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State Name: District of Columbia

State Plan Amendment (SPA)#: 18-0003

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

August 7, 2018

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

RE: State Plan Amendment 18-0003

Dear Ms. Schlosberg:

We have completed our review of State Plan Amendment (SPA) 18-0003. This SPA modifies Attachment 4.19-A of the District's Title XIX State Plan. Specifically, the SPA formalizes the District's direct medical education policy for services provided through the managed care delivery system.

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 18-0003 effective June 1, 2018. 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/

Kristin Fan
Director

Enclosures
cc: Alice Weiss

bcc: Francis McCullough, ARA, RO3
Teia Miller Manager, FMB RO3
Sabrina Tillman-Boyd, Manager, POB RO3
Frankeena Wright , DC State Lead
Lisa Carroll, CO NIRT
Official NIRT File

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: **18-003**	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: **June 1, 2018**	

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	7. FEDERAL BUDGET IMPACT
42 CFR §§ 438.6 and 438.60	**FFY 18: $ 0** **FFY 19: $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Part 1: Pages 10-10a	**Attachment 4.19-A, Part 1: Page 10**

10. SUBJECT OF AMENDMENT:

Direct Graduate Medical Education Payment to General Hospitals on behalf of Managed Care Organizations

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: D.C. Act: 21-463

12. SIGNATURE OF STATE AGENCY OFFICIAL /S/	16. RETURN TO Claudia Schlosberg, J.D. Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4th Street, NW, 9th Floor, South Washington, DC 20001
13. TYPED NAME: **Claudia Schlosberg J.D.**	
14. TITLE: **Senior Deputy Director/Medicaid Director**	
15. DATE SUBMITTED: JUN 25 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED August 7, 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL June 1, 2018	20. SIGNATURE OF REGIONAL OFFICIAL /S/
21. TYPED NAME Janet Freeze / for Kristin Fan	22. TITLE Director, FMG

23. REMARKS

FORM CMS-179 (07-92) *Instructions on Back*

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

Part 1. Payment to General Hospitals for Inpatient Medical Services

2. For discharges occurring on or after October 1, 2014, the DME add-on payment for each in-District general hospital is based on costs from each hospital's submitted or audited cost report for the fiscal year, subject to the limits described below in paragraphs L(3) and L(4).

3. For discharges occurring on or after October 1, 2014, the District limits DME to two hundred percent (200%) of the average District-wide cost of DME per Medicaid patient day. The District-wide average cost per Medicaid patient day is based on submitted cost reports for the base year. The average cost per patient day is calculated by dividing total Medicaid DME cost for all DME eligible hospitals by the total number of Medicaid days for those hospitals, as reported on the hospital cost reports. The per-day amount is translated to a per discharge amount for each hospital, based on Medicaid utilization information in the cost report.

4. For discharges occurring on or after October 1, 2015, DME costs for each hospital are limited to the per discharge equivalent of one-hundred fifty percent (150%) of the average District-wide cost of DME per Medicaid patient day. The average District-wide cost per Medicaid patient day is based on submitted cost reports for the base year.

5. 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 for which results in an increase or decrease of five percent (5%) or greater of the DME add-on payment, the add-on payment for DME add-on costs is adjusted prospectively to reflect the revised costs.

6. DME Payment to General Hospitals on behalf of Managed Care Organizations

   a. In accordance with 42 CFR 438.60, DHCF shall reimburse in-District general hospitals directly for DME on behalf of contracted managed care organizations.

   b. The per discharge DME add-on payment set forth in L(1) shall be payable by DHCF to in-District general hospitals for all District Medicaid beneficiaries enrolled in managed care plans and those receiving services under the District's fee-for-service benefit.

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

Part 1. Payment to General Hospitals for Inpatient Medical Services

M. Capital Add-on Payments

1. Capital is a per-discharge add-on payment that applies to in-District general hospitals only. For discharges occurring on or after October 1, 2014, capital add-ons are limited to one hundred percent (100%) of the District average capital cost per Medicaid patient day. This is calculated