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State Name: District of Columbia

State Plan Amendment (SPA)#: 14-011

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

Financial Management Group

APR 08 2015

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

RE: State Plan Amendment 14-011

Dear Ms. Schlosberg:

We have completed our review of State Plan Amendment (SPA) 14-011. This SPA modifies Attachment 4.19-A of the District's Title XIX State Plan. Specifically, the SPA restructures and relocates language outlining provider cost reporting, auditing, and record maintenance requirements, as well as provider appeal rights.

We conducted our review of this SPA 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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving state plan amendment 14-011 effective October 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

/S/

Timothy Hill
Director

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: 14-011	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 1923 of the Act	7. FEDERAL BUDGET IMPACT a. FFY 15 $ 0 b. FFY 16 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19A, Part V, pp. 38-44	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* NEW

10. SUBJECT OF AMENDMENT:
Cost Reports, Auditing, Records Maintenance and Appeals for Hospital 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

/S/	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
13. TYPED NAME Claudia Schlosberg, JD	
14. TITLE Interim State Medicaid Director	
15. DATE SUBMITTED October 10, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED APR 08 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL OCT 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL /S/
21. TYPED NAME Kristin FAN	22. TITLE Deputy Director, FMG

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PART V. COST REPORTS, AUDITING, RECORDS MAINTENANCE, AND APPEALS – HOSPITAL SERVICES

I. COST REPORTS & VALIDATION PROCEDURES

A. Each participating hospital shall be required to submit to DHCF Form CMS-2552-10, or its successor, issued by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS), in accordance with the requirements of this section. A valid Form CMS 2552-10 shall include a current Office of Management and Budget (OMB) control number. A complete cost report shall consist of Form CMS-2552-10 and all required supplemental documentation, including an Executive Compensation Schedule.

B. The cost report shall be completed using Title XVIII (Medicare) Principles of Reimbursement, as described in 42 C.F.R. §§ 413.5-413.178 and the District of Columbia Municipal Regulations.

C. Each hospital shall notify DHCF in writing if the CMS extends the submission date for the cost report filed with the Medicare program.

D. For purposes of compliance with timeframes established in this Part, all references to calendar days exclude any federal and District holidays that occur within that span of time.

E. All references to timeframes for sending or receiving documents shall consider receipt to occur five (5) calendar days from the date on the letter, notice or communication.

F. Each in-District hospital delivering services covered under Attachments 4.19-A, Parts I and II "Inpatient and Specialty Services," and 4.19-B "Outpatient Services", shall submit a complete cost report as follows:

1. Annually, within one hundred fifty (150) calendar days after the close of the hospital's fiscal year; or

2. Within ninety (90) calendar days after the close of the hospital's fiscal year under the following circumstances:

   a. Upon terminating participation in D.C. Medicaid;
   b. Upon a change in ownership; or

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c. Upon a change in licensure status.

3. Specialty hospitals paid transitional rates, as described in Attachment 4.19-A, Part II, shall submit a cost report within ninety (90) calendar days after the close of the hospital's fiscal year.

G. Within thirty (30) calendar days of the date on which the cost report is due, DHCF shall issue a Notice of Delinquency to a hospital that has not timely submitted its cost report or when a submitted cost report is incomplete. The submission of an incomplete cost report shall be treated as a failure to file a cost report.

H. If a hospital has not submitted a complete cost report within thirty (30) calendar days of the date on the Notice of Delinquency, the DHCF shall withhold seventy-five percent (75%) of the hospital's payment for the month in which the cost report is due and any subsequent monthly payments occurring prior to the receipt of a complete cost report. DHCF shall promptly disburse withheld payments upon receipt of a complete cost report.

I. Validation Of Cost Report Data Used For Rate Setting: DHCF shall provide each hospital with a written summary of its submitted (i.e., unaudited) annual cost report data for the hospital's FY that ends before October 1 of the previous calendar year. The data will be used to calculate the hospital's payment rates for the District's next fiscal year beginning October 1 and the following will apply:

1. A hospital shall have thirty (30) calendar days from the date of the cost report summary to review and certify the accuracy of cost report data, in writing, or to submit a written request for review and correction of the cost report data.

2. A hospital's cost report data shall be deemed complete and validated thirty (30) calendar days after the date of the cost report summary unless the hospital requests a data review and correction or if the hospital does not provide a timely response.

3. DHCF's review of the cost report data shall be:

a. Limited to the hospital's allegations that data is incomplete or incorrect;
b. Supported by documentation submitted by the hospital; and
c. Solely a data review.

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4. If the data review for validating the cost report data results in changes to the data used, then DHCF shall use the updated data to determine base rates and add on payments for the District's next fiscal year beginning on October 1.

5. Within thirty (30) calendar days of receipt of the hospital's request, DHCF shall notify the hospital of the results of the data review.

6. A hospital's request for a cost report data review by DHCF shall not be subject to appeal through the Office of Administrative Hearings (OAH).

II. RECONCILING TRANSITION RATES: FOR SPECIALTY HOSPITALS

A. For a specialty hospital paid a transition rate, described in Attachment 4.19-A, Part II, DHCF will conduct a post-audit reconciliation after completion of the first District FY during which the transition rate was used. The reconciliation process is intended to evaluate the impact of the transition rates compared to the hospital's costs for the base year.

B. The process for reconciliation only applies to specialty hospitals that are paid transition rates.

C. The process for reconciliation is as follows:

1. Affected specialty hospitals shall submit to DHCF a cost report as described in item I.F.3. of this Part;

2. DHCF, or its designee, will audit the cost report and determine allowable costs by using Worksheet C, or its successor, of the audited cost report (i.e., determine audited CCR amount);

3. DHCF, or its designee, will evaluate claims data representing paid hospitals stays during the District's corresponding FY.

4. Final hospital costs for the District's corresponding FY will then be determined by applying the audited CCR amount against the charges from the stays during the District's corresponding FY.

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5. Based on the final costs, a hospital's base rate, for the District's FY under review, will be adjusted in order to reconcile the difference between costs represented in the transition rate and actual costs calculated from the hospital's FY stays and audited CCR amount.

6. A new hospital base rate will be calculated using the methodology established for each hospital, taking into account the new cost amount. The new rate shall be the base rate, adjusted annually for inflation, until the next rebasing period.

7. The hospital's stays during the FY under review will be reprocessed using the new rate, which may result in an overpayment to the hospital or an additional payment to the hospital.

8. All claims occurring after FY 2015, but prior to the reconciliation described in this Part, will be subject to reprocessing. Reprocessing may result in repayment from the hospital or an additional payment to the hospital.

III. AUDITING

A. DHCF, or its designee, acting on behalf of the District of Columbia, and the U.S. Department of Health and Human Services (HHS), or its designee, shall have the right to conduct audits at any time, upon reasonable notice to the hospital.

B. Each hospital shall maintain sufficient financial records and data to properly determine allowable costs, and shall allow authorized agents of HHS and the District of Columbia to verify claims and reported costs.

C. For purposes of this section, "audit" includes a desk or field review or a field or on-site audit.

IV. RECORDS MAINTENANCE

A. Each hospital shall maintain all of its accounting and related records, including the general ledger and records of original entry, and all transaction documents and statistical data, which shall be considered as permanent records and be retained for a period of not less than six (6) years after the filing of a cost report.

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B. Each hospital shall also maintain all related documentation for any audit or appeal that is in progress when the required six (6) year period has tolled until the conclusion of that audit or appeal.

C. Each hospital shall ensure that representatives of the District or federal government have access to any records pertaining to related organizations, as defined in 42 C.F.R. § 413.7, including relevant financial records and statistical data to verify costs previously reported to DHCF.

V. ADMINISTRATIVE REVIEW:

All requests for administrative review shall be made in writing and delivered or e-mailed to the Department of Health Care Finance, Reimbursement Analyst (Hospitals), Office of Rates, Reimbursement and Financial Analysis, 441 4th Street, NW, Suite 900 South, Washington, DC 20001, ORRFA-AdminReview@dc.gov .

A. Notice of Audit Adjustments: Post-Audit of Base Year and Any Rebasing Years

1. Upon completion of review or audit of annual cost reports (including rebasing years), DHCF shall provide the hospital with written notice of any audit adjustment(s) determined to apply to the hospital's payment rates or cost to charge ratio (CCR).

2. The notice from DHCF shall include the following:

   a. A description of the audit or rate adjustment including an explanation, by appropriate reference to law, rules, state plan amendment or program manual of the reason in support of the of the adjustment;

   b. The effective date of the adjustment or change in payment rate;

   c. A summary of all audit or payment rate adjustments made to reported costs, including an explanation, by appropriate reference to law, rules, or program manual, of the reasons in support of the adjustment; and

   d. An explanation of the right to request Administrative Review within sixty (60) calendar days after the date of the decision.

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3. A hospital seeking Administrative Review shall, at minimum, provide the following information:

    a. The nature of the adjustment sought;

    b. The amount of the adjustment sought and the total dollar amount involved;

    c. The reasons or factors that the hospital believes justify an adjustment; and

    d. The documentation being submitted to support the hospital's position, subject to the following conditions:

        i. A description of the total dollar amount involved must be supported by generally accepted accounting principles; and

        ii. A demonstration by the hospital that additional costs are necessary, proper and consistent with efficient and economical delivery of covered patient services.

4. If changes are necessary as a result of the administrative review process, DHCF shall use the recalculated information to determine the rate for the period under review, or make appropriate adjustments (for under or overpayments) to the hospital's payments during the period under review.

5. DHCF shall issue a final written notice within one hundred twenty (120) calendar days after receipt of all requested additional documentation and/or information. The final notice shall include an explanation of the right to request an Administrative Hearing through the OAH within forty-five (45) calendar days of receipt of DHCF's final notice.

B. **Scope of Administrative Review: Limitations**

1. The methodologies governing reimbursement for inpatient hospital services, Parts I and II of this Attachment, shall not be subject to Administrative Review or Appeal. This limitation on review and appeal includes reimbursement methodology components that are national standards (e.g., relative weights), the District-wide Base Rate (under Part I), and add-on payments.

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2. With regard to outpatient hospital services under Attachment 4.19-B, hospitals may not request Administrative Review of the reimbursement methodology, the Enhanced Ambulatory Patient Grouping (EAPG) base price, bundling techniques utilized under the EAPG methodology, or the national weights established under the EAPG reimbursement software.

VI. APPEALS

A. A hospital may appeal DHCF's final Administrative Review decision if the request for appeal is filed with the District of Columbia Office of Administrative Hearings (OAH) within forty-five (45) calendar days of receipt of DHCF's notice of the decision.

B. The filing of an administrative appeal with OAH shall not stay DHCF's action to adjust the hospital's payment rate or recover any overpayments made to the hospital.