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:

1. 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).

e. The total amount expended by the District for services under Attachment 4.19A(d)(1) shall be an amount, as determined ninety (90) days after the end of each fiscal

year, which shall equal 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 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 January 1, 2012, and in accordance with section 1923(c) (3) of the Social Security Act, the District of Columbia Medicaid Program shall establish two (2) 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; and

2. The second category shall include all remaining qualifying hospitals that are not included in the first category.

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 Section h.1 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 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 Section h2 by the percent of inpatient days attributable to individuals served for those costs;

c. For each hospital, multiply the outpatient costs as determined in section 2a by the percent of outpatient visits attributable to individuals served for those costs;

d. Add the products for sections 2(b) and (c) for all hospitals;

e. For each hospital, calculate the percent distribution by adding the products of sections 2(b) and (c) and then divide by section 2(d); and

f. Multiply the percent distribution for each hospital determined in accordance with Section 2(f) by the annual District DSH limit.

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 Section 2(a)(i) shall be zero.

k. DHCF shall recalculate the DSH payments every year.

l. Any payment adjustment computed in accordance with Section i 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 Section i 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 category, 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 Section i, then each hospital in the first and second 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 Section i and a fraction determined by the following formula:

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

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

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.

OS Notification

State/Title/Plan Number:	**District of Columbia 11-010**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**March 19, 2012**
Fiscal Impact in Millions:	**FY 2012 $0** **FY 2013 $0**

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: **Effective January 1, 2012, DC 11-010 updates the District's DSH payment methodology by reducing the District's annual DSH allotment by an amount equal to the total amount expended for services provided under any approved Medicaid Waiver to expand coverage for populations or services not covered as of July 3, 2010. The amount of the reduction is equal to the District's best estimate of the total incurred but not yet received liabilities for the approved Medicaid Waiver.**

DC 11-010 also eliminates one DSH payment pool that provides an additional $12.5 million to the licensed specialty hospital that provides acute care pediatric services and the greatest number of Medicaid inpatient days of all hospitals in that category. This elimination does not reduce overall DSH reimbursement. Rather, it moves the $12.5 million from a payment pool for the specific qualifying hospital meeting the above criteria over to a payment pool for all qualifying hospitals.

SPA 11-010 also continues the District's approved redistribution methodology for interim DSH payments that exceed any individual hospital-specific-limits and the methodology to redistribute interim IMD DSH payments in excess of the annual IMD limit to inpatient hospitals with room remaining under their hospital-specific-limits.

Finally, DC 11-010 removes/updates obsolete references to old State Plan language.

Access question were not asked because the amendment is DSH related and because there is no reduction in reimbursement.

FFP impact is $0.

Other Considerations:

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

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

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

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