DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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 (2016 Repl. & 2017 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) (2013 Repl.)), hereby gives notice of the adoption of an amendment to Chapter 48 (Medicaid Reimbursement for Inpatient Hospital Services) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulation (DCMR).

Section 1886(h) of the Social Security Act, as added by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) (COBRA), and implemented in regulations at 42 CFR §§ 413.75 through 413.83, establish a methodology for determining payments to hospitals for the costs of approved graduate medical education (GME) programs. Direct Medical Education (DME) adjustments are meant to compensate hospitals for inpatient care costs related to GME program teaching activities.

This final rulemaking makes a technical amendment to 29 DCMR § 4805, concerning Medicaid reimbursement for inpatient hospital services DME add-on payments. This rule clarifies the longstanding policy that DHCF reimburses in-District hospitals directly for DME costs attributable to District Medicaid beneficiaries enrolled in managed care plans. Consistent with the authority DHCF previously exercised under 42 CFR § 438.60, this final rulemaking formalizes DHCF's current policy on reimbursement for DME. There is no anticipated fiscal impact associated with this final rule.

This rule corresponds to a related State Plan Amendment (SPA), which was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services on August 9, 2018 with an effective date of June 1, 2018. The corresponding SPA has been added to the District's Medicaid State Plan, which can be found on DHCF's website at https://dhcf.dc.gov/page/medicaid-state-plan.

A Notice of Proposed Rulemaking was published in the *D.C. Register* on June 1, 2018 at 65 DCR 006054. DHCF received no comments and made no changes to this rule.

This final rule was adopted on September 4, 2018 and shall become effective upon publication of this notice in the *D.C. Register.*

Chapter 48, MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Section 4805, INPATIENT SERVICES: DIRECT MEDICAL EDUCATION (DME), is amended to read as follows:

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.

4805.7 In accordance with 42 CFR § 438.60, DHCF shall reimburse in-District general hospitals directly for DME on behalf of contracted managed care organizations.

4805.8 The per discharge DME add-on payment set forth in Subsection 4805.1 shall be payable by DHCF to in-District general hospitals for all District Medicaid beneficiaries enrolled in managed care plans and those receiving services under the District's fee-for-service benefit.