

DEPARTMENT OF HEALTH CARE FINANCE**NOTICE OF EMERGENCY AND PROPOSED RULEMAKING**

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in section 1 of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), and section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6)), hereby gives notice of the adoption, on an emergency basis, of an amendment to Chapter 9 (Medicaid Program) of Title 29 of the District of Columbia Municipal Regulations (DCMR). The effect of the amendment is to establish a new payment distribution for those hospitals who qualify as disproportionate share hospitals (DSH) in the District of Columbia. The DSH payment methodology provides a payment to hospitals that serve a disproportionate share of low income or uninsured patients. This payment is made in addition to the regular payments such hospitals receive for providing care to Medicaid recipients.

These proposed rules will: (1) create a new qualifying criterion for DSH hospitals which will ensure the hospitals that provide a disproportionate share of uncompensated care in the District of Columbia qualify as a DSH hospital; (2) modify the distribution of DSH funds paid to District hospitals by limiting the distribution formula to only include uncompensated care delivered to District residents; (3) change the distribution formula from the standard federal formula that is not based on uncompensated care to a District specific formula that is based on actual reported uncompensated care; (4) adjust the DSH distribution formula to reward hospitals that serve a relatively higher percentage of individuals that are insured through public insurance programs such as Medicaid and the D.C. Healthcare Alliance Program; and (5) require all participating District hospitals to report certain data to DHCF through the DSH Data Collection tool.

The reason for the proposed changes is to ensure that hospitals that serve a disproportionate share of District residents with public insurance or without insurance receive a fair share of the DSH dollars to cover the losses associated with serving these individuals. Because the total DSH pool is determined pursuant to federal law, there will not be an increase or decrease in aggregate expenditures. There will only be a redistribution of DSH dollars.

Many of the hospitals receiving DSH funding are in financial distress. If the corresponding State Plan amendment is approved, these rules will allow the District to distribute the DSH funding in the fourth quarter of the District's fiscal year 2010. Emergency action is necessary for the immediate preservation of the health, safety, and welfare of persons who are in need of hospital services.

The corresponding amendment to the District of Columbia State Plan for Medical Assistance (State Plan) was approved by the Council of the District of Columbia through

the Fiscal Year 2010 Budget Support Act of 2009, effective March 3, 2010 (D.C. Law 18-111; 57 DCR 181). These rules shall become effective on July 3, 2010, if the corresponding State Plan amendment has been approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) with an effective date of July 3, 2010, or the effective date established by CMS in its approval of the corresponding State Plan amendment. If approved, DHCF will publish a notice which sets forth the effective date of the rules.

The emergency rulemaking was adopted on June 18, 2010 and shall become effective on July 3, 2010. The emergency rules will remain in effect for one hundred and twenty (120) days or until October 16, 2010, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 908 (QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

908 QUALIFICATIONS FOR A DISPROPORTIONATE SHARE HOSPITAL

908.1 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 has 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%).

908.2 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 as required in § 908.1.

908.3 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.

908.4 The District of Columbia may limit the total DSH payments that it will make to qualifying DSH hospitals beginning July 3, 2010, and 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 the sum of the following:

- (a) The total amount expended by the District for services provided in the same fiscal year under the authority of the Medicaid Waiver to enable the District government to expand coverage of the Medicaid program to childless adults 50 to 64 years of age;
- (b) 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; and
- (c) Five million, six hundred thirty-six thousand, five hundred and seventy-one dollars (\$5,636,571) paid to the D.C. Health Care Safety Net Administration for inpatient hospital services and coordinated health care for the uninsured under the D.C. Healthcare Alliance Program (Alliance).

908.5 The total amount expended by the District for services provided under § 908.4(a) and (b) shall be an amount, as determined ninety (90) days after the end of each fiscal year, which shall equal the sum of:

- (a) The actual liabilities incurred and received by the District for waiver services to expand coverage of the Medicaid program to childless adults 50 to 64 years of age and any other Medicaid Waiver to expand coverage of the Medicaid program for a population or service not covered as of July 3, 2010; and
- (b) 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.

908.6 Any hospital which meets the disproportionate share eligibility requirements set forth in §§ 908.1 and 908.2 shall be paid on a quarterly basis.

908.7 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 DSH hospital.

- 908.8 Effective July 3, 2010, and in accordance with section 1923(c)(3) of the Social Security Act, the District of Columbia Medicaid Program shall establish three (3) categories of hospitals to pay each hospital that qualifies as a DSH hospital:
- (a) The first category shall include all public psychiatric hospitals, which includes St. Elizabeths Hospital;
 - (b) The second category shall include the District's licensed specialty hospital that provides acute care pediatric services and provides the greatest number of Medicaid inpatient days of all hospitals in this category; and
 - (c) The third category shall include all remaining qualifying hospitals that are not included in the first or second categories.
- 908.9 The annual District DSH limit to DSH qualifying hospitals shall be distributed as follows:
- (a) Each qualifying public psychiatric DSH hospital as set forth in § 908.8(a) shall be paid an amount equal to its total uncompensated care. 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 CFR § 447; and
 - (3) Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 CFR § 447.
 - (b) The qualifying hospitals in the second and 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'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 CFR § 447; and
 - (iii) Uncompensated inpatient and outpatient care determined in accordance with the requirements set forth in 42 CFR § 447;
- (2) For each hospital, multiply the inpatient costs as determined in § 908.9(b)(1) by the percent of inpatient days attributable to individuals served for those costs;
 - (3) For each hospital, multiply the outpatient costs as determined in § 908.9(b)(1) by the percent of outpatient visits attributable to individuals served for those costs;
 - (4) Add the products of §§ 908.9(b)(2) and (3) for all hospitals;
 - (5) For each hospital, calculate the percent distribution by adding the products of §§ 908.9(b)(2) and (3) and then divide by § 908.9(b)(4); and
 - (6) Multiply the percent distribution for each hospital determined in accordance with § 908.9(b)(5) by the annual District DSH limit.
- (c) The qualifying DSH hospital in the second category shall receive twelve million five hundred thousand dollars (\$12,500,000) in addition to the amount calculated in § 908.9(b).

908.10 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 § 908.9(b)(1)(i) shall be zero.

908.11 DHCF shall recalculate the DSH payments every year.

908.12 Any payment adjustment computed in accordance with § 908.9 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.

908.13 Any DSH payment adjustments computed in accordance with § 908.9 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 in the second and third categories, based on the ratio of the hospital's hospital-specific payment adjustment to the aggregate DSH payment adjustment for all hospitals.

908.14 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 § 908.9, then each hospital in the first, second, and third 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 § 908.9 and a fraction determined by the following formula:

- (a) The numerator shall equal the annual District DSH limit; and
- (b) The denominator shall equal the aggregate DSH payment adjustment for all hospitals computed in accordance with § 908.9.

908.15 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.

908.99 DEFINITIONS

908.99 For purposes of this section, the following terms shall have the meanings 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 such 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 charity care in the fiscal year, minus the portion of the cash subsidies reasonably 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.

New Provider - Any District hospital that meets the qualifications of a DSH hospital pursuant to the requirements set forth in § 908.1 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 forth in 42 CFR § 447.

Persons desiring to comment on these proposed rules should submit comments in writing within thirty (30) days after publication of this notice in the *D.C. Register* to Dr. Julie Hudman, Director, the Department of Health Care Finance, 825 North Capitol Street, N.E., 6th Floor, Washington, D.C. 20002. Copies of these proposed rules and related information may be obtained between 8:30 a.m. and 5:00 p.m. Monday through Friday, excluding holidays, at the address stated above.