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State/Territory Name: DC

State Plan Amendment (SPA) #: 21-0021

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

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

March 1, 2022

Melisa Byrd
Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

RE: State Plan Amendment 21-0021

Dear Ms. Byrd:

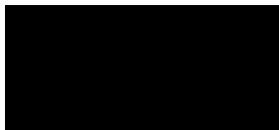
We have reviewed the referenced amendment to Attachment 4.19-A of your Medicaid State Plan. This amendment establishes a new category of disproportionate share hospitals and implements updated payment standards for the newly created class.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This letter is to inform you that Medicaid State Plan Amendment is approved effective October 1, 2021. The CMS-179 and amended plan pages are enclosed.

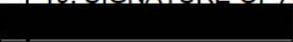
If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Respectfully,



Rory Howe
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 21-0021	2. STATE: DC
		3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT	
TO: CENTER DIRECTOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: October 1, 2021	
5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR § 447.294-299 and Title XIX of the Social Security Act		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars): a. FFY 2022: <u>\$9,400,000.00</u> b. FFY 2023: <u>\$9,200,000.00</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19 A Part III, pages 29-34a		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19 A Part III, pages 29-34	
9. SUBJECT OF AMENDMENT: Disproportionate Share Hospital Payment			
10. GOVERNOR'S REVIEW (Check One)			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: D.C. Act: <u>22-434</u>	
11. SIGNATURE OF STATE AGENCY OFFICIAL 		15. RETURN TO Melisa Byrd Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 th Street, NW, 9 th Floor, South Washington, DC 20001	
12. TYPED NAME Melisa Byrd			
13. TITLE Senior Deputy Director/Medicaid Director			
14. DATE SUBMITTED December 23, 2021			
FOR CMS USE ONLY			
16. DATE RECEIVED December 23, 2021		17. DATE APPROVED 3/1/2022	
PLAN APPROVED – ONE COPY ATTACHED			
18. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2021		19. SIGNATURE OF APPROVING OFFICIAL 	
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe		21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group	
22. REMARKS			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES:
HOSPITAL CARE

**PART III. QUALIFICATIONS FOR A DISPROPORTIONATE SHARE
HOSPITALS**

1. 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 have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals and:
 - A. 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
 - B. The hospital's low income utilization rate exceeds twenty-five per cent (25%).
 2. 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.
 3. 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. This 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.
 4. The District of Columbia may limit the total DSH payments that it will make to qualifying DSH hospitals beginning July 3, 2010, and make 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:
 - A. 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:
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FY 11 \$25,955,244; FY12 \$42,482,047; FY13 \$63,062,394; and FY14 \$19,218,676 (FY14 represents the 1st quarter of FY2014).

5. The total amount expended by the District for services under Attachment 4.19A, III.4.A, 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.
6. Any hospital which meets the disproportionate share eligibility requirements shall be paid on a quarterly basis.
7. 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 a DSH hospital.
8. Effective October 1, 2021, and in accordance with section 1923(c)(3) of the Social Security Act, the District of Columbia Medicaid Program shall establish the following three (3) categories of hospitals to pay each hospital that qualified as a DSH hospital:
 - A. The first category shall include all public psychiatric hospitals, which includes St. Elizabeth’s Hospital.
 - B. The second category shall include qualifying hospitals who provide more than 25% of total uncompensated care days for all qualifying hospitals and more than 25% of total uncompensated care outpatient visits for all qualifying hospitals, as reported to the District on the DHCF DSH Data Collection Tool.
 - C. The third category shall include all remaining qualifying hospitals that are not included in the first or second categories.
9. The annual District DSH limit to DSH qualifying hospitals shall be distributed as follows:

TN NO. 21-0021

Approval Date March 1, 2022

Effective Date October 1 2021

Supersedes

TN No. 14-13

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- A. Each qualifying public psychiatric DSH hospital as set forth in Part III.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:
 - 1. Medicaid allowable inpatient and outpatient hospital costs, minus reimbursement for these costs;
 - 2. 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 C.F.R. § 447; and
 - 3. Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth 42 CFR § 447.

- B. The qualifying hospitals in the second category shall be paid in accordance with the following methodology:
 - 1. 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 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 C.F.R. §447; and
 - iii. Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 C.F.R. § 447.

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2. In years when total payment to all qualifying hospitals would cause the District to exceed the annual District DSH limit there shall be deemed no qualifying hospitals in the second category and all qualifying hospitals not in the first category shall be paid in accordance with section 9.C.
- C. The qualifying hospitals in the third category shall be paid in accordance with the following methodology:
1. 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 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 C.F.R. §447; and
 - iii. Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 C.F.R. § 447.
 2. For each hospital, multiply the inpatient costs as determined in Part III.9.C.1.i-iii by the percent of inpatient days attributable to individuals served by those costs;
 3. For each hospital, multiply the outpatient costs as determined in Part III.9.C.1.i-iii by the percent of outpatient visits attributable to individuals served for those costs;
 4. Add the products for Part III.9.C.2 and 3 for all hospitals and the uncompensated care for the hospitals in category two determined in Part III.B.1;

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- 5. For each hospital, except those in category one, calculate the percent distribution by adding the products of Part III.9.C.2 and 3 and the uncompensated care for the hospitals in category two determined in Part III.B.1 and then divide by Part III.9.C.4; and
 - 6. To determine the DSH payment for each hospital, except those in category 1, multiply the percent distribution for each hospital determined in accordance with Part III.9.C.5 by the annual District DSH limit reduced by the payment to hospitals in category one determined in Part III.9.A.
10. 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 Part III.9.A.1 shall be zero.
 11. DHCF shall recalculate the DSH payments every year.
 12. Any payment adjustment computed in accordance with Part III.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.
 13. Any DSH payment adjustments computed in accordance with Part III.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, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

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 Part III.9, 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 Part III.9 and a

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fraction determined by the following formula:

- A. The numerator shall equal the annual aggregate DSH limit; and
- B. The denominator shall equal the aggregate DSH payment adjustment for all hospitals computed in accordance with Part III.9.

14. 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 Part, the following terms shall have the meaning 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 revenues of the 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 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.

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New Provider — Any District hospital that meets the qualifications of a DSH hospital pursuant to the requirements set forth in this Part 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 for in 42 C.F.R. § 447.