DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2012 Repl. & 2014 Supp.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of an amendment, on an emergency basis, to Chapter 48 (Medicaid Program: Reimbursement) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These emergency and proposed rules establish updated methods and standards for the reimbursement of inpatient hospital services under the Medicaid program.

Under these rules, DHCF shall base Medicaid reimbursement for inpatient hospital services on an All Patient Refined Diagnosis Related Groups (APR-DRGs) prospective payment system (PPS). Inpatient hospital services subject to the APR-DRG PPS include inpatient hospital stays and services provided in general hospitals, including acute care hospitals and children's hospitals; and Medicare-designated distinct-part psychiatric units and distinct-part rehabilitation units of acute care hospitals. DHCF shall apply these rules to general and specialty hospitals both within and outside of the District of Columbia, with the exception of hospitals located in Maryland. In addition, these rules also establish (a) the District-wide base rate; (b) policy adjustors; (c) enhanced rates for hospitals located in economic development zones; (d) limits on reimbursement for direct and indirect medical education and capital add-ons; (e) thresholds for high-cost and low-cost outlier payments; and (f) policy updates to the Three-Day Payment Window. Lastly, these rules shall establish a new benefit, sub-acute psychiatric services for children.

This emergency rulemaking is necessitated by the immediate need to ensure that District residents have continued access to quality inpatient hospital services. The current cost-based reimbursement, based on an older Diagnosis Related Groups (DRG) system, no longer accurately reflects the severity of patient illness and the true cost of care. Moreover, current reimbursement is administratively burdensome and vulnerable to inconsistent provider reimbursement. In turn, these issues can impede access to quality inpatient hospital services. Conversely, APR-DRG PPS, using a District-wide base rate, incentivizes hospitals to provide cost-efficient care. As APR-DRG reimbursement is closely tied to casemix, hospitals that take sicker patients can expect higher payments, which should improve access to care. Reimbursement methodologies are intertwined with access to care as well as the cost and quality of that care. Moreover, the District's Medicaid program currently pays for services delivered in Psychiatric Residential Treatment Facilities (PRTFs). PRTF services are an essential component of children's behavioral health; however, there are no PRTFs located in the District. As such, Medicaid enrolled children receiving treatment in PRTFs often reside far outside of the District for several months. By implementing sub-acute psychiatric services, DHCF seeks to expand the continuum of behavioral health services to include an intermediate level of care below inpatient psychiatric hospitalization and above the nature of services rendered in PRTFs. In conjunction with the Department of Behavioral Health, DHCF has

developed clinically sound coverage requirements for the sub-acute level of care. Accordingly, emergency action is necessary for the immediate preservation of the health, safety and welfare of persons receiving these services.

The emergency and proposed rules correlates to an amendment to the District of Columbia State Plan for Medical Assistance (State Plan) which requires approval by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS). The State Plan amendment (SPA) has been approved by the Council through the Medicaid Assistance Program Emergency Amendment Act of 2014, signed July 14, 2014 (D.C. Act 20-377; 61 DCR 007598 (August 1, 2014)). Implementation of these emergency and proposed rules is contingent upon approval of the corresponding SPA by CMS, with an effective date of October 1, 2014, if the corresponding SPA has been approved by CMS with an effective date of October 1, 2014 or the effective date established by CMS in its approval of the of the corresponding SPA, whichever is later.

The emergency and proposed rules were adopted on September 19, 2014 and became effective for dates of services on or after October 1, 2014. The emergency rules will remain in effect for one hundred and twenty (120) days or until January 17, 2015, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director also gives notice of the intent to take final rulemaking action to adopt this emergency and proposed rule not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Chapter 48, MEDICAID PROGRAM: REIMBURSEMENT, of Title 29 DCMR, PUBLIC WELFARE, is amended to read as follows:

4800 INPATIENT SERVICES: GENERAL PROVISIONS

4800.1 Effective for inpatient hospital discharges occurring on or after October 1, 2014, Medicaid reimbursement for inpatient hospital discharges shall be on All Patient Refined Diagnosis Related Groups (APR-DRGs) prospective payment system (PPS) for all general hospitals, including acute and pediatric hospitals, except:

(a) Hospitals located in the State of Maryland as identified in Subsection 4800.12;

(b) Specialty hospitals as identified in Subsection 4800.14; and

(c) Hospitals providing inpatient services under certain extenuating circumstances as identified in Subsections 4800.15-16.

4800.2 Inpatient hospital discharges subject to the APR-DRG PPS shall include inpatient hospital stays that last at least one (1) day or more and services provided in Medicare-designated distinct-part psychiatric units and distinct-part rehabilitation units within those hospitals.

4800.3 Payment for each APR-DRG claim, excluding transfer claims, low-outlier claims, or interim claims, shall be based on the following formula:

APR-DRG Hospital-Specific Relative Value (HSRV)
(relative weight for that Diagnosis-related group (DRG)
x
Policy Adjustor (if applicable)
x
District-wide base rate adjusted for Indirect Medical Education (IME), if applicable
=
DRG Base Payment

The final APR-DRG payment may include a high outlier payment adjustment, add-on payments for capital and direct medical education costs, and subtraction of other health coverage or patient share of cost if applicable.

DRG Base Payment
+
High-Outlier Payment Adjustment
+
Add-on Payments for Capital and Direct Medical Education Costs
-
Other Health Coverage
-
Patient Share of Cost
=
APR-DRG PPS Payment

4800.4 The following methods and standards may apply under APR-DRG PPS:

(a) The APR-DRG classification system as contained in version 31 of the 3M™ APR-DRG Classification System Definitions Manual, and any subsequently adopted versions, shall apply for purposes of calculating reimbursement for all inpatient discharges, including specialty, under this Chapter;

(b) The District may update the APR-DRG grouper biennially;

(c) As described under Section 4801, APR-DRG PPS shall include a single, District-wide base rate for all general hospitals providing inpatient hospital services;

(d) As described under Section 4802, the implementation of APR-DRG PPS shall include an annual calculation of hospital-specific cost-to-charge ratios (CCRs);

(e) As described under Section 4803, the implementation of APR-DRG PPS shall include a calculation of the District-wide cost and average cost per discharge;

(f) As described under Section 4804, the base rate may include Indirect Medical Education (IME) for hospitals located within the District;

(g) As described under Sections 4805 and 4807, APR-DRG PPS may include Direct Medical Education (DME) as well as capital add-on payments;

(h) As described under Section 4806, APR-DRG PPS reflects a severity of illness (SOI) in its associated relative weight;

(i) As described under Section 4808, APR-DRG PPS may include an adjustment to reimbursement for high-cost and low-cost outliers;

(j) As described under Section 4809, the implementation of APR-DRG PPS may include policy adjustors;

(k) As described under Section 4810, hospitals located in an Economic Development Zone (EDZ) shall receive an increased reimbursement rate;

(l) As described under Section 4811, for each claim involving a transfer to another general hospital, DHCF shall pay the transferring hospital the lesser of the otherwise applicable DRG base payment amount or a prorated payment based on the ratio of covered days to the average length of stay associated with APR-DRG;

(m) As described under Section 4812, reimbursement for short-term stays shall be limited; and

(n) As described under Section 4813, implementation of APR-DRG PPS shall include consideration of third party liability and patient cost sharing.

4800.5 All non-emergency, inpatient admissions shall require prior authorization.

4800.6 Medicaid payment adjustments for Provider Preventable Conditions, including Health Care-Acquired Conditions pursuant to 29 DCMR § 9299 shall be processed and paid in accordance with the criteria for payment adjustment for provider preventable conditions described under 29 DCMR §§ 9200 *et seq*.

4800.7 Outpatient diagnostic services provided by any general hospital, not located in Maryland, one (1) to three (3) days prior to an inpatient admission at the same hospital shall not be separately payable and shall be billed as part of the inpatient stay.

4800.8 All hospital outpatient services that occur on the same day as an inpatient admission at the same general hospital, not located in Maryland, shall be considered part of the inpatient stay and shall not be payable separately.

4800.9 A general hospital located in the District shall be required to submit cost reports and comply with audits in accordance with the requirements described at Section 4822.

4800.10 All general hospitals that provide inpatient services shall maintain records in accordance with the requirements described at Section 4822.

4800.11 Hospitals that provide inpatient services shall be subject to the appeal and administrative review requirements described at Section 4822.

4800.12 General hospitals located in Maryland shall act in accordance with Health Services Cost Review Commission (HSCRC)'s All-Payer Model Contract with Center for Medicare and Medicaid Innovation, or its successor, for inpatient hospital discharges.

4800.13 Out-of-District general hospitals, not located in Maryland, shall be reimbursed by DRG. The DRG base rate for out-of-District hospitals is the District-wide Base Rate, without IME.

4800.14 Specialty hospitals, identified at Section 4814, shall be reimbursed either on a per diem or a per stay basis under APR-DRG PPS for inpatient hospital discharges.

4800.15 Where the Director of DHCF determines extenuating circumstances, including but not limited to closure or bankruptcy, exist within the District's specialty hospital system, a general hospital may receive reimbursement either on a per diem or a per stay basis under APR-DRG PPS for services provided to a patient who would have been transferred from the general hospital to a Long Term Care Hospital, if a bed were available.

4800.16 Reimbursement under Subsection 4800.14 may be adjusted based on the acuity of the patient to ensure appropriate payment.

4800.17 Appeal and administrative review rights, and cost reporting, auditing, and record maintenance requirements, identified at Sections 4822-4823, shall apply to all general hospitals receiving reimbursement under APR-DRG PPS.

4801 INPATIENT SERVICES: CALCULATION OF DISTRICT-WIDE BASE RATE

4801.1 For Medicaid reimbursement of inpatient hospital discharges occurring on or after October 1, 2014, DHCF shall use a single, District-wide base rate for all general hospitals.

4801.2 Effective October 1, 2014, and annually thereafter, the base year period is the District's fiscal year that ends prior to October 1 of the prior calendar year.

4801.3 The District-wide base rate is based on aggregate costs for the base year. Aggregate cost is calculated using the hospital specific cost-to-charge ratio, as described in Section 4802, as well as facility casemix data, and claims data from all in-District participating hospitals for the base year.

4801.4 Subject to federal upper payment limits, the District-wide base rate shall not exceed a rate that approximates an aggregate payment to cost ratio of ninety-eight percent (98%) for the base year for in-District general hospitals. The payment to cost ratio is determined by modeling payments to all hospitals using claims data relevant to the base year.

4801.5 The District-wide base rate calculated pursuant to Sections 4801.3 and 4801.4 may be adjusted for IME as set forth in Section 4804.

4801.6 The Indirect Medical Education (IME) component of the District-Wide Base Rate shall be hospital-specific for each in-District general hospital with IME costs, as recognized on their cost report.

4802 INPATIENT SERVICES: CALCULATION OF COST-TO-CHARGE RATIO (CCR)

4802.1 For Medicaid reimbursement of inpatient hospital discharges, hospital-specific cost-to-charge ratios (CCRs) shall be calculated annually.

4802.2 The CCR shall be developed based on each hospital's submitted cost reports for the hospital's fiscal year that ends prior to October 1 of the prior calendar year.

4802.3 The CCR used to calculate the cost of a claim shall be hospital-specific for hospitals providing in-patient hospital services.

4802.4 DHCF shall apply a weighted average of in-District hospitals CCRs to out-of-District hospitals.

4802.5 For the purposes of determining the overall hospital CCR, total costs reported shall be allocated to inpatient and outpatient costs based on the ratio of inpatient and outpatient charges reported in each cost center.

4802.6 For the purpose of excluding inpatient capital costs, capital costs associated with each ancillary cost center shall be allocated to inpatient and outpatient capital costs based on the ratio of inpatient and outpatient charges reported by each cost center.

4803 INPATIENT SERVICES: CALCULATION OF THE HOSPITAL-SPECIFIC COST PER DISCHARGE

4803.1 For Medicaid reimbursement of inpatient hospital discharges, the hospital specific cost per discharge shall equal a hospital's Medicaid inpatient operating costs standardized for indirect medical education (IME) costs and variations in casemix, divided by the number of Medicaid discharges in the base year data set and adjusted for outlier reserve.

4803.2 Medicaid inpatient operating costs for the base year period shall be calculated by applying the hospital-specific CCR, as determined in Section 4802, to allowed charges from the base year claims data.

4803.3 Medicaid inpatient operating costs shall be standardized for IME costs by removing IME costs to determine the District-wide component of the base rate. IME costs shall be removed by dividing Medicaid operating costs for each hospital with IME costs by the IME factor for that hospital.

4803.4 The IME adjustment factor for each hospital shall be calculated using the Medicare algorithm for each hospital based on the hospital cost report for the base year period.

4803.5 Medicaid inpatient operating costs shall be standardized for variations in casemix by dividing Medicaid operating costs standardized for IME by the appropriate casemix adjustment factor.

4803.6 The Hospital-specific cost per discharge shall be adjusted for IME and casemix and shall be reduced by a net one percent (1%) to account for five percent (5%) of the cost reserved for payment of high-cost outlier claims and four percent (4%) of the cost restored to account for the reduction in payment for low-cost outlier claims.

4804 INPATIENT SERVICES: INDIRECT MEDICAL EDUCATION (IME)

4804.1 For Medicaid reimbursement of inpatient hospital discharges, the amount of the hospital-specific cost per discharge adjusted for IME shall be added to the District-wide base rate for each in-District general hospital to determine the hospital-specific base rate.

4804.2 The hospital-specific cost per discharge of IME shall be calculated annually as follows:

(a) The hospital-specific cost per discharge adjusted for casemix shall be divided by the IME factor.

(b) For discharges occurring on or after October 1, 2014, the amount calculated in Subsection 4804.2(a) shall be multiplied by a factor of 0.75 to determine the IME payment per discharge for each hospital.

(c) For discharges occurring on or after October 1, 2015, and annually thereafter, the amount calculated in Subsection 4804.2(a) is multiplied by a factor of 0.50 to determine the IME payment per discharge for each hospital.

(d) The amount established pursuant to Subsection 4804.2(b) or (c) shall be subtracted from the average cost per discharge for each hospital before determining the District-wide base rate.

4805 INPATIENT SERVICES: DIRECT MEDICAL EDUCATION (DME)

4805.1 For Medicaid reimbursement of inpatient hospital discharges, DME shall be a per-discharge add-on payment for each in-District general hospital that is eligible for DME. The DME add-on shall be calculated annually by dividing the Medicaid DME costs determined in accordance with Subsection 4805.2 by the number of Medicaid discharges in the base year, subject to the limits described in this section.

4805.2 For discharges occurring on or after October 1, 2014, and annually thereafter, the DME add-on payment for each in-District general hospital shall be based on costs from each hospital's submitted or audited cost report for the hospital's fiscal year that ends September 30 of the prior calendar year, subject to the limits described in this section.

4805.3 The District-wide average cost of DME per Medicaid patient day shall be based on submitted cost reports for the base year. The average cost per patient day is calculated by dividing total Medicaid DME cost for all DME eligible hospitals by the total number of Medicaid days for those hospitals, as reported on the hospital cost reports. The per-day amount is converted to a per discharge amount for each hospital, based on Medicaid utilization information in the cost report.

4805.4 For discharges occurring on or after October 1, 2014, DME shall be limited to two hundred percent (200%) of the average District-wide cost of DME per Medicaid patient day.

4805.5 For discharges occurring on or after October 1, 2015, and annually thereafter, DME costs for each hospital shall be limited to the per discharge equivalent of one-hundred fifty percent (150%) of the average District-wide cost of DME per Medicaid patient day.

4805.6 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 DME add-on payment, the add-on payment for DME add-on costs shall be adjusted prospectively to reflect the revised costs.

4806 INPATIENT SEVICES: CALCULATION OF RELATIVE WEIGHTS

4806.1 For Medicaid reimbursement of inpatient hospital discharges occurring on or after October 1, 2014, DHCF shall use hospital-Specific Relative Value (HSRV) version 31 national weights for APR-DRGs. The HSRV method adjusts for differences in cost-to-charge ratios (CCR) among hospitals nationwide.

4806.2 Each DRG assignment shall reflect a severity of illness (SOI) in its associated relative weight. Relative weights are updated biennially at the time the APR-DRG grouper version is updated. The annual APR-DRG documentation from 3M™ describes the changes made each year.

4807 INPATIENT SERVICES: CALCULATION OF CAPITAL ADD-ON PAYMENTS

4807.1 For Medicaid reimbursement of inpatient hospital discharges, Capital payments shall be per-discharge add-on payments that apply to in-District general hospitals only.

4807.2 For discharges occurring on or after October 1, 2014, capital add-ons shall be limited to one hundred percent (100%) of the District average capital cost per Medicaid patient day. This payment shall be calculated based on submitted cost reports for in-District general hospitals for the base year.

4807.3 The average cost per patient day shall be calculated by dividing total Medicaid capital cost for all eligible hospitals by the total number of Medicaid days for those hospitals, as reported on the hospital cost reports.

4807.4 The per-day amount shall be converted to a per discharge amount for each hospital, based on Medicaid utilization information in the cost report.

4807.5 Effective October 1, 2014, and annually thereafter, the capital cost add-on payment shall be calculated by dividing the sum of Medicaid capital costs applicable to inpatient routine services costs, as reported in the cost report, and capital costs applicable to inpatient ancillary services, as determined in Subsection 4807.6, by the number of Medicaid discharges in the base year.

4807.6 Capital costs applicable to inpatient ancillary services shall be allocated to inpatient capital by applying the facility's ratio of ancillary inpatient charges to total ancillary charges for each ancillary line on the cost report.

4807.7 For discharges occurring on or after October 1, 2014, and annually thereafter, the capital cost add-on payment for each in-District general hospital shall be based on costs from each hospital's submitted cost report for the hospital's fiscal year that ends prior to October 1 of the prior calendar year.

4807.8 If after an audit of the hospital's cost report for the base year period an adjustment is made to the hospital's reported costs which results in an increase or decrease of five percent (5%) or greater of the capital cost add-on payment, the add-on payment for capital costs shall be adjusted, subject to District-wide limits.

4808 INPATIENT SERVICES: CALCULATION OF OUTLIER PAYMENTS

4808.1 For Medicaid reimbursement of inpatient hospital discharges, the APR-DRG PPS shall provide an additional payment for outliers, high-cost and low-cost, based on inpatient costs.

4808.2 For discharges on or after October 1, 2014, DHCF shall provide an additional payment for inpatient stays when the cost of providing care results in a loss to the hospital that exceeds the high-cost outlier threshold (*i.e.*, high-cost outlier). The goal for District-wide high-cost outlier payments is to identify an estimated maximum of five percent (5%) of inpatient payments as high-cost outliers.

4808.3 The loss to the hospital shall be calculated pursuant to the following formula:

LOSS
=
COST (ALLOWED CHARGES X COST TO CHARGE RATIO (CCR))
-
THE DRG BASE PAYMENT

4808.4 The outlier payment is calculated as follows if the loss exceeds the outlier threshold:

OUTLIER PAYMENT
=
(LOSS – OUTLIER THRESHOLD)
X
THE MARGINAL COST FACTOR

4808.5 The DRG PPS payment for the stay shall be the sum of the DRG base payment and the outlier payment, adjusted for transfer pricing, if applicable.

4808.6 The CCR used to calculate the cost of a claim shall be hospital-specific as described at Section 4802.

4808.7 The high-cost outlier threshold shall be reviewed annually and updated when necessary based upon a review of claims history from the District's previous fiscal year.

4808.8 For discharges occurring on or after October 1, 2014, and annually thereafter, DHCF shall adjust payments for extremely low-cost inpatient cases.

4808.9 Low-cost outliers shall be those cases where the gain on the claim (claim costs minus DRG base payment) exceeds the low-cost outlier threshold.

4808.10 Low-cost outliers shall be determined by using the formula identified at Subsection 4808.13.

4808.11 Each claim with a gain that exceeds the low-cost outlier threshold shall be paid at the lesser of the APR-DRG payment amount or a prorated payment.

4808.12 DHCF shall set the low-cost outlier threshold at a level that results in four percent (4%) or less of APR-DRG payments being associated with low-cost outlier cases.

4808.13 The low-cost outlier calculation shall use the national average lengths of stay (ALOS) available with the APR-DRG grouper as follows:

LOW-COST OUTLIER PAYMENT
=
(DRG BASE PAYMENT / NATIONAL ALOS)
X
(LOS FOR ELIGIBLE DAYS OF THE STAY +1)

4808.14 If the low-cost outlier payment results in an amount greater than the DRG base payment, DHCF shall disregard the low-cost outlier payment.

4808.15 DHCF shall review and calculate the low-cost outlier threshold annually and update where necessary based upon a review of claims history from the previous District fiscal year.

4809 INPATIENT SERVICES: POLICY ADJUSTOR(S)

4809.1 DHCF may utilize policy adjustors to increase or decrease APR-DRG relative weights for certain care categories or for a range of DRGs to meet policy goals.

4809.2 For Medicaid reimbursement of inpatient hospital discharges occurring on or after October 1, 2014, DHCF shall apply the following policy adjustors to the DRG weights for all inpatient stays according to Medicaid Care Category (MCC) for children under the age of twenty-one (21), excluding normal newborns:

(a) Pediatric mental health MCC equal to a factor of 2.25;

(b) Neonate MCC equal to a factor of 1.25; and

(c) All other pediatric stays except normal newborns equal to a factor of 1.5.

4809.3 The value of the policy adjustor(s) shall be reevaluated annually or more frequently when necessary.

4810 INPATIENT SERVICES: SPECIAL CONSIDERATION FOR HOSPITALS LOCATED IN ECONOMIC DEVELOPMENT ZONES

4810.1 A general hospital whose primary location is in an area identified as an Economic Development Zone and certified by the District's Department of Small and Local Business Development as a Developmental Zone Enterprise (DZE) pursuant to D.C. Official Code § 2-218.37 shall receive a District-wide base rate increase of two percent (2%).

4811 INPATIENT SERVICES: TRANSFER AND ABBREVIATED STAY PAYMENT

4811.1 For each claim for Medicaid reimbursement involving a beneficiary transfer to another general hospital, DHCF shall pay the transferring hospital the lesser of the otherwise applicable DRG base payment amount or a prorated payment based on the ratio of covered days to the average length of stay associated with the APR-DRG.

4811.2 The transfer calculation shall apply to the transferring hospital according to the following calculation using the national average lengths of stay (ALOS) available with the APR-DRG grouper:

TRANSFER PAYMENT
=
(DRG BASE PAYMENT / NATIONAL ALOS)
X
(LOS FOR ELIGIBLE DAYS OF THE STAY +1)

4811.3 If the transfer payment adjustment results in an amount greater than the DRG base payment amount without the adjustment, the transfer payment shall be disregarded and the APR-DRG PPS payment amount shall apply.

4811.4 The hospital receiving the beneficiary shall receive the full DRG payment (unless the referring hospital also transfers the beneficiary).

4811.5 All transfers, except for documented emergency cases shall be prior authorized and approved by DHCF, or its designee, as a condition of payment.

4812 INPATIENT SERVICES: SHORT-TERM STAYS AND INELIGIBLE DAYS

4812.1 DHCF shall deny claims for Medicaid reimbursement arising out of a patient admission and discharge on the same date (same-day discharge); and shall instruct the billing provider to bill the services as outpatient services.

4812.2 DHCF shall deny Medicaid reimbursement for same-day discharges unless the patient status indicates death.

4812.3 DHCF shall identify a discharge as a one-day stay when the discharge date occurs on the day following the admission date.

4812.4 DHCF may reimburse a one-day stay as follows:

(a) A claim reflecting a one-day stay may be reimbursed as a hospital stay, but may be subject to post-payment review of the medical necessity of the admission; or

(b) A one-day stay may qualify for a low-cost outlier adjustment pursuant to the low-cost outlier.

4812.5 DHCF shall deny any claim for an inpatient stay that includes ineligible days.

4812.6 A denied claim may be resubmitted for eligible days.

4813 INPATIENT SERVICES: THIRD PARTY LIABILITY AND PATIENT COST-SHARING

4813.1 For Medicaid reimbursement of inpatient hospital discharges, DHCF shall calculate the allowed amount for a service and then subtract third party liability (TPL) and patient cost-sharing in determining the actual payment to the provider.

4813.2 DHCF shall consider a beneficiary to have TPL when the individual receives health care benefits from organizations such as Medicare, commercial health insurance companies, prepaid health plans, health maintenance organizations, and other benefit plans.

4813.3 Where a commercial payer or some other third party (except Medicare) is liable for some portion of the claim, that portion shall be subtracted from the allowed amount.

4813.4 Patient cost-sharing shall relate to any portion that may be due from the patient such as coinsurance, deductibles, or spend-down payments. The cost-sharing amount shall be subtracted from the allowed amount.

4814 SPECIALTY INPATIENT SERVICES: GENERAL PROVISIONS

4814.1 The District of Columbia's Medicaid program shall reimburse claims associated with discharges from specialty hospitals, occurring on and after October 1, 2014, in accordance with the methodology described in Sections 4814 through 4819 of these rules. A claim eligible for payment shall reflect an approved specialty inpatient hospital stay of at least one (1) day or more by a beneficiary who is eligible for Medicaid.

4814.2 A specialty hospital shall be reimbursed either on a per diem (PD) or a per stay (PS) basis using the All Payer Refined-Diagnostic Related Group (APR-DRG) perspective payment system. DHCF adopted the APR-DRG classification system, as contained in the 2014 APR-DRG Classification System Definitions Manual, version 31.0, for purposes of calculating rates set forth in this section. Subsequent versions representing significant changes to the APR-DRG Classification System Definitions Manual may be adopted by DHCF at a later date.

4814.3 For purposes of Medicaid reimbursement, a specialty hospital meets the definition of "special hospital" as set forth in 22-B DCMR § 2099. Specialty hospitals classified as psychiatric hospitals shall be eligible for reimbursement for services that meet the definition at 42 C.F.R. § 440.160 and are provided to beneficiaries ages 21 and under. Specialty hospitals classified as rehabilitation hospitals or Long term care hospitals (LTCHs) shall be eligible for reimbursement for services that meet the definition at 42 C.F.R. § 440.10.

4814.4 For discharges occurring on or after October 1, 2014, the following types of specialty hospitals in the District shall be reimbursed on a PD basis as described at Section 4815:

(a) Psychiatric hospitals;

(b) Pediatric hospitals not eligible for APR-DRG payment under Sections 4800-4813; and

(c) Rehabilitation hospitals.

4814.5 For discharges occurring on or after October 1, 2014, Long-term Care specialty hospitals (LTCHs) in the District shall be reimbursed on a PS basis as described at Section 4816.

4814.6 Out-of-District hospitals that deliver services meeting the definitions at 42 C.F.R. §§ 440.10 and 440.160 shall be reimbursed in accordance with the requirements set forth in Sections 4813, 4814, and 4815.

4814.7 A hospital entering the District of Columbia market after October 1, 2014 shall demonstrate substantial compliance with all applicable laws and policies,

including licensure, prior to contacting DHCF to initiate the rate setting process, including classification as either a per diem or per stay hospital.

4814.8 Each hospital classified within the specialty category shall have a hospital-specific base PD calculated in accordance with Section 4815 or base PS rate calculated in accordance with Section 4816. For purposes of this section, the base year period shall be Fiscal Year (FY) 2013, or October 1, 2012 through September 30, 2013.

4814.9 Cost classifications and allocation methods shall be applied in accordance with the CMS Guidelines for Form CMS 2552-10 and the Medicare Provider Reimbursement Manual 15, or subsequent, superseding issuances from CMS.

4814.10 The hospital specific cost-to-charge ratio (CCR) for specialty hospitals located in the District shall be calculated annually in accordance with 42 C.F.R. § 413.53 and 42 C.F.R. §§ 412.1 through 412.125, as reported on cost reporting Form HFCA 2552-10, Worksheet C Part I, or its successor. For purposes of specialty hospital reimbursement, organ acquisition costs shall not be included in the CCR calculation.

4814.11 Effective FY 2016, beginning on October 1, 2015, and annually thereafter, except during a rebasing year, DHCF shall apply an inflation adjustment to the then current base per diem or per stay rate associated with each specialty hospital. The inflation adjustment factor shall be calculated by multiplying the current base rate with the Medicare inflation factor to equal the adjusted base rate. DHCF shall base the inflation adjustment factor on the appropriate, hospital type specific inflation factor proposed under the Medicare program, set forth in the Hospital Inpatient Prospective Payment Systems (PPS) for general hospitals and the LTCH PPS for the same federal FY in which the rates will be effective.

4814.12 Effective in FY 2019, beginning on October 1, 2018, and every four (4) years thereafter (*i.e.*, quadrennially), the base rate for each specialty hospital shall be rebased as follows:

(a) For rebasing occurring quadrennially on October 1, the updated base rate shall rely on the data set forth in the cost report for the preceding fiscal year, case mix, claims, and discharge data; and

(b) For rebasing of any hospital that enters the District of Columbia market during a non-rebasing year the rebasing shall be paid an interim rate equal to the base rate associated with a comparable specialty hospital until the next rebasing period, provided at least twelve (12) months of data are available prior to rebasing.

4814.13 Out-of-District specialty hospitals, not located in Maryland, shall be reimbursed for inpatient discharges in the same manner as general hospitals, pursuant to Sections 4800-4813.

4814.14 In the event that an out-of-District hospital offers inpatient specialty services that are distinct from services offered by other hospitals, DHCF may consider alternative reimbursement for those specialty inpatient services, provided the needs of Medicaid beneficiaries cannot be met by an in-District hospital.

4814.15 Maryland hospitals shall be reimbursed for specialty inpatient hospital services in accordance with Subsection 4800.12.

4814.16 All specialty hospital inpatient stays and non-emergency transfers shall be prior authorized pursuant to Subsection 4800.5.

4814.17 A specialty hospital located in an EDZ shall receive an increased reimbursement rate pursuant to Subsection 4810.1.

4814.18 Reimbursement of same-day discharges shall occur in accordance with Subsections 4812.1 through 4812.2.

4815 SPECIALTY INPATIENT SERVICES: PER DIEM REIMBURSEMENT (PD-APR-DRG)

4815.1 Reimbursement to the specialty hospitals reimbursed on a PD basis shall be calculated as set forth in this section.

4815.2 Payment based on the PD-APR-DRG method shall be determined as follows:

APR-DRG RELATIVE WEIGHT FOR EACH CLAIM X FINAL BASE RATE
X

NUMBER OF APPROVED DAYS
+
ADJUSTMENTS BASED ON TRANSFER RULE

4815.3 DHCF shall apply national hospital-specific relative value (HSRV) service weights, supplied by 3M™, for each APR-DRG. The case mix adjustment factor may be adjusted to account for any unexpected change in case mix related to improved coding practices.

4815.4 The hospital-specific PD base rate shall be based on costs from each specialty hospital's FY 2013 cost report standardized for variations in case mix, claims, and discharge data. The final PD base rate shall be determined by dividing the Medicaid inpatient operating costs by the Number of Medicaid Discharges in FY 2013.

4815.5 For each PD-APR-DRG specialty hospital claim that involves a transfer to another hospital or health care facility, DHCF shall pay the specialty hospital for the last day of the beneficiary's stay.

4815.6 For discharges occurring on or after October 1, 2014, psychiatric and pediatric hospitals not covered under Sections 4800-4813 shall be paid transition rates. Following submission of the cost report, in accordance with Section 4822, DHCF shall determine allowable costs, notify the hospital of any over- or under-payments made during FY 2015, and establish a final rate for FY 2016.

4816 SPECIALTY INPATIENT SERVICES: PER STAY REIMBURSEMENT (PS-APR-DRG)

4816.1 Reimbursement to the specialty hospitals reimbursed on a PS basis shall be calculated as set forth in this section.

4816.2 Payment based on the PS-APR-DRG method shall be determined as follows:

APR-DRG RELATIVE WEIGHT FOR EACH CLAIM
X
FINAL BASE RATE
+
OUTLIER PAYMENT

4816.3 APR-DRG Relative Weight: DHCF shall apply national hospital specific relative value (HSRV) service weights, supplied by 3M™, for each APR-DRG. The case mix adjustment factor may be adjusted to account for any unexpected change in case mix related to improved coding practices.

4816.4 Final Base Rate: The PS-APR-DRG specialty hospitals shall be combined into one (1) peer group for purposes of establishing base payment rates. The final base year payment rate for each PS-APR-DRG specialty hospital shall be equal to the peer group average cost per discharge, calculated using the weighted average of the hospital specific cost per discharge (CPD) for each specialty hospital in the peer group.

4816.5 The hospital specific CPD shall be adjusted for outlier reserve and shall be determined using the following formula.

MEDICAID INPATIENT OPERATING COSTS
(STANDARDIZED FOR VARIATIONS IN CASE MIX)
÷
NUMBER OF MEDICAID DISCHARGES IN FY 2013

4816.6 The hospital specific CPD shall be determined by dividing Medicaid inpatient operating costs by the Number of Medicaid discharges in FY 2013. The specialty hospital specific CPD, adjusted for case mix, shall be reduced by a net one percent (1%). The one percent (1%) reduction shall be based on five percent (5%) of the cost reserved for payment of claims for the highest cost stays and four percent (4%) of the cost restored to account for the reduction in payment for low cost claims.

4816.7 Medicaid inpatient operating costs shall be calculated by applying the specialty hospital-specific operating CCR, pursuant to Subsection 4814.10, to the allowed charges from the base year claims data.

4817 SPECIALTY INPATIENT SERVICES: CALCULATION OF OUTLIER PAYMENTS FOR PS

4817.1 DHCF shall provide an additional payment for high and low cost outliers.

4817.2 For discharges on or after October 1, 2014, DHCF shall provide an additional payment for specialty inpatient stays when the cost of providing care results in a loss to the hospital that exceeds the high-cost outlier threshold (*i.e.*, high-cost outlier).

4817.3 The Marginal Cost Factor shall be used when calculating the high-cost outlier payment and may be adjusted to limit high-cost payments to no more than five percent (5%) of the overall payments.

4817.4 The loss to the hospital shall be calculated pursuant to the following formula:

LOSS
=
COST (ALLOWED CHARGES X COST TO CHARGE RATIO (CCR))
-
THE DRG BASE PAYMENT

4817.5 The outlier payment is calculated as follows if the loss exceeds the outlier threshold:

OUTLIER PAYMENT
=
(LOSS – OUTLIER THRESHOLD)
X
THE MARGINAL COST FACTOR

4817.6 The PS-APR-DRG payment for the stay shall be the sum of the DRG base payment and the outlier payment, adjusted for transfer pricing, if applicable.

4817.7 The CCR used to calculate the cost of a claim shall be hospital-specific as described at Subsection 4814.10.

4817.8 The high-cost outlier threshold shall be reviewed annually and updated when necessary based upon a review of claims history from the District's previous fiscal year.

4817.9 For discharges occurring on or after October 1, 2014, and annually thereafter, DHCF shall adjust payments for extremely low-cost specialty inpatient cases.

4817.10 Low-cost outliers shall be those cases where the gain on the claim (claim costs minus DRG base payment) exceeds the low-cost outlier threshold. Low-cost outliers shall be determined by using the formula identified at Subsection 4817.4. Each claim with a gain that exceeds the low-cost outlier threshold shall be paid at the lesser of the PS-APR-DRG payment amount or a prorated payment.

4817.11 DHCF shall set the low-cost outlier threshold at a level that results in four percent (4%) or less of PS-APR-DRG payments being associated with low-cost outlier cases.

4817.12 The low-cost outlier calculation shall use the national average lengths of stay (ALOS) available with the APR-DRG grouper as follows:

LOW-COST OUTLIER PAYMENT
=
(DRG BASE PAYMENT / NATIONAL ALOS)
X
(LOS FOR ELIGIBLE DAYS OF THE STAY +1)

4817.13 If the low-cost outlier payment results in an amount greater than the DRG base payment, DHCF shall disregard the low-cost outlier payment.

4817.14 DHCF shall review and calculate the low-cost outlier threshold annually and update where necessary based upon a review of claims history from the previous District fiscal year.

4817.15 For PS-APR-DRG categories where there is insufficient data available to use in calculating a reliable mean or standard deviation, the outlier threshold shall be calculated by multiplying the Weight of the APR-DRG by the Average Outlier Multiplier.

4817.16 For each PS-APR-DRG specialty hospital claim that involves a transfer to another hospital or health care facility, DHCF shall pay the transferring specialty hospital the lesser of the APR-DRG amount or prorated payment shall be calculated as follows:

TRANSFER PAYMENT

=
(DRG BASE PAYMENT / NATIONAL ALOS)
X
(LOS FOR ELIGIBLE DAYS OF THE STAY +1)

4817.17 For specialty inpatient discharges on or after October 1, 2014, LTCHs shall be paid transition rates. Following submission of the cost report, pursuant to Section 4822, DHCF shall determine allowable costs, notify the hospital of any over- or under-payments made during FY 2015, and establish a final rate for FY 2016.

4818 SPECIALTY INPATIENT SERVICES: POLICY ADJUSTER(S)

4818.1 DHCF may apply an age-adjuster to claims associated with specialty hospital inpatient stays where the beneficiary's age falls outside of the age range used to calculate the base rate as is typically associated with that hospital's patient population.

4818.2 In order to ensure budget predictability, monitor payments, and identify deviations from budget targets, DHCF shall make a documentation and coding adjustment (DCA) that reduces the base rate to offset case mix increases due to operational improvements in documentation and coding. DHCF, or its designee, shall evaluate the DCA every six (6) months.

4818.3 Where Healthcare-Acquired Conditions (HAC) assignment impacts the relative weights of a claim, DHCF shall use the weight minus the HAC diagnosis to determine final payment to the specialty hospital.

4819 SPECIALTY INPATIENT SERVICES: CLAIMS SUBMISSION AND UTILIZATION CONTROL

4819.1 A specialty hospital reimbursed on a per diem basis (PD-APR-DRG) shall be required to submit a final claim using Bill Type 114. DHCF, or its designee, shall retrospectively analyze hospital claims records in order to ensure compliance with this requirement.

4819.2 Specialty hospitals shall comply with federally prescribed utilization control standards, pursuant to 42 C.F.R. Part 456 as a condition of receipt of Medicaid reimbursement.

4820 SUB-ACUTE INPATIENT SERVICES: COVERAGE STANDARDS

4820.1 Sub-acute inpatient behavioral health services for Medicaid beneficiaries under the age of twenty-two (22) shall be provided in a structured, twenty-four (24) hour inpatient psychiatric hospital setting and shall represent a lower level of care then acute psychiatric hospital services.

4820.2 Sub-acute services shall be delivered in hospitals that are licensed in accordance with § 3 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1983(D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.* (2012 Repl.)), and meet the definition of "psychiatric hospital," pursuant to 22-B DCMR § 4099.

4820.3 A Medicaid beneficiary shall be eligible for sub-acute services when he or she requires ongoing treatment in an inpatient setting due to persistent symptoms related to a psychiatric episode that required an acute psychiatric hospital stay. A beneficiary may also be eligible for sub-acute services when the services are ordered by a physician or advanced practice registered nurse (APRN) who shall be licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1202, *et seq.*) and implementing regulations.

4820.4 General eligibility criteria for assessing the appropriateness of sub-acute services shall be as follows:

(a) The beneficiary has been diagnosed with the following:

(1) A psychiatric disorder classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM); or

(2) Severe functional impairment as evidenced in the presenting history; and

(b) The beneficiary's psychological and/or physical examination reports at least one of the following:

(1) Suicidal or homicidal ideation without intent, plans, or means;

(2) Impulsivity and/or aggression;

(3) Psycho-physiological condition (*e.g.*, eating disorder);

(4) Affect or function impairment (*i.e.*, withdrawn, reclusive, labile, or reactive);

(5) Sexually inappropriate or abusive behavior;

(6) Psychomotor agitation or retardation;

(7) Increasing mania, hypomania, psychotic, or delusional symptoms;

(8) Habitual substance use with mood disturbances increasing; or

(9) The symptoms associated with the beneficiary's behavioral health condition are expected to improve with continued inpatient treatment and cannot be treated successfully at a lower level of care; and

(c) The beneficiary's family situation and dynamics are such that he or she is unable to safely remain in the home (biological or adoptive).

4820.5 Prior and continued stay authorizations shall be required for Medicaid reimbursement of all sub-acute admissions. DHCF, or its designated agent, shall conduct clinical reviews and determine the appropriateness of authorizing an admission into sub-acute services.

4820.6 All clinical assessments and authorization processes related to sub-acute services shall employ nationally recognized clinical decision support standards.

4820.7 A comprehensive treatment plan shall describe the services to be delivered during the beneficiary's stay in sub-acute and a comprehensive discharge plan shall be developed prior to discharge.

4820.8 At minimum, sub-acute services shall include the following:

(a) Behavior and symptom management;

(b) Clinical assessment;

(c) Milieu therapy focused on skill building and time management;

(d) Multi-disciplinary evaluation;

(e) Nursing services;

(f) Psychopharmacology;

(g) Substance Abuse Education/Counseling; and

(h) Therapy/Counseling (Individual, Family, and Group).

4820.9 Sub-acute services shall not be used as an alternative to diligent, good faith efforts to ensure appropriate community or PRTF placement.

4821 SUB-ACUTE INPATIENT SERVICES: REIMBURSEMENT PRINCIPLES AND METHODS

4821.1 Medicaid reimbursement for sub-acute inpatient behavioral health ("sub-acute") services shall be provided to private, psychiatric hospitals located in the District in accordance with the standards specified in this section.

4821.2 All sub-acute services eligible for Medicaid reimbursement shall be delivered by licensed practitioners of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-77; D.C. Official Code §§ 3-1201.01 *et seq.*), and implementing rules, or comparable law in the state where the practitioner is licensed.

4821.3 Medicaid reimbursement for sub-acute services provided in a psychiatric hospital shall require pre-authorization from DHCF or its designee.

4821.4 Effective Fiscal Year (FY) 2015, beginning October 1, 2014, DHCF shall determine the interim per diem rate for Medicaid reimbursement of sub-acute services using historical rates paid by Medicaid Managed Care Organizations (MCOs) as follows:

(a) DHCF shall take the weighted average of the rates paid by MCOs during the prior FY 2013 for a comparable level of care; and

(b) The weighted average shall become the interim per diem rate paid for sub-acute services during FY 2015, subject to adjustments based on audit findings.

4821.5 For FY 2015 and beyond, DHCF shall determine the final per diem for Medicaid reimbursement of sub-acute services using actual sub-acute costs indicated on the audited cost report.

4821.6 A private, psychiatric hospital shall ensure that the costs associated with providing sub-acute services are distinctly listed in its submitted cost report.

4821.7 The "sending hospital" shall not receive Medicaid reimbursement for the last day of the sub-acute inpatient hospital stay (discharge). Instead, the "receiving hospital" (*i.e.*, private psychiatric hospital) shall receive Medicaid reimbursement for the transfer day as the first day in sub-acute.

4821.8 A psychiatric hospital that delivers sub-acute services under this subsection shall ensure that DHCF, its designee, other District agencies, and representatives from the U.S. Department of Health and Human Services have access to all records for six (6) years after a Medicaid beneficiary reaches age twenty-two (22) as a condition of receipt of Medicaid reimbursement.

4821.9 No Medicaid reimbursement shall be available to a psychiatric hospital that incurs costs for a Medicaid beneficiary's stay that is not authorized by DHCF or its designee.

4821.10 Medicaid reimbursement for sub-acute services' inpatient stays shall not exceed forty-five (45) days.

4822 COST REPORT, AUDIT, AND RECORD MAINTENANCE

4822.1 All general and specialty hospitals enrolled in the District of Columbia Medicaid program shall meet the applicable cost report, audit and record maintenance requirements, as set forth in Sections 4822 and 4823, as a condition of receipt of Medicaid reimbursement.

4822.2 Each hospital shall notify DHCF in writing if the Centers for Medicare and Medicaid Services (CMS) extends the submission date for the cost report filed with the Medicare program.

4822.3 For purposes of compliance with timeframes established within this section, all references to calendar days exclude any federal and District holidays that occur within that span of time.

4822.4 All references to timeframes for sending or receiving documents shall consider receipt to occur five (5) calendar days from the date on the letter, notice or communication.

4822.5 Each in-District general and specialty hospital shall be required to submit to DHCF Form CMS-2552-10, or its successor, issued by CMS, U.S. Department of Health and Human Services (HHS). A valid Form CMS 2252-10 shall include a current Office of Management and Budget (OMB) control number.

4822.6 A complete cost report shall consist of a valid Form CMS-2250-10 and all required supplemental documentation, including an Executive Compensation Schedule.

4822.7 Each in-District hospital delivering inpatient services, identified at Sections 4800 through 4813; specialty services, identified at Sections 4813 through 4819; and outpatient services, identified at 29 DCMR § 903, shall submit a complete cost report as follows:

(a) Annually, within one hundred fifty (150) calendar days after the close of the hospital's fiscal year; or

(b) Within ninety (90) calendar days after the close of the hospital's fiscal year (FY) under the following circumstances:

(1) Upon terminating participation in the District's Medicaid program;

(2) Upon a change in ownership; or

(3) Upon a change in licensure status.

(c) Specialty hospitals paid transition rates, as described in Subsection 4815.6, shall submit a cost report within ninety (90) calendar days after the close of the hospital's fiscal year.

4822.8 Within thirty (30) calendar days of the date on which the cost report is due, the Department of Health Care Finance (DHCF) shall issue a Notice of Delinquency to a hospital that has not timely submitted its cost report or when a submitted cost report is incomplete. The submission of an incomplete cost report shall be treated as a failure to file a cost report.

4822. 9 If a hospital has not submitted a complete cost report within thirty (30) calendar days of the date on the Notice of Delinquency, DHCF shall withhold seventy-five percent (75%) of the hospital's Medicaid reimbursement for the month in which the cost report is due and any subsequent monthly reimbursement occurring prior to the receipt of a complete cost report. DHCF shall promptly disburse withheld reimbursement upon receipt of a complete cost report.

4822.10 DHCF shall provide each hospital with a written summary of its submitted (*i.e.*, unaudited) annual cost report data for the hospital's FY that ends before October 1 of the previous calendar year. The data shall be used to calculate the hospital's reimbursement rates for the District's next FY beginning October 1.

4822.11 Each hospital shall have thirty (30) calendar days from the date of the cost report summary to review and certify the accuracy of cost report data, in writing, or to submit a written request for review and correction of the cost report data.

4822.12 Each hospital's cost report shall be deemed complete and validated thirty (30) calendar days after the date of the cost report summary unless the hospital requests a data review and correction or if the hospital does not provide a timely response.

4822.13 DHCF's review of the cost report data shall be:

(a) Limited to the hospital's allegations that data is incomplete or incorrect;

(b) Supported by documentation submitted by the hospital; and

(c) Solely a data review.

4822.14 If the data review for validating the cost report data results in changes to the data used then DHCF shall use the updated data to determine base rates and add on payments for the District's next fiscal year beginning on October 1.

4822.15 Within thirty (30) days of receipt of the hospital's request, DHCF shall notify the hospital of the results of the data review.

4822.16 A hospital's request for a cost report data review by DHCF shall not be subject to appeal through the Office of Administrative Hearings (OAH).

4822.17 For a specialty hospital that is paid a transition rate, as described in Subsection 4815.6, DHCF shall conduct a post-audit reconciliation after completion of the first District FY during which the transition rate was used. The reconciliation process shall be intended to evaluate the impact of the transition rates compared to the hospital's costs for the base year.

4822.18 The process for reconciliation shall only apply to hospitals that are paid transition rates.

4822.19 The process for reconciliation shall be as follows:

(a) Affected hospitals shall submit to DHCF a cost report as described in Subsection 4822.6;

(b) DHCF, or its designee, shall audit the cost report and determine allowable costs by using Worksheet C, or its successor, of the audited cost report (*i.e.*, determine audited CCR amount);

(c) DHCF, or its designee, shall evaluate claims data representing paid hospital stays during the District's corresponding fiscal year;

(d) Final hospital costs for the District's corresponding fiscal year shall then be determined by applying the audited CCR amount against the charges from the stays during the District's corresponding fiscal year;

(e) Based on final costs, a hospital's base rate for the District's fiscal year under review shall be adjusted in order to reconcile the difference between costs represented in the transition rate and actual costs calculated from the hospital's fiscal year stays and audited CCR amount;

(f) A new hospital base rate shall be calculated using the methodology established for each hospital, taking into account the new cost amount. The new rate shall be the base rate, adjusted annually for inflation until the next rebasing period;

(g) The hospital's stays during the fiscal year under review shall be reprocessed using the new rate, which may result in an overpayment to the hospital or an additional payment to the hospital; and

(h) All claims occurring after FY 2015, but prior to the reconciliation described in Subsections 4822.19(a)-(h), shall be subject to reprocessing. Reprocessing may result in repayment from the hospital or an additional payment to the hospital.

4822.20 DHCF, or its designee, acting on behalf of the District and the U.S. Department of Health and Human Services (HHS), or its designee, shall have the right to conduct audits at any time, upon reasonable notice to the hospital.

4822.21 Each hospital shall maintain sufficient financial records and data to properly determine allowable costs, and shall allow authorized agents of the United States Department of Health and Human Services (HHS) and the District to verify claims and reported costs.

4822.22 For purposes of this rule, an audit shall include a desk or field review or a field or on-site audit.

4822.23 Each hospital shall maintain all of its accounting and related records, including the general ledger and records of original entry, and all transaction documents and statistical data, which shall be considered as permanent records and be retained for a period of not less than six (6) years after the filing of a cost report.

4822.24 Each hospital shall also maintain all related documentation for any audit or appeal that is in progress when the required six (6) year period has tolled until the conclusion of that audit or appeal.

4822.25 Each hospital shall ensure that representatives of the District or federal government have access to any records pertaining to related organizations, as defined in 42 C.F.R § 413.7, including relevant financial records and statistical data to verify costs previously reported to DHCF.

4823 NOTICE AND ADMINISTRATIVE REVIEW

4823.1 All requests for administrative review shall be made in writing and delivered or emailed to the Department of Health care Finance, Reimbursement Analyst (Hospitals), Office of Rates, Reimbursement and Financial Analysis, 441 4th Street, NW, Suite 900 South, Washington, DC 20001, ORRFA-AdminReview@dc.gov. Upon completion of review or audit of annual cost reports (including rebasing years), DHCF shall provide the hospital with written notice of any audit adjustment(s) determined to apply to the hospital's payment rates or cost to charge ratio (CCR).

4823.2 The notice issued from DHCF shall include the following, where applicable:

(a) A description of the audit or rate adjustment including an explanation, by appropriate reference to law, rules, State Plan Amendment, or program manual of the reason in support of the adjustment;

(b) The effective date of the adjustment or change in 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 reasons in support of the adjustment; and

(d) An explanation of the right to request Administrative Review within sixty (60) calendar days after the date of the decision.

4823.3 Each hospital seeking Administrative Review, shall at minimum, provide the following information:

(a) The nature of the adjustment sought;

(b) The amount of the adjustment sought and the total dollar amount involved;

(c) The reasons or factors that the hospital believes justify an adjustment; and

(d) The documentation needed to support the hospital's position, shall be subject to the following:

(1) A description of the total dollar amount involved shall be supported by generally accepted accounting principles; and

(2) A demonstration by the hospital that additional costs are necessary, proper and consistent with efficient and economical delivery of covered patient services.

4823.4 If changes are necessary as a result of the administrative review process, DHCF shall use the recalculated information to determine the rate for the period under review or make appropriate adjustments (for under-or overpayments) to the hospital's payments during the period under review.

4823.5 DHCF shall issue a final written notice within one hundred twenty (120) calendar days after receipt of all requested additional documentation and/or information. The final notice shall include an explanation of the right to request an Administrative Hearing through the OAH within forty-five (45) calendar days of receipt of the final notice.

4823.6 The filing of an administrative appeal with the OAH shall not stay DHCF's action to adjust a hospital's payment rate or recover any overpayments made to the hospital.

4823.7 The methodologies in Sections 4800 through 4819 for all inpatient, including specialty, hospital services shall not be subject to Administrative Review or Appeal. This limitation on review and appeal shall include reimbursement methodology components that are national standards (*e.g.*, relative weights), the District-wide Base Rate, and add-on payments.

4823.8 Hospitals shall not request Administrative Review of the reimbursement methodology for outpatient hospital services under 29 DCMR § 903, the Enhanced Ambulatory Patient Grouping (EAPG) base price, bundling techniques utilized under the EAPG methodology, or the national weights established under the EAPG reimbursement software.

4899 DEFINITIONS

4899.1 For the purposes of this chapter, the following terms shall have the meanings ascribed:

Acute care hospital: The term "acute care hospital" shall include those hospitals providing inpatient services as defined at 42 C.F.R. § 440.10.

APR-DRG Relative Weight: A numerical value which reflects the relative resource requirements for the DRG to which it is assigned.

Base year: The standardized year on which rates for all hospitals for inpatient hospital services are calculated to derive a prospective payment system.

Capital add-on: An add-on payment per discharge that contributes toward hospitals' capital costs by adding supplemental monies to inpatient claim payments.

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

Direct medical education (DME): An add-on payment to reimburse teaching hospitals for direct costs associated with graduate medical education (GME).

District-wide Base Rate: A standardized base amount used to reimburse hospitals reimbursed by DRG. The base rate is the basis of payment for DRG stays.

General Hospital: A hospital that has the facilities and provides the services that are necessary for the general medical and surgical care of patients, including the provision of emergency care by an Emergency Department pursuant to 22-B DCMR § 2099.

Hospital: As defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. § 1395x(e), as revised 1988).

High-cost outliers: Claims in which the computed loss to the hospital exceeds the outlier threshold to qualify for an additional payment.

Indirect medical education (IME): A component of the DRG base rate that is associated with indirect graduate medical education (GME costs and included in the hospital-specific base rate for each in-District general hospital paid under the APR-DRG PPS.

In-District hospitals: Any hospital located within the District of Columbia

Ineligible day: Any day that a patient was not eligible for District Medicaid on the day of service.

Low-cost outliers: Claims in which the computed gain to the hospital exceeds the outlier threshold to qualify for an adjustment to the DRG payment.

Marginal cost factor: A factor used to determine the additional payment for a high-cost outlier.

Medicaid Care Category (MCC): A categorization accepted by DHCF to categorize DRGs into clinical care groupings. Each DRG is categorized into one MCC.

Normal Newborn: A liveborn neonate whose diagnosis is categorized by APR-DRG.

Outlier threshold: The annual minimum dollar amount that the hospital's loss or gain for a claim under APR-DRG PPS must meet in order for a high or low-cost outlier adjustment to DRG payment to be applied, *e.g.*, high cost outlier threshold ($65,000) and low cost outlier threshold ($30,000).

Out-of-District hospital: Any hospital that is not located within the District of Columbia. The term does not include hospitals located in the State of Maryland and specialty hospitals identified at 22-B DCMR § 2099.

Pediatric (Children's) hospital: A hospital engaged in furnishing services to inpatients who are predominantly individuals under the age of twenty-one (21).

Rebase: To review and/or update hospital reimbursement rates when necessary based upon a review of claims history and other relevant financial information.

Specialty Hospital: A hospital that meets the definition of "special hospital" as set forth in 22-B DCMR § 2099 as follows: (a) defines a program of specialized services, such as obstetrics, mental health, orthopedics, long term acute care, rehabilitative services or pediatric services; (b) admits only patients with medical or surgical needs within the defined program; and (c) has the facilities for and provides those specialized services.

Specialty Hospital Per-Diem Payment Method: A payment method which reimburses specific specialty hospitals on a daily basis.

Specialty Hospital Per-Stay Payment Method: A payment method which reimburses specific specialty hospitals based upon the entire time a person is hospitalized.

Transition Rate: An interim PS-APR-DRG or PD-APR-DRG rate established to allow for changes in reimbursement for specialty hospital discharges occurring October 1, 2014-September 30, 2015.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Interim Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, NW, Suite 900, Washington DC 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.