

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES:  
HOSPITAL CARE

**PART II. PAYMENT TO SPECIALTY HOSPITALS FOR INPATIENT  
HOSPITAL SERVICES**

- A. General Provisions:** 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 this section. A claim eligible for payment under this Part shall reflect an approved specialty inpatient hospital stay of at least one (1) day or more by a beneficiary who is eligible for Medicaid.
1. For purposes of Medicaid reimbursement, a specialty hospital meets the definition of "special hospital" as set forth in PART I.A.22.
  2. As described in this section, 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) prospective 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.
  3. Eligible Specialty Hospitals and Classification: The Department of Health Care Finance (DHCF) shall assign each specialty hospital to a reimbursement category based on the nature of the hospital's license, patient case mix, and current billing practices.
    - a. Effective in Fiscal Year (FY) 2015, beginning on October 1, 2014, specialty hospitals in the District shall be categorized as follows:
      - i. Per Diem
        1. Psychiatric hospitals;
        2. Pediatric hospitals not eligible for APR-DRG payment under Part I of this Attachment; and
        3. Rehabilitation hospitals.
      - ii. Per Stay: Long-term care hospitals (LTCHs).
    - b. 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.

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- c. Specialty hospitals classified as rehabilitation hospitals or LTCHs shall be eligible for reimbursement for services that meet the definition at 42 C.F.R. § 440.10.
- d. 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 Item J of this Part.
- e. 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.

4. Cost Reports and Audits

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

5. Records Maintenance and Access to Records

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

6. Appeals

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

**B. Base Year/Base Rate:** Each specialty hospital shall have a hospital-specific base per diem or per stay rate. The base year period shall be the District's Fiscal Year (FY) 2013, or October 1, 2012 through September 30, 2013.

**C. Cost Classification and Allocation Methods:** Cost classifications and allocation methods shall be applied in accordance with the CMS Guidelines applicable to Form CMS 2552-10 and the Medicare Provider Reimbursement Manual 15, or subsequent, superseding issuances from CMS.

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**D. Inflation Adjustment:** 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.

1. DHCF shall base inflation adjustment 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.
2. The inflation adjustment factor shall be calculated using the following formula:

$$\begin{array}{c} [1] \\ \text{Current Base Rate} \\ \times \\ [2] \\ \text{Medicare Inflation Factor} \\ = \\ [3] \\ \text{Adjusted Base Rate} \end{array}$$

**E. Rebasing:** 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.

1. 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, including case mix, claims, and discharge data.
2. Any hospital that enters the District of Columbia market during a non-rebasing year 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.

**F. Policies Specific to Specialty Hospitals:** Reimbursement to specialty hospitals shall be subject to the following policies:

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1. Authorization: All specialty hospital inpatient stays and non-emergency transfers shall be prior authorized and approved by DHCF, or its designee, in order to qualify for reimbursement under this section.
2. Add-on Payment: DHCF shall apply add-on payments to reimbursements to specialty hospitals whose primary location is in an area identified as an Economic Development Zone (EDZ) and certified by the District Department of Small and Local Business Development as a Developmental Zone Enterprise (DZE) pursuant to D.C. Code § 2-218.37. *et seq.* The add-on payment for a hospital considered to be a DZE shall be a two-percent (2%) increase to the hospital's base rate.
3. Same Day Discharges: Same day discharges shall not be reimbursed as inpatient specialty hospital claims unless the patient discharge status indicates the beneficiary's death.

**G. Per Diem Method (PD APR-DRG)**: Reimbursement to the hospitals identified in Item A.3.a.i. of this Part shall be subject to the following:

1. Payment based on the PD APR-DRG method shall be determined using the following formula:

<b>PD APR-DRG FORMULA</b>	
[1] ([APR-DRG Relative Weight for Each Claim] x x [3] [Number of Approved Days])	[2] [Final Base Rate]
+	
[4] Adjustments Based on Transfer Rule	

- a. APR-DRG Relative Weight [1]: DHCF shall apply national hospital-specific relative value (HSRV) service weights, supplied by 3M, for each APR-DRG. The casemix adjustment factor may be adjusted to account for any unexpected change to the casemix related to improved coding practices.

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- b. Final Base Rate [2]: The hospital-specific PD base rate shall be based on costs from each specialty hospital's FY 2013 cost report standardized for variation in case mix, claims, and discharge data. The case mix adjustment factor may be modified to account for any unexpected change in case mix related to improved coding practices. The PD base rate shall be based on the following formula:

$$\frac{\begin{array}{c} \text{[a]} \\ \text{Medicaid inpatient operating costs} \\ \text{(Standardized for variations in case mix)} \\ \div \end{array}}{\begin{array}{c} \text{[b]} \\ \text{Number of Medicaid discharges in FY 2013} \end{array}}$$

- c. Medicaid inpatient operating costs [a] shall be calculated by applying the specialty hospital-specific operating CCR to the allowed charges from the base year claims data.
2. ***Cost-to-Charge Ratio***: 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 each specialty hospital's cost report. For purposes of specialty hospitals reimbursement, organ acquisition costs shall not be included in the CCR calculation.
3. ***Transfer Cases***: 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.
4. ***Transition Base Rate***: Effective for FY 2015, beginning on October 1, 2014 through September 30, 2015, psychiatric and pediatric hospitals not covered under Part I of this attachment shall be paid transition rates. Following submission of the cost report, in accordance with Part V of Attachment 4.19-A, DHCF shall determine allowable costs, notify the hospital of any over- or under-payments made during FY2015, and establish a final rate for FY 2016.

**H. Per Stay Method (PS APR-DRG)**: Reimbursement to the hospitals identified in Item A.3.a.ii. of this Part shall be subject to the following:

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1. Payment based on the PS APR-DRG method shall be determined using the following formula:

**PS APR-DRG FORMULA**

$$\begin{array}{c} [1] \\ \text{([APR-DRG Relative Weight for Each Claim]} \\ \times \\ [2] \\ \text{[Final Base Rate)} \\ + \\ [3] \\ \text{[Outlier Payment]} \end{array}$$

- a. *APR-DRG Relative Weight [1]*: 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.
- b. *Final Base Rate [2]*: 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 (CPD), calculated using the weighted average of the hospital-specific CPD for each specialty hospital in the peer group. The weighted average is obtained by combining cost per discharge detail for all PS APR-DRG stays to form an overall average. The case mix adjustment factor may be modified to account for any unexpected change in case mix related to improved coding practices.
- i. The hospital-specific CPD shall be adjusted for outlier reserve and shall be determined using the following formula:

$$\begin{array}{c} [a] \\ \text{Medicaid inpatient operating costs} \\ \text{(Standardized for variations in case mix)} \\ \div \\ [b] \\ \text{Number of Medicaid discharges in FY 2013} \end{array}$$

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The specialty hospital-specific CPD, adjusted for case mix, shall be reduced by a net one percent (1%). This one percent (1%) reduction is 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.

- ii. Medicaid inpatient operating costs [a] shall be calculated by applying the specialty hospital-specific operating CCR to the allowed charges from the base year claims data. The CCR shall be calculated 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 hospitals reimbursement, organ acquisition costs shall not be included in the CCR calculation.
- c. Outlier Payment [3]: The PS APR-DRG method provides an additional payment for outliers based on inpatient costs.
  - i. High-cost Outliers: 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 that exceeds the high-cost outlier threshold (i.e., high-cost outlier). The goal for PS APR-DRG hospital high-cost outlier payments is to identify an estimated maximum of five percent (5%) of inpatient payments as high-cost outliers. 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 (5%) of the overall payments,

- 1. The loss to the hospital is determined using the following formula:

Cost (Allowed Charges x CCR) - DRG Base Payment

- 2. If the loss exceeds the outlier threshold, then the outlier payment is calculated using the following formula:

(Loss – Outlier Threshold) x Marginal Cost Factor

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3. The PS APR-DRG payment for the stay is the sum of the DRG base payment as described in section H of Attachment 4.19-A, Part I and the outlier payment calculated pursuant to paragraphs R(1)(a)-(b) of Attachment 4.19-A, Part I adjusted for transfer pricing if applicable.
  4. The CCR used to calculate the cost of a claim is hospital-specific as described in section F of Attachment 4.19-A, Part I.
  5. The high-cost outlier threshold is reviewed annually and updated when necessary based upon a review of claims history from the District's previous fiscal year.
- ii. Low-cost Outliers: For discharges occurring on or after October 1, 2014 and annually thereafter, DHCF shall adjust payments for extremely low-cost specialty inpatient cases. Low-cost outliers are cases where the gain on the claim (claims costs minus DRG base payment) exceeds the low-cost outlier threshold. Each claim with a gain that exceeds the low-cost outlier threshold is paid at the lesser of the PS APR-DRG payment amount or a prorated payment as specified in paragraph R(2)(a) of Attachment 4.19-A, Part I. The low-cost outlier threshold is set by DHCF at a level that results in four percent (4%) or less of PS APR-DRG payments being associated with low-cost outlier cases.
1. The low-cost outlier calculation uses the national average lengths of stay (ALOS) available with the APR-DRG grouper as follows:  
$$\frac{(\text{DRG Base payment} \div \text{National ALOS})}{(\text{LOS for eligible days of the stay} + 1)}$$
  2. If the low-cost outlier payment results in an amount greater than the DRG base payment, the low-cost outlier payment is disregarded.

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3. The low-cost outlier threshold is calculated annually and updated when necessary based upon a review of claims history from the District's previous fiscal year.
2. Cost-to-Charge Ratio: 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 each specialty hospital's cost report. For purposes of specialty hospitals reimbursement, organ acquisition costs shall not be included in the CCR calculation
3. Transfer Cases: 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 based on the ratio of covered days to the average length of stay associated with the APR-DRG category. The prorated payment shall rely on the formula described in Item H.1.c.ii. of this Part.
4. Transition Base Rate: For specialty inpatient discharges during the period October 1, 2014 through September 30, 2015, LTCHs shall be paid transition rates. Following submission of the cost report, in accordance with Part V of Attachment 4.19-A, DHCF shall determine allowable costs, notify the hospital of any over- or under-payments made during FY2015, and establish a final rate for FY 2016.

**I. Adjustments**

1. Policy Adjustor: 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.
2. Documentation/Coding Adjustment: 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.
3. Health Care Acquired Conditions (HCACs): HCACs will be processed and paid in accordance with the State Plan standards for payment adjustment for provider preventable conditions, established in Part IV of Attachment 4.19-A.

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**J. Specific Specialty Hospital Reimbursement for Out-of-District Hospitals**

1. Except for hospitals located in Maryland, hospitals located outside of the District of Columbia, that deliver inpatient, specialty services (as described below in item a) shall be reimbursed under the same policy as general hospitals located outside of the District.
  - a. In the event that a hospital outside of the District offers specialty inpatient 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.
2. Maryland hospitals shall be reimbursed in accordance with the Health Services Cost Review Commission (HSCRC)'s All-Payer Model Contract with Center for Medicare and Medicaid Innovation, or its successor.

**K. Claims Submission**

1. In General: All claims shall be submitted in accordance with the requirements established in Attachment 4.19E of the State Plan for Medical Assistance and the most current version of the D.C. Medicaid Inpatient Hospital Billing Manual.
2. Interim Claims: 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.

**L. Utilization Control Requirements**: Specialty hospitals shall comply with federally prescribed utilization control standards, pursuant to 42 C.F.R. Part 456.