j. 17 RESERVED

J. 18 RESERVED

j. 19 RESERVED

K. MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

k.00.1 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 of the hospitals in the District of Columbia, except:

(a) Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill (MedLink) Hospital and National Rehabilitation Hospital as set forth in section k.10;

(b) Psychiatric hospitals as set forth in section k.10; and

(c) Out-of-state hospitals other than hospitals located in Maryland as set forth in section k.00.5.

k.00.2 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.

k.00.3 Payment for each APDRG claim, excluding transfer claims as described in section k.09, shall be based on the following formula:

APDRG Service Intensity Weight for each claim
X
Final Base Payment Rate
+
Add-on Payments for Capital and Graduate Medical Education Costs
+
Outlier Payment

k.00.4 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.

k.00.5 Effective for inpatient hospital discharges occurring on or after April 1, 2010, Medicaid reimbursement to out-of-state hospitals, including hospitals located within the state of Maryland, shall be reimbursed utilizing the Maryland Medicaid reimbursement methodology, with the exception of out-of-state specialty hospitals providing long term care to children and adolescents which will be paid at a per diem rate.

k.01 CALCULATION OF BASE PAYMENT RATES

k.01.1 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

k.01.2 The base year period shall be the District's fiscal year ending on September 30, 2007.

k.01.3 The base year payment rate for each participating hospital shall be based on costs from each hospital's fiscal year 2006 submitted cost report.

k.01.4 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.

k.01.5 The costs set forth in section k.01.3 shall be updated to 2007 by applying the 2006 cost-to-charge ratio to claims data for 2007.

k.01.6 The final base year payment rate for each hospital shall be equal to the peer group average cost per discharge calculated pursuant to section k.03.1, plus the hospital specific cost per discharge of indirect medical education calculated pursuant to section k.04.1, subject to a gain/loss corridor as set forth in section k.01.7 and adjusted for inflation pursuant to section k.01.8.

k.01.7 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.

k.01.8 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.

k.02 CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE

k.02.1 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.

k.02.2 Medicaid inpatient operating costs for the base year period shall be calculated in accordance with 42 CFR 413.53 (Determination of cost of services to beneficiaries) and 42 CFR 412.1 through 412.125 (Prospective payment systems for inpatient hospital services), as reported on cost reporting Form HCFA 2552-92, Worksheet D-1, Part II, Line 53 (Computation of inpatient operating cost).

k.02.3 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.

k.02.4 Medicaid inpatient operating costs calculated pursuant to section k.02.2 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 section k.02.5.

k.02.5 The indirect medical education adjustment factor for each hospital shall equal 1 + 1.72*(e raised to the power of (ln(1+IR/B))*.405) minus 1) where e is the natural anti log of 1.0 and ln is the natural log of 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 One.

k.02.6 Medicaid inpatient operating costs calculated pursuant to k.02.2 shall be standardized for variations in case mix by dividing Medicaid operating costs standardized for indirect medical education pursuant to k.02.4 by the appropriate case mix adjustment factor set forth in k.02.7.

k.02.7 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 2.5%, which accounts for an expected change in case mix related to improved coding of claims.

k.02.8 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.

k.02.9 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

k.03 CALCULATION OF THE PEER GROUP AVERAGE COST PER DISCHARGE

k.03.1 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 k.02 for each hospital in the peer group.

k.04 CALCULATION OF THE HOSPITAL SPECIFIC COST PER DISCHARGE OF INDIRECT MEDICAL EDUCATION

k.04.1 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 section k.02.5.

(b) The amount established pursuant to section k.04.1(a) shall be subtracted from the average cost per discharge adjusted for case mix.

k.05 INFLATION ADJUSTMENTS AND REBASING

k.05.1 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.

k.05.2 After two years of operations of the APDRG prospective payment system, DHCF shall evaluate the need for rebasing and adjustment of the APDRG service intensity weights.

k.05.3 All inflation adjustments shall be based on the CMS Hospital Market Basket Index.

k.06 CALCULATION OF APDRG SERVICE INTENSITY WEIGHTS

k.06.1 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.

k.06.2 The average charge per discharge shall be determined by identifying the average charge for cases within each discharge category, excluding outliers.

k.06.3 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.

k.06.4 The amount calculated in section k.06.3 shall be adjusted by a common factor to achieve a District wide case mix of 1.00 for the base year.

k.06.5 The service intensity weights shall be modified periodically as the 3M APDRG weights are updated and new grouper versions are adopted.

k.07 CALCULATION OF ADD-ON PAYMENTS

k.07.1 The final base payment rate calculated pursuant to section k.01 shall be supplemented by additional payments for capital costs and graduate medical education, as appropriate.

k.07.2 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 section k.07.3, by the number of Medicaid discharges in the base year.

k.07.3 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.

k.07.4 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.

k.07.5 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.

k.08 CALCULATION OF OUTLIER PAYMENTS

k.08.1 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 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 section k.00.3 and the outlier payment calculated pursuant to section k.08.2.

k.08.2 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:

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

k.08.3 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.

k.08.4 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 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.

k.08.5 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 section k.08.5(a) shall be multiplied by the sum of the number of covered days plus one (1) day.

k.08.6 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 2.5 standard deviations above the mean.

k.09 TRANSFER CASES AND ABBREVIATED STAYS

k.09.1 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 section k.08.5.

k.09.2 The hospital from which the patient is ultimately discharged shall receive a payment equal to the total APDRG payment.

k.09.3 All transfers, except for documented emergency cases shall be prior authorized and approved by the Department of Health Care Finance as a condition of payment.

k.09.4 Same day discharges shall not be paid as inpatient hospital stays unless the patient's discharge status is death.

k.10 PAYMENT TO OTHER HOSPITALS FOR INPATIENT HOSPITAL SERVICES

k.10.1 The Hospital for Sick Children, Washington Specialty-Hadley Memorial Hospital, Washington Specialty-Capitol Hill (MedLink) Hospital and National Rehabilitation Hospital shall be reimbursed on a per diem basis subject to the TEFRA Target Rate.

k.10.2 St. Elizabeth's 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.

k.10.3 The per diem for the Psychiatric Institute of Washington will be calculated in the following manner. The base year for purposes of reimbursement shall be the District's FY 2007. Inlier claims paid by Medicaid for children will 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 Public Law 106-113, the Balance Budget Requirement Act of 1999. The inlier claims paid by Medicaid for children shall be used to develop the reimbursement rate for all beneficiaries including those age sixty-five (65) and above. For each claim an average per diem will be calculated by dividing the output of the pricer by the length of stay on the claim. The average per diems will be summed and divided by the total number of claims to obtain the final per diem.

k.11 COST REPORTING AND RECORD MAINTENANCE

k.11.1 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.

k.11.2 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.

k.11.3 The submission of an incomplete cost report shall be treated as a failure to file a cost report as required by section k.11.1, and the hospital shall be so notified.

k.11.4 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 section k.11.3, that its submitted cost report is

incomplete.

k.11.5 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.

k.11.6 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.

k.11.7 Each hospital shall maintain sufficient financial records and statistical data for proper determination of allowable costs.

k.11.8 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.

k.11.9 If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

k.11.10 Payments made to related organizations and the reason for each payment to related organizations shall be disclosed by the hospital.

k.11.11 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.

k.12 AUDITING AND ACCESS TO RECORDS

k.12.1 On-site audits shall be conducted not less than once every three (3) years.

k.12.2 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.

k.13 APPEALS FOR HOSPITALS THAT ARE NOT COMPENSATED ON AN APDRG BASIS

k.13.1 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.

k13.2 Within sixty (60) days after the date of the NPR, any 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.

k.13.3 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.

k.13.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days after the date of receipt of the hospital's written request for administrative review.

k13.5 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.

k.13.6 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.

k.14 APPEALS FOR HOSPITALS THAT ARE COMPENSATED ON AN APDRG BASIS

k.14.1 Hospitals that are compensated on an APDRG discharge basis shall receive a Remittance Advice each payment cycle.

k.14.2 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 k.14.3 or the APDRG assignment shall submit a written request for administrative review to the Agency Fiscal Officer, Audit and Finance, DHCF.

k.14.3 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.

k14.4 The Medicaid Program shall mail a written determination relative to the administrative review to the hospital no later than one hundred and twenty (120) days after the date of receipt of the hospital's written request for administrative review under section k.14.2.

k.14.5 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.

k.14.6 Filing an appeal with the Office of Administrative Hearings shall not stay an action to recover an overpayment to the hospital.

k.15 APPEAL OF ADJUSTMENTS TO THE SPECIFIC HOSPITAL COST PER DISCHARGE OR ADD-ON PAYMENTS

k.15.1 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.

k.15.2 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.

k.15.3 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.

k.15.4 DHCF shall mail a formal response of its determination to the hospital not later than one hundred and twenty (120) days after the date of the hospital's written request for administrative review.

k.15.5 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.

k.15.6 Filing an appeal with the Office of Administrative Hearings shall not stay any action to adjust the hospital's payment rate.

k.16 DEFINITIONS

For 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 department 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 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.

OS Notification

State/Title/Plan Number:	**District of Columbia 10-00**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**April 6th, 2011**
Fiscal Impact in Millions:	**FY 2010 $1,020,881** **FY 2011 $2,041,762**

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: No
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail: **DC proposes to update their 15 year old PPS. This SPA moves DC's PPS reimbursement methodology to an All-Payer DRG. The APDRG rates are developed using 3 peer groups (children's hospitals, community hospitals, and major-teaching hospitals). The base rates are established using 2006 submitted cost report date inflated to 2007 by applying the '06 cost-to-charge ratio to '07 claims. The hospital specific base year rates (peer group average plus hospital specific IME adjustment) will be adjusted from 2007 to 2010 using CMS' Hospital Market Basket Index.**

Public process requirements were met through publication of an emergency rulemaking in March 2010, along with District hosted provider and association meetings.

DC provided satisfactory answers to the standard funding questions. DC does not currently have supplemental payments to inpatient hospitals.

FFP impact for this amendment is an incremental increase of $1.02 million for 2010 and $2.04 million for 2011.

NFS is from general appropriations, part of which originates from a hospital bed tax. A single public facility provides NFS by CPE through its parent agency – Department of Mental Health – about $115,000 (total comp.) annually.

The SPA is effective April 1 2010.

Other Considerations:

The District of Columbia does not have any federally recognized Indian tribes or Urban Indian Organizations, therefore the Tribal Consultation requirements do not apply.

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and the approval of the SPA is not in violation of ARRA provisions.

CMS Contact: **Gary Knight (304) 347-5723**
National Institutional Reimbursement Team