Table of Contents

State/Territory Name: Washington, D.C.

State Plan Amendment (SPA) #: 10-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification

Mr. John McCarthy
Deputy Director
Department of Health Care Finance
825 N. Capitol St. NE
Washington, DC 20002

OCT - 6 2010

RE: State Plan Amendment 10-007

Dear Mr. McCarthy:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-007. This amendment modifies DSH reimbursement to add new criteria for qualification and modify the distribution by changing to a District specific formula that uses only uncompensated care related to District residents. This amendment also prescribes certain data reporting requirements for DSH facilities.

We conducted our review of this amendment according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. I am pleased to inform you that Medicaid State plan amendment 10-007 is approved effective July 4, 2010. I have enclosed the approved HCFA-179 and the amended state plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

/s/

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 10-07	2. STATE: District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE July 4, 2010	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447.252 Sections 1902(a)(13) & 1902(e)(7)	7. FEDERAL BUDGET IMPACT a. FFY 10 $0 b. FFY 11 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19A, pp 17-24 a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19A, pp 17-24c

10. SUBJECT OF AMENDMENT:

Disproportionate Share Hospital SPA

11. GOVERNOR'S REVIEW *(Check One)*
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☒ OTHER, AS SPECIFIED
  Resolution Number: 18-187

12. SIGNATURE OF STATE AGENCY OFFICIAL /s/	16. RETURN TO John McCarthy Deputy Director Department of Health Care Finance 825 N. Capitol St., NE Washington, DC 20002
13. TYPED NAME John McCarthy	
14. TITLE Deputy Director, Department of Health Care Finance	
15. DATE SUBMITTED July 9, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED 10-26-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL – 4 2010	20. SIGNATURE OF REGIONAL OFFICIAL /s/
21. TYPED NAME William Lasowski	22. TITLE Deputy Director, CMCS

23. REMARKS

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

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

8. QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL

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

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

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

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

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

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

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

1. The total amount expended by the District for services provided in the same fiscal year under the authority of the Medicaid Waiver to enable the District government to expand coverage of the Medicaid program to childless adults 50 to 64 years of age;

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

3. Five million, six hundred thirty-six thousand, five hundred and seventy-one dollars ($5,636,571) paid to the D.C. Health Care Safety Net Administration for inpatient hospital services and coordinated health care for the uninsured under the D.C. Healthcare Alliance Program (Alliance).

e. The total amount expended by the District for services provided under § 908.4(a) and (b) shall be an amount, as determined ninety (90) days after the end of each fiscal year, which shall equal the sum of:

1. The actual liabilities incurred and received by the District for waiver services to expand coverage of the Medicaid program to childless adults 50 to 64 years of age and any other Medicaid Waiver to expand coverage of the Medicaid program for a population or service not covered as of July 3, 2010; and

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

f. Any hospital which meets the disproportionate share eligibility requirements set forth in §§ 908.1 and 908.2 shall be paid on a quarterly basis.

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

h. Effective July 3, 2010, and in accordance with section 1923(c) (3) of the Social Security Act, the District of Columbia Medicaid Program shall establish three (3) categories of hospitals to pay each hospital that qualifies as a DSH hospital:

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

2. The second category shall include the District's licensed specialty hospital that provides acute care pediatric services and provides the greatest number of Medicaid inpatient days of all hospitals in this category; and

3. The third category shall include all remaining qualifying hospitals that are not included in the first or second categories.

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

1. Each qualifying public psychiatric DSH hospital as set forth in § 908.8(a) shall be paid an amount equal to its total uncompensated care for District residents. The total amount of uncompensated care shall consist of the sum of the following:

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

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

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

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

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

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

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

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

b. For each hospital, multiply the inpatient costs as determined in § 908.9(b) (1) by the percent of inpatient days attributable to individuals served for those costs;

c. For each hospital, multiply the outpatient costs as determined in § 908.9(b) (1) by the percent of outpatient visits attributable to individuals served for those costs;

d. Add the products of §§ 908.9(b) (2) and (3) for all hospitals;

e. For each hospital, calculate the percent distribution by adding the products of §§ 908.9(b) (2) and (3) and then divide by § 908.9(b) (4); and

f. Multiply the percent distribution for each hospital determined in accordance with § 908.9(b) (5) by the annual District DSH limit.

3. The qualifying DSH hospital in the second category shall receive twelve million five hundred thousand dollars ($12,500,000) in addition to the amount calculated in § 908.9(b).

j. For any District Medicaid participating hospital that is reimbursed on a cost settled reimbursement methodology for inpatient hospital services, the uncompensated care amount for Medicaid inpatient services calculated in § 908.9(b)(1)(i) shall be zero.

k. DHCF shall recalculate the DSH payments every year.

l. Any payment adjustment computed in accordance with § 908.9 is subject to the limit on payments to individual hospitals established by section 1923(g) of the Social Security Act. The amount of any payment that would have been made to any hospital, but for the limit on payments established by section 1923(g), shall be distributed proportionately among the remaining qualifying hospitals based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

m. Any DSH payment adjustments computed in accordance with § 908.9 are subject to the limits on payments to Institutions for Mental Disease, established by section 1923(h) of the Social Security Act. The amount of any payment that would have been made to a public or private hospital, but for the limit on payments established by

section 1923(h), shall be distributed proportionately among the remaining qualifying hospitals in the second and third categories, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

n. If, during any fiscal year, the annual District DSH limit is not sufficient to pay the full amount of any DSH payment adjustment computed in accordance with § 908.9, then each hospital in the first, second, and third categories shall be paid a proportional amount of their computed DSH adjustment amount. The final DSH payment for each hospital shall equal the product of its DSH payment adjustment computed in accordance with §908.9 and a fraction determined by the following formula:

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

   2. The denominator shall equal the aggregate DSH payment adjustment for all hospitals computed in accordance with § 908.9.

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

13. Except as provided in section 5d with respect to transplantation surgery performed at Fairfax Hospital in Virginia, reimbursement to out-of-state hospitals for inpatient hospital services shall be based upon a rate equal to the lesser of charges, or the average APDRG payment rate for the District of Columbia peer group in which the hospital providing the service would be classified if it were located in the District. Reimbursement to out-of-state specialty hospitals shall be the lesser of charges, the rate paid had the service been provided in a District specialty hospital or a rate calculated in accordance with the State plan for the state in which the facility is located.