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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 14-009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 122320144001

AUG 27 2015

Claudia Schlosberg, J.D.
Senior Deputy Director/State Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., Suite 900 South
Washington, D.C. 20001

Dear Ms. Schlosberg:

I am writing to inform you that we have reviewed the District of Columbia's State Plan Amendment (SPA) 14-009 entitled, Payment to Outpatient Hospital for Medical Services. This amendment provides the District with a new reimbursement methodology for Outpatient Hospital Services.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is October 1, 2014.

A copy of the approved SPA pages and signed CMS-179 form are included under this cover.

If you have any further questions regarding this SPA, please contact Alice Robinson Penn at 215-861-4261 or by email at Alice.RobinsonPenn@cms.hhs.gov.

Sincerely,

[redacted]

Francis McCullough
Associate Regional Administrator

Enclosures

cc: M. Diane Fields, DHCF

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: **14-009**

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
October 1, 2014

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 C.F.R. Part 447, Subpart C
1902(a)(13) (E)
1903(a)(1)
1903(n)
1920 and 1926 of the Act

7. FEDERAL BUDGET IMPACT
a. FFY 15 $ 37,700,000
b. FFY 16 $ 38,700,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19B, Part 1, pp.5-6a7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19B, Part 1, pp. 5-6a3

10. SUBJECT OF AMENDMENT:
Payment to Outpatient Hospital for Medical Services

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: PL20-377

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Claudia Schlosberg, JD

14. TITLE
Interim State Medicaid Director

15. DATE SUBMITTED
October 10, 2014

16. RETURN TO

Claudia Schlosberg, J.D.
Interim State Medicaid Director
Department of Health Care Finance
441 4th St. N.W., Suite 900 South
Washington, DC 20001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 10, 2014

18. DATE APPROVED AUG 27 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Frances McCullough

22. TITLE
Associate Regional Administrator

8. OUTPATIENT HOSPITAL SERVICES

a. Reimbursement Methodology Overview

1) This section establishes payment rates for hospital outpatient care defined in accordance with 42 CFR § 440.20 (a). In accordance with 42 CFR § 447.321, the reimbursement methodology to establish payment rates for outpatient hospital services shall not exceed the upper payment limits for similar services under comparable circumstance paid by the Medicare program to hospital providers. The district is using a Cost Based Upper Payment Limit for its Outpatient Services demonstration. Base Cost for the UPL was derived from 2013 Cost Reports, and then inflated to 2015 values, using Health Care specific inflation factors derived by Global Insight. The method for determining cost entailed applying Cost to Charge Ratios (CCRs) from the as filed 2013 2552-10, utilizing Worksheet B, Col. 21, 22, & 26 and Worksheet C, Part I, Col. 6 and 7. CCRs were applied to MMIS Charges from the same base year of 2013. For comparison to the Cost Based 2013 UPL, which was inflated to 2015 values, prospective payments under the newly implemented EAPG methodology were utilized. As the EAPG Outpatient methodology was not implemented until after the base year of 2013, using existing 2013 MMIS data was not as accurate, as those payments were made under a reimbursement method that was obsolete in 2015. Prospective 2015 EAPG payments, developed by Xerox, were used for all but Specialty Hospitals of Washington and Psychiatric Institute of Washington. As those two facilities were not included in the Xerox analysis, 2013 MMIS payments were used, which were proportionally inflated to 2015. Other details associated with this UPL are that out-of--state charges, crossover claims and physician services were excluded.

2) All hospitals, with the exception of Maryland outpatient hospital services, that deliver outpatient services and are enrolled as providers under the Department of Health Care Finance's (DHCF) Medicaid program shall be reimbursed for outpatient services by a prospective payment system (PPS) under the Enhanced Ambulatory Patient Grouping (EAPG) classification system for dates of services beginning on October 1, 2014. Except as otherwise noted in the plan, rates are the same for both governmental and private providers.

3) EAPG is a visit-based patient classification system designed by 3M Health Information Systems (HIS), which uses grouper/pricer software or a grouping algorithm for outpatient services, to characterize the amount and type of resources used during a hospital outpatient visit for patients with similar clinical characteristics. The use of the EAPG classification system shall result in higher payments for higher intensity services and lower payments for lower intensity services.

4) There is no cost settlement for the PPS EAPG system. Prospective payments using the EAPG classification system are considered final. There shall be no retrospective cost settlements after the claim is paid.

5) Maryland hospitals shall be reimbursed in accordance with the Health Services Cost Review Commission (HSCRC)'s All-Payer Model Contract with Centers for Medicare and Medicaid Innovation, or its successor. Under this model Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland will limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent. For more information, please visit http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/.

b. Reimbursement of Outpatient Services Applicable to In-District General Hospitals and Specialty Hospitals

1) **Grouper version and quarterly updates**

a) For dates of services beginning on October 1, 2014, DHCF shall use version 3.8 of the EAPG grouper/pricer software.

b) DHCF shall use an updated EAPG grouper/pricer software version every two (2) years, or when necessary, with an effective date of October 1. The first update shall be implemented in FY 2017, beginning on October 1, 2016.

c) DHCF shall update the EAPG grouper/pricer software on a quarterly basis to accommodate changes in the national Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code sets.

2) **EAPG Relative Weights**

a) For dates of services beginning October 1, 2014, DHCF shall use the national relative weights calculated by 3M for version 3.8 of the EAPG grouper/pricer software.

b) DHCF shall update the EAPG relative weights at a minimum of every two (2) years to coincide with the grouper version upgrades, or more frequently as needed.

3) **Calculating EAPG Conversion Factor:**

a) DHCF shall apply one of three conversion factors to calculate payment:

i. In-District rehabilitation hospitals factor;

ii. District-wide conversion factor for other in-District and out-of-District hospitals (except Maryland hospitals); or

iii. A factor that is two percent (2%) higher than the District-wide conversion factor for hospitals whose primary location is in an area identified as an Economic Development Zone and certified by the District's Department of Small and Local Business Development as a Developmental Zone Enterprise (DZE) pursuant to D.C. Code § 2-218.37.

b) The conversion factors are dependent upon DHCF's budget target, and are calculated using outpatient hospital paid claims data from DHCF's most recent available fiscal year.

i. The base year data for the conversion factors effective FY 2015, beginning on October 1, 2014, shall be historical claims data for outpatient hospital services from the DHCF's FY 2013 (dates of services beginning on October 1, 2012 through September 30, 2013). The budget target for FY 2015 is based on 77% of FY13 costs (average for all hospitals combined) that are inflated forward to FY15 using the CMS Inpatient Prospective Payment System (IPPS)

Hospital Market Basket rate. The base year shall change when the EAPG payment system is rebased and recalibrated with a grouper version and relative weights update every other year.

ii. The budget target for FY15, beginning on October 1, 2014 through September 30, 2015, will be reduced by a 5% coding improvement factor due to the expectation that hospitals will improve coding above 77% of cost. During rate setting simulations, conversion factors were adjusted as necessary to attain the DHCF's overall budget target.

iii. The budget target is subject to change each year. Initially, DHCF shall monitor claim payments at least biannually during DHCF fiscal years 2015 and 2016 to ensure that expenditures do not significantly exceed or fall short of the budget target and will make adjustments to conversion factors. DHCF will provide written notification to the hospitals of the initial conversion factors and any future adjustments to the conversion factors.

iv. DHCF shall analyze claims data annually thereafter to determine the need for an update of the conversion factors. The conversion factors in subsequent years shall be based on budget implications and/or other factors deemed necessary by DHCF. Future changes in the calculation, or reimbursement methodology, of the EAPG conversion factors shall be contingent upon the approval of a state plan amendment.

v. New hospitals shall receive the District-wide conversion factor on an interim basis until the conversion factor annual review during which conversion factors for all hospitals are analyzed and potentially updated. Any changes in rates shall be effective on October 1 of each year.

4) **Calculating Final EAPG Payments**

Payment based on the EAPG method shall be determined using the following formula:

EAPG payment
=
Adjusted EAPG relative weight x policy adjustor (if applicable)
x
Conversion factor

a) Each CPT/HCPCS procedure code on a claim line is assigned to the appropriate EAPG at the line level.

b) Each EAPG has an assigned national relative weight. This relative weight is adjusted by the applicable payment mechanisms including discounting, packaging, and/or consolidation. The adjusted relative weight is then multiplied by the conversion factor to yield the EAPG payment amount for each claim line. The total reimbursement rate for an outpatient hospital claim is the sum of all claim lines.

c) DHCF may also utilize policy adjustors, as appropriate, to ensure that Medicaid beneficiaries maintain access to outpatient services, and ensure adequate provider networks. Effective October 1, 2014, a pediatric policy adjustor will be applied to the national weight for all outpatient visits for children under the age of 21.

d) The amount and type of policy adjustors shall be published in the District of Columbia Municipal Regulations. Any future changes in the types of policy adjustors will be included in state plan amendments and published in the District of Columbia Municipal Regulations.

c. **Reimbursement of Outpatient Services applicable to Out-of-District Hospital Providers**

1) With the exception of Maryland hospitals, outpatient hospital services provided at all out-of-District hospitals shall be paid under the reimbursement methodology based on the EAPG classification system.

2) EAPG relative weights and conversion factors that apply to out-of-District hospitals shall be the same relative weights and conversion factors utilized for in-District hospitals.

d. Coverage and Payment for Specific Services under the EAPG Reimbursement System

1) Laboratory and radiology shall be processed and paid by EAPG, subject to consolidation, packaging, or discounting.

2) Physical therapy, occupational therapy, speech therapy, and hospital dental services shall be processed and paid by EAPGs, subject to consolidation, packaging or discounting.

3) Services with an observation status may be paid under the EAPG payment method. In order to receive reimbursement under the EAPG, claims must include at least eight (8) consecutive hours (billed as units of service). Observation hours in excess of forty-eight (48) shall not be covered.

e. Prior authorizations

DHCF policies for services requiring prior authorization shall apply under the EAPG classification system reimbursement methodology.

f. Exceptions to Reimbursement Under the EAPG Classification System

1) Vaccines for children shall not be payable under EAPG if they are currently paid under the federal government's Vaccine for Children (VFC) program. Vaccines for adults shall be covered and paid under the EAPG pricing.

2) Professional services provided by physicians are not included in the EAPG payment method and shall be billed separately. Payment for physicians' services shall be made in accordance with the DHCF's Medicaid fee schedule.

3) Claims originating from Maryland hospitals, St. Elizabeths Hospital, and managed care organizations shall be excluded from EAPG pricing.

g. Three-day Payment Window

1) Outpatient diagnostic services provided by a hospital one (1) to three (3) days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay.

2) All hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are considered part of the inpatient stay and are not separately payable.

3) This policy applies to general hospitals, both in-District and out-of-District, with the exception of specialty hospitals (described in Part II of Attachment 4.19-A) and Maryland hospitals.

h. Payment Adjustment for Provider Preventable Conditions Policy

Medicaid payment adjustments for Provider Preventable Conditions set forth in Chapter 92 of Title 29 of the District of Columbia Municipal Regulations shall be processed and paid in accordance with the criteria for payment adjustment for provider preventable conditions described under Attachment 4.19-B of the State Plan and corresponding rules.

i. Cost Reports and Audits

An in-District hospital 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.

j. Record Maintenance and Access to Records

All in-District and out-of-District hospitals that provide outpatient services shall maintain records in accordance with the requirements described under Part V, Attachment 4.19-A of the State Plan.

k. Appeals

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

Definitions

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

1. Base year – The standardized year on which rates for all hospitals for outpatient hospital services are calculated to derive a prospective payment system.

2. Budget target- The total amount of claims payment that DHCF anticipates spending on all hospital outpatient claims during its fiscal year.

3. Conversion Factor – The dollar value which is dependent upon the District's budget target and multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable payment for a visit.

4. Consolidation – Collapsing multiple significant procedures into one EAPG during the same visit which is then used to determine payment under the EAPG classification system reimbursement methodology.

5. Discounting - The reduction in payment for an EAPG when significant procedures or ancillary services are repeated during the same visit or in the presence of certain CPT/HCPCS modifiers.

6. Department of Health Care Finance – The single state agency responsible for the administration of the District of Columbia's Medicaid program.

7. DHCF Fiscal year – The period between October 1st and September 30th; used to calculate the District's annual budget.

8. Enhanced Ambulatory Patient Grouping (EAPG) – A group of outpatient procedures, encounters, and/or ancillary services reflecting similar patient characteristics and resource use; incorporates the use of diagnosis codes Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes, and other outpatient data submitted on the claim.

9. EAPG Grouper/Pricer Software – A system designed by 3M Health Information Systems to process HCPCS/CPT and diagnosis code information in order to assign patient visits at the procedure code level to the appropriate EAPG and apply appropriate bundling, packaging, and discounting logic to calculate payments for outpatient visits.

10. EAPG Relative Weight -The national relative weights calculated by 3M Health Information Systems.

11. EAPG Adjusted Relative Weight – The weight assigned to the patient grouping after discounting, packaging, and/or consolidation.

12. General Hospital- A hospital that has the facilities and provides the services that are necessary for the general medical and surgical care of patients, including the provision of emergency care by an Emergency Department in accordance with 22-B DCMR § 2099.

13. New Hospital- A hospital without an existing Medicaid provider agreement that is enrolled to provide Medicaid outpatient hospital services, after September 30, 2014.

14. In-District Hospital- Any hospital that is located within the District of Columbia in accordance with 22-B DCMR§ 2099.

15. Observation Status – Services rendered after a physician writes an order to evaluate the patient for services and before an order for inpatient admission is prescribed.

16. Outpatient Hospital Services – Preventative, diagnostic, therapeutic, rehabilitative, or palliative services rendered in accordance with 42 C.F.R. § 440.20(a).

17. Out-of-District Hospital- Any hospital that is not located within the District of Columbia. The term does not include hospitals located in the State of Maryland and specialty hospitals identified at 22-B DCMR § 2099.

18. Packaging – Including or wrapping payment for certain services in the EAPG payment, along with services that are ancillary to a significant procedure or medical visit.

19. Pediatric Policy Adjustor - A policy adjustor that is based upon the age of the beneficiary and will adjust payment levels based upon a targeted population. The value of the adjustor is determined by comparing payment levels for pediatric visits versus adult visits. The adjustor is a percentage increase of the total payment for the outpatient visit. The value of the policy adjustor will be determined annually during the rate setting process and may be adjusted year to year to ensure necessary access to outpatient hospital services. During claim adjudication, the dollar amount of the adjustor will be calculated as a percent of the EAPG payment and added to the total claim payment. The increased EAPG payment will only be applied to claims for beneficiaries under the age of 21.

20. Specialty Hospital - A hospital that meets the definition of "special hospital" as set forth in 22-B DCMR § 2099 as follows:

    (a) Defines a program of specialized services, such as obstetrics, mental health, orthopedics, long term acute care, rehabilitative services or pediatric services;

    (b) Admits only patients with medical or surgical needs within the defined program; and

    (c) Has the facilities for and provides those specialized services

21. Visit – A basic unit of payment for an outpatient prospective payment system.