OS Notification

State/Title/Plan Number:	**District of Columbia 12-06**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**January 1, 2013**
Fiscal Impact in Millions:	**FY 2013 ($27,057,046)** **FY 2014 ($28,896,925)**

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 12-006 modifies the District's inpatient hospital reimbursement methodology to approximate an average payment-to-cost ratio of 98% for all hospitals. The current methodology was effective on April 1, 2010. Near the end of 2011, DC analyzed the impact of that payment methodology and discovered that reimbursements were higher than intended. This SPA implements a methodology that maintains payments at a level slightly below cost.

DC 12-006 moves hospitals in Maryland (and other out-of-state hospitals) serving District Medicaid recipients from reimbursement based on the Maryland inpatient methodology to reimbursement at 94% of covered charges as allowed by Maryland's rate commission, with a couple exceptions for specialty facilities. The out-of-state specialty hospitals will be reimbursed at the rate of their DC peers. This SPA also removes automatic annual inflation adjustments from rates, and limits post-audit reimbursement adjustments to only those exceeding +/- 5%.

DC satisfactorily responded to access questions. Public notice was provided on September 21, 2012. Non-federal share from appropriations

Other Considerations:

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

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

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

CMS Contact: **Gary Knight – 304.347.5723**
National Institutional Reimbursement Team

9. All claims for inpatient services are settled in accordance with the D.C. State Plan and federal laws and regulations in effect on the date of service.

10. Participating inpatient hospital providers are required to submit uniform cost reports.

11. The Medical Assistance Administration provides for periodic audits of financial and statistical records and cost reports of participating providers.

12. The Medical Assistance Administration provides an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates.

(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 reason in support of the adjustment; and

(d) A statement informing the hospital of the right to request and 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 direct 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. 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.

k.14.4 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 a review or 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;

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, an amount equal to seventy-five percent (75 %) of the hospital's payment for the month that the cost report was due shall be withheld each month until the cost report is received.

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 The Medicaid Program reserves the right to conduct an audit at any time upon reasonable notice to the provider.

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. Effective October 1, 2012 and annually thereafter, thresholds shall be adjusted for inflation, based upon the CMS market basket factor for hospitals.

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] or other factors that results in an estimated maximum of 5% of inpatient payments as high cost outliers. This factor shall be set as of October 1, 2012 and annually thereafter, based upon a review of claims history from the District's previous fiscal year.

k.08.3 The cost to charge ratio is hospital specific. Effective October 1, 2012 and annually thereafter, it shall be developed based upon information obtained from each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior calendar year.

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. Effective October 1, 2012, and annually thereafter, the threshold shall be adjusted for inflation, based upon the CMS market basket factor for hospitals.

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

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 direct medical education; as appropriate.

k.07.2 Effective October 1, 2012, 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 2552-10, Worksheet D, Part I, Line 200, Columns 1 and 3, or its successor, 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 Direct medical education add-on shall be calculated by dividing the Medicaid direct medical education costs by the number of Medicaid discharges in the base year.

k.07.5 Effective October 1, 2012, and annually thereafter, the base year payment rate for capital costs and direct medical education add-on payments for each participating hospital shall be based on costs from each hospital's submitted or audited cost report for the fiscal year that ends prior to October 1 of the prior year.

k.07.6 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 direct medical education add- on payment, the add-on payment for capital or direct 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

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 **REBASING**

k.05.1 Effective October 1, 2012, DHCF shall evaluate the need for rebasing and adjustment of the APDRG service intensity weights subsequent to hospital audits.

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.

calculated by applying the hospital specific operating cost-to-charge ratio to allowed charges from the base year claims data. The cost-to-charge ratio 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 2552-10. Worksheet C Part I, (Computation of ratio of cost to charges), or its successor, except that organ acquisition costs shall be excluded.

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 2552-10 and the Medicare Provider Reimbursement Manual 15 or any subsequent guidance issued by the federal Department of Health and Human Services.

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 be the factor calculated by Medicare for each hospital based on the hospital cost report for the base year period as defined in k.01.2.

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.01.2 Effective October 1, 2012, the base year period shall be each hospital's fiscal year that ends prior to October 1, 2011.

k.01.3 Effective October 1, 2012, the payment rate for each participating hospital shall be based on costs from each hospital's submitted cost report for the fiscal year that ends prior to October 1, 2011, as well as facility case mix data, claims data, and discharge data from all participating hospitals for the District's fiscal year ending September 30, 2011.

k.01.4 Effective October 1, 2013 and annually thereafter, the base payment rate for each hospital shall be based on costs from each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior year, as well as facility case mix data, claims data, and discharge data from all participating hospitals for the District's most recently completed fiscal year.

k.01.5 Effective October 1, 2012 and annually thereafter, the costs set forth in section k.01.3 shall be updated annually by applying the cost-to-charge ratio determined by each hospital's submitted cost report for the fiscal year that ends prior to October 1 of the prior calendar year.

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 Subject to federal upper payment limits, each hospital's base year payment rate shall not exceed a rate that approximates an overall payment to cost ratio of ninety-eight percent (98%) for the base year. The payment to cost ratio is determined by modeling payments to each facility using claims data from the District's most recently completed fiscal year.

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

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 Medicaid inpatient discharges occurring on or after October 1, 2012, hospitals located within the State of Maryland shall be reimbursed 94 percent of covered charged as allowed by the Maryland Health Services Cost Review Commission (MHSCRC), except that:

(a) Adventist Behavioral Health (Potomac Ridge), Sheppard Pratt and any other specialty psychiatric hospital located within the State of Maryland shall be paid the lessor of the hospital's submitted charges or the rate paid to hospitals in k.00.1(b); and

(b) Adventist Rehabilitation Hospital and any other specialty rehabilitation hospital shall be paid the lessor of the hospital's submitted charges or the TEFRA Target Rate for National Rehabilitation Hospital as set forth in k.10.1.

(c) Kennedy Krieger shall be paid a per diem consistent with Maryland's reimbursement methodology.

k.00.6 Out of state hospitals in states other than Maryland shall be reimbursed a DRG payment. The DRG base rate for out of state hospitals is the weighted average of the base rates for hospitals in the Community Hospital peer group, as defined in k.01.1(b).

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

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 Hospital, Hospital for Sick Children and National Rehabilitation Hospital as set forth in section k.10;

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

(c) Hospitals located in Maryland as set forth in section k.00.5.

(d) Other out-of-state hospitals as set forth in section k.00.6.

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 Direct Medical

Education Costs

+

Outlier Payment