

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. 774; D.C. Official Code § 1-307.02(2001; Supp. 2008)) 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)(2001; Supp. 2008)) 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 Regulations (DCMR). The effect of these rules is to change the current prospective payment reimbursement methodology for inpatient hospital services for hospitals participating in the Medicaid Program.

The District is updating the payment method for hospital stays based on more current data. The payment rates were originally developed using four (4) peer groups. The four (4) peer groups are children's hospitals, community hospitals, major teaching hospitals, and long-term hospitals. Eight (8) hospitals located in the District of Columbia will now be paid by All Patient-Diagnosis Related Group (APDRG). The method for paying for transfer cases has been changed, consistent with standard practice for Medicaid and Medicare payors. Low-cost inpatient claims will now be paid a partial APDRG payment. Additional changes have been made to the payment methodology for out-of-state hospitals. Out-of-state hospitals, other than hospitals located in Maryland, will be paid by APDRG. The Code of Federal Regulations that is referenced in these rules may be obtained at www.gpoaccess.gov/cfr/index.html.

DHCF is updating its methods and standards, bringing the inpatient payment method to a more current level. The APDRG software currently in use is fifteen (15) years old and does not accommodate current standards of medical coding or claims processing. The updated software will be the 2009 version. Payment rates will be updated to reflect a more current cost of inpatient care.

The corresponding amendment to the District of Columbia State Plan for Medical Assistance ("State Plan") was approved by the Council of the District of Columbia through the Fiscal Year 2010 Budget Support Act of 2009, effective March 3, 2010 (D.C. Law 18-111; 57 DCR 181 (January 8, 2010)). The U.S. Department of Human Services, Centers for Medicare and Medicaid Services (CMS) approved the corresponding State Plan amendment with an effective date of April 1, 2010. The rules became effective April 1, 2010, consistent with CMS approval.

A notice of emergency and proposed rulemaking was published in the *D.C. Register* on March 26, 2010, at 57 DCR 2691. A second notice of emergency and proposed rulemaking was published in the *D.C. Register* on July 30, 2010, at 57 DCR 6837. Comments were received and no changes have been made in response to the comments. No substantive changes were made to the proposed rules. These rules were adopted on May 11, 2011 and shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 48 of title 29 of the District of Columbia Municipal Regulations is amended to read as follows:

Chapter 48 MEDICAID PROGRAM: REIMBURSEMENT

4800 MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

4800.1 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 hospitals in the District of Columbia except:

- (a) Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill (MedLink) Hospital, and National Rehabilitation Hospital;
- (b) Psychiatric hospitals; and
- (c) Out-of-state hospitals other than hospitals located in Maryland as set forth in subsection 4800.6.

4800.2 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 within those hospitals.

4800.3 Payment for each APDRG claim, excluding transfer claims as described in section 4809, shall be based on the following formula:

$$\begin{aligned}
 & \text{APDRG Service Intensity Weight for each claim} \\
 & \quad \times \\
 & \quad \text{Final Base Payment Rate} \\
 & \quad + \\
 & \quad \text{Add-on Payments for Capital and Graduate Medical} \\
 & \quad \quad \text{Education Costs} \\
 & \quad + \\
 & \quad \text{Outlier Payment}
 \end{aligned}$$

4800.4 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.

4800.5 Effective for inpatient hospital discharges occurring on or after April 1, 2010, Medicaid reimbursement to out-of-state hospitals other than hospitals located in Maryland shall be the weighted average base rate of all hospitals in the Community Hospital and Major Teaching Hospital peer groups. Hospitals located in Maryland shall be reimbursed a percentage of charges.

4801 CALCULATION OF BASE PAYMENT RATES

4801.1 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.

4801.2 The base year period shall be the District's fiscal year ending on September 30, 2007.

4801.3 The base year payment rate for each participating hospital shall be based on costs from each hospital's fiscal year 2006 submitted cost report.

4801.4 The base year payment rate shall also be developed using facility case mix data, claims data, and discharge data from all participating hospitals for the District's fiscal year ending September 30, 2007.

4801.5 The costs set forth in subsection 4801.3 shall be updated to 2007 by applying the 2006 cost-to-charge ratio to claims data for 2007.

4801.6 The final base year payment rate for each hospital shall be equal to the peer group average cost per discharge calculated pursuant to section 4803, plus the hospital specific cost per discharge of indirect medical education calculated pursuant to section 4804, subject to a gain/loss corridor as set forth in subsection 4801.7 and adjusted for inflation pursuant to subsection 4801.8.

4801.7 Each hospital's base year payment rate shall not exceed a rate that approximates an overall payment to cost ratio between ninety-five percent (95%) and one hundred percent (100%) for the base year, unless the hospital is in a public-private partnership with the District. The payment to a hospital in a public-private partnership's base year payment shall be set at a rate that approximates an overall payment to cost ratio of one hundred percent (100%) for the base year. The

payment to cost ratio is determined by modeling payments to each facility using claims data from the base year data set.

4801.8 Each hospital's base year payment shall be adjusted from 2007 to June 30, 2010, using an inflation factor obtained from the Centers for Medicare and Medicaid Services (CMS) Hospital Market Basket Index.

4802 CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE

4802.1 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.

4802.2 Medicaid inpatient operating costs for the base year period shall be calculated in accordance with 42 C.F.R. § 413.53 (Determination of cost of services to beneficiaries) and 42 C.F.R. § 412.1 through 412.125 (Prospective payment systems for inpatient hospital services), and as reported on cost reporting Form HCFA 2552-92, Worksheet D-1, Part II, Line 53 (Computation of inpatient operating cost).

4802.3 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 2552-92 and the Medicare Provider Reimbursement Manual 15.

4802.4 Medicaid inpatient operating costs calculated pursuant to subsection 4802.2 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 subsection 4802.5.

4802.5 The indirect medical education adjustment factor for each hospital shall equal $1 + 1.72 * (e \text{ raised to the power of } (\ln(1 + IR/B)) * .405) \text{ minus } 1$ where e is the natural anti log of one point zero (1.0) and \ln is the natural log of one (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 12, Column 1.

4802.6 Medicaid inpatient operating costs calculated pursuant to 4802.2 shall be standardized for variations in case mix by dividing Medicaid operating costs standardized for indirect medical education pursuant to subsection 4802.4 by the appropriate case mix adjustment factor set forth in subsection 4802.7.

4802.7 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 two point five percent (2.5%), which accounts for an expected change in case mix related to improved coding of claims.

4802.8 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.

4802.9 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 cost per discharge, the hospital specific cost per discharge shall be adjusted

4803 CALCULATION OF THE PEER GROUP AVERAGE COST PER DISCHARGE

4803.1 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 4802 for each hospital in the peer group.

4804 CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE OF INDIRECT MEDICAL EDUCATION

4804.1 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 subsection 4802.5.
- (b) The amount established pursuant to subsection 4804.1(a) shall be subtracted from the average cost per discharge adjusted for case mix.

4805 INFLATION ADJUSTMENTS AND REBASING

4805.1 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.

4805.2 After two (2) years of operations of the APDRG prospective payment system, DHCF shall evaluate the need for rebasing and adjustment of the APDRG service intensity weights.

4805.3 All inflation adjustments shall be based on the CMS Hospital Market Basket Index.

4806 CALCULATION OF APDRG SERVICE INTENSITY WEIGHTS

4806.1 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.

4806.2 The average charge per discharge shall be determined by identifying the average charge for cases within each discharge category, excluding outliers.

4806.3 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.

4806.4 The amount calculated in subsection 4806.3 shall be adjusted by a common factor to achieve a District wide case mix of one point zero (1.0) for the base year.

4806.6 The service intensity weights shall be modified periodically as the 3M APDRG weights are updated and new grouper versions are adopted.

4807 CALCULATION OF ADD-ON PAYMENTS

4807.1 The final base payment rate calculated pursuant to section 4801 shall be supplemented by additional payments for capital costs and graduate medical education, as appropriate.

4807.2 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 2552-92, Worksheet D, Part I, Line 101, Columns 4 and 6 and capital costs applicable to hospital inpatient ancillary services, as determined pursuant to subsection 4807.3, by the number of Medicaid discharges in the base year.

4807.3 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.

4807.4 Graduate medical education add-on shall be calculated by dividing the Medicaid graduate medical education costs by the number of Medicaid discharges in the base year.

4807.5 If after an audit of the hospital's cost report for the base year period an adjustment is made to the hospital's reported costs which results in an increase or decrease of

five percent (5%) or greater of the capital cost or graduate medical education add-on payment, the add-on payment for capital or graduate medical education add-on costs shall be adjusted.

4808 CALCULATION OF OUTLIER PAYMENTS

4808.1 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 two point five (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 subsection 4800.3 and the outlier payment calculated pursuant to subsection 4808.2.

4808.2 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:

Outlier threshold minus (allowed charges X hospital cost to charge ratio) X 0.80.

4808.3 The cost to charge ratio is hospital specific and shall be developed based upon information obtained from each hospital's FY 2006 cost report as desk audited by the Department of Health Care Finance.

4808.4 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 twenty-five percent (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.

4808.5 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 subsection 4808.5(a) shall be multiplied by the sum of the number of covered days plus one (1) day.

4808.6 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 two point five (2.5) standard deviations above the mean.

4809 TRANSFER CASES AND ABBREVIATED STAYS

- 4809.1 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 subsection 4808.5.
- 4809.2 The hospital from which the patient is ultimately discharged shall receive a payment equal to the total APDRG payment.
- 4809.3 All transfers, except for documented emergency cases shall be authorized and approved by the Department of Health Care Finance before the transfer as a condition of payment.
- 4809.4 Same day discharges shall not be paid as inpatient hospital stays unless the patient's discharge status is death.

4810 PAYMENT TO OTHER HOSPITALS FOR INPATIENT HOSPITAL SERVICES

- 4810.1 The Hospital for Sick Children, Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill (Medlink), and National Rehabilitation Hospital shall be reimbursed on a per diem basis subject to the TEFRA Target Rate.
- 4810.2 St. Elizabeths 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.
- 4810.3 The Psychiatric Hospital shall be reimbursed on a per diem basis. The per diem rate shall be calculated as follows:
- (a) The base year for purposes of reimbursement shall be the District's FY 2007;
- (b) Inlier claims paid by the Medicaid program for children in the District's FY 2007 shall 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 the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, approved November 29, 1999 (113 Stat.1501; 42 U.S.C. § 1395wwnote);

- (c) The inlier claims paid by Medicaid for children shall be used to develop the reimbursement rates for all beneficiaries, including those age sixty-five (65) and above; and
- (d) For each claim an average per diem shall be calculated by dividing the output of the pricer by the length of stay on the claim. The average per diems shall be summed and divided by the total number of claims to determine the final per diem rate.

4811 COST REPORTING AND RECORD MAINTENANCE

- 4811.1 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.
- 4811.2 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.
- 4811.3 The submission of an incomplete cost report shall be treated as a failure to file a cost report as required by subsection 4811.1, and the hospital shall be so notified.
- 4811.4 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 subsection 4811.3, that its submitted cost report is incomplete.
- 4811.5 If the hospital does not submit a complete cost report within thirty (30) days after 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.
- 4811.6 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.

- 4811.7 Each hospital shall maintain sufficient financial records and statistical data for proper determination of allowable costs.
- 4811.8 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.
- 4811.9 If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.
- 4811.10 Payments made to related organizations and the reason for each payment to related organizations shall be disclosed by the hospital.
- 4811.11 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.

4812 AUDITING AND ACCESS TO RECORDS

- 4812.1 On-site audits shall be conducted not less than once every three (3) years.
- 4812.2 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.

4813 APPEALS FOR HOSPITALS THAT ARE NOT COMPENSATED ON AN APDRG BASIS

- 4813.1 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.
- 4813.2 Within sixty (60) days after the date of the NPR, a 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.
- 4813.3 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.

4813.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred twenty (120) days after the date of receipt of the hospital's written request for administrative review.

4813.5 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.

4813.6 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.

4814 APPEALS FOR HOSPITALS THAT ARE COMPENSATED ON AN APDRG BASIS

4814.1 Hospitals that are compensated on an APDRG discharge basis shall receive Remittance Advice each payment cycle.

4814.2 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 4814.3 or the APDRG assignment shall submit a written request for administrative review to the Agency Fiscal Officer, Audit and Finance, DHCF.

4814.3 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.

4814.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred twenty (120) days after the date of receipt of the hospital's written request for administrative review under subsection 4814.2.

4814.5 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.

4814.6 Filing an appeal with the Office of Administrative Hearings shall not stay an action to recover an overpayment to the hospital.

4815 APPEAL OF ADJUSTMENTS TO THE SPECIFIC HOSPITAL COST PER DISCHARGE OR ADD-ON PAYMENTS

4815.1 After completion of an 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 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 an administrative review within sixty (60) days after the date of the determination.

4815.2 A hospital that disagrees with an audit adjustment or payment rate calculation for the Hospital Specific cost per discharge, capital add-on, or graduate medical education add-on costs shall submit a written request for administrative review to the Agency Fiscal Officer, Audit and Finance Office, DHCF.

4815.3 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.

4815.4 DHCF shall mail a formal response of its determination to the hospital not later than one hundred twenty (120) days after the date of the hospital's written request for administrative review.

4815.5 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.

4815.6 Filing an appeal with the Office of Administrative Hearings shall not stay any action to adjust the hospital's payment rate.

4899 DEFINITIONS

4899.1 For the 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 agency 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 two point five (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.

TEFRA Target Rate – The rate ceiling for hospitals that are not reimbursed on a prospective payment system.