated and new grouper versions are adopted.

k.07 **CALCULATION OF ADD-ON PAYMENTS**

k.07.1 The final base payment rate calculated pursuant to section k.01 shall be supplemented by additional payments for capital costs and direct medical education; as appropriate.

k.07.2 Effective October 1, 2012, the capital cost add-on payment shall be calculated by dividing Medicaid capital costs applicable to hospital 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 hospital inpatient ancillary services, as determined pursuant to section k.07.3, by the number of Medicaid discharges in the base year.

k.07.3 Capital costs applicable to hospital inpatient ancillary services, as reported on Worksheet D, Part II, Column 2 shall be allocated to inpatient capital by applying the facility ratio of ancillary inpatient charges to total ancillary charges for each ancillary line on the cost report.

k.07.4 Direct medical education add-on shall be calculated by dividing the Medicaid direct medical education costs by the number of Medicaid discharges in the base year.

k.07.5 Effective October 1, 2012, and annually thereafter, the base year payment rate for capital costs and direct medical education add-on payments for each participating hospital shall be based on costs from each hospital's submitted or audited cost report for the fiscal year that ends prior to October 1 of the prior year.

k.07.6 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 or direct medical education add- on payment, the add-on payment for capital or direct medical education add-on costs shall be adjusted.

k.08 **CALCULATION OF OUTLIER PAYMENTS**

k.08.1 The APDRG prospective payment system shall provide for an additional payment for outliers based on inpatient costs. High cost outliers are cases with costs exceeding 2.5 times the standard deviation from the mean for each APDRG classification. When the cost of a case exceeds the high

cost outlier threshold, the payment for the case shall be the sum of the base payment as described in section k.00.3 and the outlier payment calculated pursuant to section k.08.2. Effective October 1, 2012 and annually thereafter, thresholds shall be adjusted for inflation, based upon the CMS market basket factor for hospitals.

k.08.2 Each claim with a cost that exceeds the high cost outlier threshold shall be subject to an outlier payment. The amount of the outlier payment shall be calculated pursuant to the following formula:

High cost outlier threshold minus (allowed charges X hospital cost to charge ratio) X [0.80] or other factors that results in an estimated maximum of 5% of inpatient payments as high cost outliers. This factor shall be set as of October 1, 2012 and annually thereafter, based upon a review of claims history from the District's previous fiscal year.

k.08.3 The cost to charge ratio is hospital specific. Effective October 1, 2012 and annually thereafter, it shall be developed based upon information obtained from each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior calendar year.

k.08.4 The APDRG prospective payment system shall provide for an adjustment to payments for extremely low cost inpatient cases. Low cost outliers are cases with costs less than 25% of the average cost of a case. Each claim with a cost that is less than the low cost outlier threshold shall be subject to a partial DRG payment. The amount of the payment shall be the lesser of the APDRG amount and a prorated payment, based on the ratio of covered days to the average length of stay associated with the APDRG category. Effective October 1, 2012, and annually thereafter, the threshold shall be adjusted for inflation, based upon the CMS market basket factor for hospitals.

k.08.5 The prorated payment shall be calculated as follows:

(a) The base APDRG payment (Base payment times the APDRG service intensity weight) shall be divided by the average length of stay

(b) The amount established in section k.08.5(a) shall be multiplied by the sum of the number of covered days plus one (1) day.

k.08.6 For those APDRG categories where there was insufficient data to calculate a reliable mean or standard deviation the outlier threshold shall be calculated using an alternate method as set forth below:

(a) The outlier threshold shall be equal to the product of the weight of the APDRG and the average outlier multiplier.

(b) The average outlier multiplier shall be determined by dividing the outlier threshold by the APDRG weight for all categories where the outlier threshold is calculated as 2.5 standard deviations above the mean.

k.09 TRANSFER CASES AND ABBREVIATED STAYS

k.09.1 For each claim involving a transfer, the Department of Health Care Finance shall pay the transferring hospital the lesser of the APDRG amount or prorated payment based on the ratio of covered days to the average length of stay associated with the APDRG category. The prorated payment shall be calculated pursuant to the formula set forth in section k.08.5.

k.09.2 The hospital from which the patient is ultimately discharged shall receive a payment equal to the total APDRG payment.

k.09.3 All transfers, except for documented emergency cases shall be prior authorized and approved by the Department of Health Care Finance as a condition of payment.

k.09.4 Same day discharges shall not be paid as inpatient hospital stays unless the patient's discharge status is death.

k.10 PAYMENT TO OTHER HOSPITALS FOR INPATIENT HOSPITAL SERVICES

k.10.1 The Hospital for Sick Children, Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill (MedLink) Hospital and National Rehabilitation Hospital shall be reimbursed on a per diem basis subject to the TEFRA Target Rate.

k.10.2 St. Elizabeth's Hospital shall be reimbursed on a per diem basis and shall not be paid more than for inpatient and in-and-out surgery services to Medicaid patients in any hospital fiscal year than the sum of its charges.

k.10.3 The per diem for the Psychiatric Institute of Washington will be calculated in the following manner. The base year for purposes of reimbursement shall be the District's FY 2007. Inlier claims paid by Medicaid for children will be priced pursuant to the Inpatient Psychiatric Facility Prospective Payment System PC PRICER as described and in accordance with the requirements set forth in Section 124(c) of Public Law 106-113, the Balance Budget Requirement Act of 1999. The inlier claims paid by Medicaid for children shall be used to develop the reimbursement rate for all beneficiaries including those age sixty-five (65) and above. For each claim an average per diem will be calculated by dividing the output of the pricer by the length of stay on the claim. The average per diems will be summed and divided by the total number of claims to obtain the final per diem.

k.11 COST REPORTING AND RECORD MAINTENANCE

k.11.1 Each hospital shall submit an annual cost report to the Medicaid Program within one hundred fifty (150) days after the close of the hospital's cost reporting period. Each cost report shall cover a twelve (12) month cost reporting period, which shall be the same as the hospital's fiscal year, unless the Medicaid Program has approved an exception.

k.11.2 Each hospital shall complete its cost report in accordance with Medicaid Program instructions and forms and shall include any supporting documentation required by the Medicaid Program. The Medicaid Program shall review the cost report for completeness, accuracy, compliance and reasonableness through a desk audit.

k.11.3 The submission of an incomplete cost report shall be treated as a failure to file a cost report as required by section k.11.1, and the hospital shall be so notified.

k.11.4 The Medicaid Program shall issue a delinquency notice to the hospital if the hospital does not submit its cost report on time or when the hospital is notified pursuant to section k.11.3, that its submitted cost report is

incomplete.

k. 11.5 If the hospital does not submit a complete cost report within thirty (30) days after the date of the notice of delinquency, an amount equal to seventy-five percent (75 %) of the hospital's payment for the month that the cost report was due shall be withheld each month until the cost report is received.

k. 11.6 The Medicaid Program shall pay the withheld funds promptly after receipt of the completed cost report and documentation that meets the requirements of this section."

k. 11.7 Each hospital shall maintain sufficient financial records and statistical data for proper determination of allowable costs.

k. 11.8 Each hospital's accounting and related records, including the general ledger and books of original entry, and all transaction documents and statistical data, are permanent records and shall be retained for a period of not less than five (5) years after the filing of a cost report or until the Notice of Final Program Reimbursement is received, whichever is later.

k. 11.9 If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

k. 11.10 Payments made to related organizations and the reason for each payment to related organizations shall be disclosed by the hospital.

k. 11.11 Each hospital shall:

(a) Use the accrual method of accounting; and

(b) Prepare the cost report according to generally accepted accounting principles and all Medicaid Program instructions.

k. 12 **AUDITING AND ACCESS TO RECORDS**

k. 12.1 The Medicaid Program reserves the right to conduct an audit at any time upon reasonable notice to the provider.

k.12.2 During an on-site audit or review, each hospital shall allow appropriate Department of Health Care Finance auditors and authorized agents of the District of Columbia government and the United States Department of Health and Human Services access to financial records and statistical data necessary to verify costs reported to the Medicaid Program.

k.13 APPEALS FOR HOSPITALS THAT ARE NOT COMPENSATED ON AN APDRG BASIS

k.13.1 A hospital that is not compensated on an APDRG basis shall receive a Notice of Program Reimbursement (NPR) at the end of its fiscal year after a site audit.

k13.2 Within sixty (60) days after the date of the NPR, any hospital that disagrees with the NPR shall submit a written request for an administrative review of the NPR to the Agency Fiscal Officer, Audit and Finance, DHCF.

k.13.3 The written request for administrative review shall include a specific description of the audit adjustment or estimated budget item to be reviewed, the reason for the request for review of the adjustment or item, the relief requested, and documentation in support of the relief requested.

k.13.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days after the date of receipt of the hospital's written request for administrative review.

k13.5 Within forty-five (45) days after receipt of the Medicaid Program's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings.

k.13.6 Filing an appeal with the Office of Administrative Hearings shall not stay any action to recover any overpayment to the hospital. The hospital shall be liable immediately to the Medicaid Program for any overpayment set forth in the Medicaid Program's determination.

k. 14 **APPEALS FOR HOSPITALS THAT ARE COMPENSATED ON AN APDRG BASIS**

k. 14.1 Hospitals that are compensated on an APDRG discharge basis shall receive a Remittance Advice each payment cycle.

k. 14.2 Within sixty (60) days after the date of the Remittance Advice, any hospital that disagrees with the payment rate calculation for the amounts listed in subsection k.14.3 or the APDRG assignment shall submit a written request for administrative review to the Agency Fiscal Officer, Audit and Finance, DHCF.

k.14.3 The amounts subject to an administrative review are as follows:

(a) Add- on payment for capital costs or graduate medical education costs; and

(b) Outlier payment.

k.14.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days after the date of receipt of the hospital's written request for administrative review under section k.14.2.

k. 14.5 Within forty-five (45) days after receipt of the Medicaid Program's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings.

k. 14.6 Filing an appeal with the Office of Administrative Hearings shall not stay an action to recover an overpayment to the hospital.

k. 15 **APPEAL OF ADJUSTMENTS TO THE SPECIFIC HOSPITAL COST PER DISCHARGE OR ADD-ON PAYMENTS**

k. 15.1 After completion of a review or audit of the hospital' s cost report for the base year, DHCF shall provide the hospital a written notice of its determination of any adjustment to the Hospital's Specific Cost Per Discharge, graduate medical education add-on payment or capital add on payment for the base year. The notice shall include the following:

(a) A description of the rate adjustment, including the amount of the old payment rate and the revised payment rate;

(b) The effective date of the change in the payment rate;

(c) A summary of all audit or payment rate adjustments made to reported costs, including an explanation, by appropriate reference to law, rules or program manual of the reason in support of the adjustment; and

(d) A statement informing the hospital of the right to request and administrative review within sixty (60) days after the date of the determination.

k. 15.2 A hospital that disagrees with an audit adjustment or payment rate calculation for the Hospital Specific cost per discharge, capital add-on, or direct medical education add-on costs shall submit a written request for administrative review to the Agency Fiscal Officer, Audit and Finance Office, DHCF.

k. 15.3 The written request for the administrative review shall include a specific description of the audit adjustment or payment rate calculation to be reviewed, the reason for review of each item, the relief requested and documentation to support the relief requested.

k. 15.4 DHCF shall mail a formal response of its determination to the hospital not later than one hundred and twenty (120) days after the date of the hospital's written request for administrative review.

k. 15.5 Within forty-five (45) days after receipt of the DHCF's written determination, the hospital may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings.

k. 15.6 Filing an appeal with the Office of Administrative Hearings shall not stay any action to adjust the hospital's payment rate.

k.16 DEFINITIONS

For purposes of this chapter, the following terms shall have the meanings ascribed:

Base year – The standardized year on which rates for all hospitals for inpatient hospital services are calculated to derive a prospective reimbursement rate.

Department of Health Care Finance - the executive department of the District government responsible for administering the Medicaid program within the District of Columbia effective October 1, 2008.

Diagnosis Related Group (DRG) - a patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources.

High-cost outliers- claims with costs exceeding 2.5 standard deviations from the mean Medicaid cost for each APDRG classification.

Low-cost outliers-claims with costs less than twenty-five percent (25%) of the average cost for each APDRG classification.

Service intensity weights - A numerical value which reflects the relative resource requirements for the DRG to which it is assigned.

(a) Hospital Peer Groups - A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. Rates for all hospitals falling within a peer group are standardized. The standardization of rates incorporates incentives for efficiency within the payment system by rewarding the most efficient hospitals.

(b) Base Rate - A dollar amount based on the average historical Medicaid cost per discharge for each facility, exclusive of the outlier costs, adjusted by the case mix index. Data used to calculate the base rate are derived from the audited fiscal year 1990 Medicare/Medicaid cost report.

8. QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL

a. A hospital located in the District of Columbia shall be deemed a disproportionate share hospital (DSH) for purposes of a special payment adjustment if a hospital has at least one percent (1%) Medicaid utilization and the hospital has at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals; and

1. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the District who are Medicaid providers; or

2. The hospital's low income utilization rate exceeds twenty-five per cent (25%).

b. A hospital whose inpatients are predominately individuals under eighteen (18) years of age or did not offer non-emergency obstetric services to the general population as of December 1, 1987, shall not be required

to have two obstetricians who have agreed to provide obstetric services to Medicaid-eligibles as outlined above.

c. Not later than June 1st of each year, all District hospitals that have a valid Medicaid Provider Agreement shall file such information as the Department of Health Care Finance (DHCF) requires, including the completion of the DHCF DSH Data Collection Tool. These data, together with data from each hospital's cost report as filed for the same period shall be used to determine participation in the disproportionate share distribution. Failure to submit the DSH Data Collection Tool may result in the withholding of reimbursement to the hospital for inpatient and outpatient services rendered to Medicaid beneficiaries enrolled in fee-for-service and managed care programs.

d. The District of Columbia may limit the total DSH payments that it will make to qualifying DSH hospitals beginning July 3, 2010, and each fiscal year thereafter. The annual District DSH limit in a fiscal year shall be equal to the District's annual federal DSH allotment, expressed in total computable dollars, for the same fiscal year reduced by:

1. The total amount expended by the District for services provided in the same fiscal year under the authority of any approved Medicaid Waiver enabling the District government to expand coverage of the Medicaid program for a population or service not covered as of July 3, 2010. The proposed amounts are as follows: FY11 $25,955,244; FY12 $42,482,047; FY13 $63,062,394; and FY14 19,218,676 (FY14 represents the 1st quarter of FY2014).

e. The total amount expended by the District for services under Attachment 4.19A(d)(1) shall be an amount, as determined ninety (90) days after the end of each fiscal

year, which shall equal the District's best estimate of incurred, but not yet received, liabilities as of the same date. The District's best estimate shall not be subject to revision at a later date.

f. Any hospital which meets the disproportionate share eligibility requirements shall be paid on a quarterly basis.

g. Each new provider shall be eligible to receive a DSH Payment adjustment calculated in accordance with this section. Each new provider shall be required to submit a complete hospital fiscal year cost report and a completed DSH Data Collection tool, and any additional data required by the Medicaid program. The DSH payment adjustment shall be calculated taking into account the data submitted by each qualifying new provider and all other qualifying hospitals. The DSH payment adjustment to each new provider shall begin the following District fiscal year after the hospital qualifies as DSH hospital.

h. Effective January 1, 2012, and in accordance with section 1923(c) (3) of the Social Security Act, the District of Columbia Medicaid Program shall establish two (2) categories of hospitals to pay each hospital that qualifies as a DSH hospital:

1. The first category shall include all public psychiatric hospitals, which includes St. Elizabeth's Hospital; and

2. The second category shall include all remaining qualifying hospitals that are not included in the first category.

i. The annual District DSH limit to DSH qualifying hospitals shall be distributed as follows:

1. Each qualifying public psychiatric DSH hospital as set forth in Section h.1 shall be paid an amount equal to its total uncompensated care for District residents. The total amount of uncompensated care shall consist of the sum of the following:

   a. Medicaid allowable inpatient and outpatient hospital costs, minus reimbursement for these costs;

   b. All District funded health care programs, such as the Alliance, Immigrant Children's Program, Child and Family Services Administration, etc., inpatient and outpatient costs determined in accordance with the requirements set forth in section 1923 (g)(1) of the Social Security Act and 42 CFR § 447; and

   c. Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 CFR § 447.

2. The qualifying hospitals in the second category shall be paid in accordance with the following methodology:

   a. Calculate the total uncompensated care provided to residents of the District for each hospital. The amount of uncompensated care for District residents shall consist of the sum of the following:

      i. Medicaid allowable inpatient and outpatient hospital costs, minus reimbursement for these costs;

      ii. All District funded health care programs, such as the Alliance, Immigrant Children's Program, Child and

Family Services Administration, etc., inpatient and outpatient costs determined in accordance with the requirements set forth in section 1923(g)(1) of the Social Security Act and 42 CFR § 447; and

iii. Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 CFR 447;

b. For each hospital, multiply the inpatient costs as determined in Section h2 by the percent of inpatient days attributable to individuals served for those costs;

c. For each hospital, multiply the outpatient costs as determined in section 2a by the percent of outpatient visits attributable to individuals served for those costs;

d. Add the products for sections 2(b) and (c) for all hospitals;

e. For each hospital, calculate the percent distribution by adding the products of sections 2(b) and (c) and then divide by section 2(d); and

f. Multiply the percent distribution for each hospital determined in accordance with Section 2(f) by the annual District DSH limit.

j. For any District Medicaid participating hospital that is reimbursed on a cost settled reimbursement methodology for inpatient hospital services, the uncompensated care amount for Medicaid inpatient services calculated in Section 2(a)(i) shall be zero.

k. DHCF shall recalculate the DSH payments every year.

l. Any payment adjustment computed in accordance with Section i is subject to the limit on payments to individual hospitals established by section 1923(g) of the Social Security Act. The amount of any payment that would have been made to any hospital, but for the limit on payments established by section 1923(g), shall be distributed proportionately among the remaining qualifying hospitals based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

m. Any DSH payment adjustments computed in accordance with Section i are subject to the limits on payments to Institutions for Mental Disease, established by section 1923(h) of the Social Security Act. The amount of any payment that would have been made to a public or private hospital, but for the limit on payments established by section 1923(h), shall be distributed proportionately among the remaining qualifying hospitals in the second category, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

n. If, during any fiscal year, the annual District DSH limit is not sufficient to pay the full amount of any DSH payment adjustment computed in accordance with Section i, then each hospital in the first and second categories shall be paid a proportional amount of their computed DSH adjustment amount. The final DSH payment for each hospital shall equal the product of its DSH payment adjustment computed in accordance with Section i and a fraction determined by the following formula:

    1. The numerator shall equal the annual aggregate DSH limit; and

    2. The denominator shall equal the aggregate DSH payment adjustment for all hospitals computed in accordance with Section i.

o. DHCF shall conduct audits to ensure compliance with the requirements set forth in section 1923(j) of the Social Security Act. Each hospital shall allow appropriate staff from DHCF or authorized agents of the District of Columbia government or federal government access to all financial records, medical records, statistical data, and any other records necessary to verify costs and any other data reported to the Medicaid program.

DEFINITIONS

For purposes of this section, the following terms shall have the meanings ascribed:

Annual District DSH limit - The annual District established aggregate limit for DSH payments. This term shall not be construed as the annual federal DSH allotment for the District of Columbia.

Low Income Utilization Rate - The sum of two (2) fractions, both expressed as percentages. The numerator of the first fraction is the sum of: 1) total revenues paid the hospital during its fiscal year for Medicaid patient services; and 2) the amount of any cash subsidies for patient services received directly from the State or the District government. The denominator shall be the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same fiscal year. The numerator of the second fraction is the total amount of the hospital's charges for inpatient hospital services, which are attributable to charity care in the fiscal year, minus the portion of the cash subsidies reasonably attributable to inpatient services. The denominator of the second fraction shall be the total amount of the hospital's charges for inpatient hospital services in that fiscal year.

Medicaid Inpatient Utilization Rate - The percentage derived by dividing the total number of Medicaid inpatient days of care rendered during the hospital's fiscal year by the total number of inpatient patient days for that year.

New Provider - Any District hospital that meets the qualifications of a DSH hospital pursuant to the requirements set forth in § 908.1 after October 1, 2011.

Total Computable Dollars - Total Medicaid DSH payments, including the federal and District share of financial participation.

Uncompensated Care - The cost of inpatient and outpatient care provided to Medicaid eligible individuals and uninsured individuals consistent with the requirements set forth in 42 CFR § 447.

9. All claims for inpatient services are settled in accordance with the D.C. State Plan and federal laws and regulations in effect on the date of service.

10. Participating inpatient hospital providers are required to submit uniform cost reports.

11. The Medical Assistance Administration provides for periodic audits of financial and statistical records and cost reports of participating providers.

12. The Medical Assistance Administration provides an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates.

14. Payment for Acute Involuntary Psychiatric Admissions to Non-public hospitals in the District.

a. A hospital that has provided the notice required in paragraph b may receive the greater of the payments set forth in paragraph c as reimbursement for an involuntary psychiatric admission under Chapter 5 of Title 21 of the District of Columbia Code (commonly known as the Ervin Act)

b. Providers shall notify DMH of their intention to submit claims for per diem reimbursement for involuntary admissions no less than 45 days prior to the date of the admission for which they intend to seek such reimbursement. Once the provider notifies DMH of its intention, DMH shall issue written notification instructing the provider how to elect the manner by which per diem payments are received.

c. The provider shall have the option to receive the greater of the following: a) the APDRG payment; or b) the cumulative reimbursement from the involuntary acute care per diem reimbursement schedule on the date of discharge. The reimbursement schedule is based upon the Medicare inpatient psychiatric facility prospective payments system. The reimbursement schedule does not include all of the variables in the Medicare rule, however. In addition, under the reimbursement schedule, no additional payment is made for days after day 15, even if the provider does not elect to transfer the patient to St. Elizabeths Hospital, as it is permitted to do under paragraph d. below.

d. On the fifteenth day of the involuntary admission stay, the hospital provider can elect to transfer the patient to St. Elizabeth's Hospital, which must agree to accept the admission. If the hospital does not elect to transfer the patient, no additional payment is made for any days after day 15.

STATE Dist. of Col.	
DATE REC'D 9-28-05	
DATE APPV'D JUL 26 2006	A
DATE EFF Oct 1, 2005	
HCFA 179	

SPA-05-08

Citation

42 CFR 447,434
438, and 1902(a)(4),
1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions

The State identifies the following Other Provider preventable Conditions for non-payment under Section(s) 4.19 A____

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Payments for provider preventable conditions (PPCs) will be adjusted in the following manner:

Hospitals paid under the diagnosis-related group (DRG) basis

1. Providers are mandatorily required to report HCACs to the Agency using the applicable Present on Admission (POA) indicators on claims.
2. The Agency's claims processing system will identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the AP-DRG. Payment for the stay would only be affected if the presence of the HCAC would otherwise have pushed the stay into a higher-paying AP-DRG.

3. DRG claims will continue to be priced by the DRG, with a reduction in payment if removing the HCAC condition results in a DRG with a lower relative weight.

Hospitals paid under the non-diagnosis-related group (non-DRG) basis or the Per Diem Payment System Methodology

1. Non-DRG hospital claims will price according to existing payment methodologies for the provider (e.g. per diem).

2. Non-DRG claims will go through the HAC logic of the AP-DRG grouper software in order to determine whether the HCAC affects payments and to calculate the proper payment adjustment, if applicable.

3. This process will function in the same manner as for DRG claims. Therefore, if removing the HCAC condition results in a DRG with a lower relative weight, only then will the payment be affected and adjusted by a percentage based on the difference in the DRG weights.

Citation
42 CFR 447.26 (c)

Provider Guidelines relating to Provider Reimbursement

i. No reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition, defined as a PPC for a particular patient, existed prior to the initiation of treatment for that patient by that provider.

ii. Reductions in a provider payment may be limited to the extent that the following apply:
   a. The identified provider preventable condition would otherwise result in an increase in payment; and
   b. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

iii. The Agency assures the Centers for Medicare and Medicaid Services (CMS) that non-payment for provider preventable conditions does not prevent access to services for Medicaid beneficiaries.