STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

INPATIENT HOSPITAL

The department reimburses inpatient hospital services provided by acute care, specialty, and psychiatric hospitals using rates determined in accordance with the following principles, methods, and standards complying with sections 1902(a)(13)(A) [42 U.S.C. 1396a], 1902(a)(30), and 1923 of the Social Security Act (the Act) and the Code of Federal Regulations at 42 CFR §§ 447.250 - 447.257, 447.271, 447.272, 447.280, 447.294 - 447.299, and 447.554 – 447.555.

I. Introduction

Alaska Statutes 47.07.070 – 47.07.900 and the Alaska Administrative Code at 7 AAC 105 - 160 contain the rate-setting principles and methods.

A. For the purposes of this section, the following definitions apply:

1. Acute Care Hospital – is a facility that provides inpatient hospitalization for medical and surgical care of acute illness or injury and perinatal care.

2. Specialty Hospital – is a rehabilitation hospital operated primarily for the purpose of inpatient care, assisting in the restoration of persons with physical disabilities.

3. Psychiatric Hospital – is a facility that primarily provides inpatient psychiatric services for diagnosing and treating mental illness; “psychiatric hospital” does not include a residential psychiatric treatment center or psychiatric residential treatment facility.

B. The department uses the following data sources:

1. When rebasing occurs, the Medicare Cost Report for the facility’s fiscal year, ending 12 months before the fiscal year for which the prospective payment rates are to be re-based (base year);

2. Budgeted capital costs for the rate year, submitted by the facility and reviewed and adjusted by the department as appropriate in accordance with Section II, for capital projects or acquisitions placed in service after the base year and before the end of the rate year, and for which the department grants a certificate of need;

3. Year-end reports containing historical financial and statistical information submitted by the facility for past rate-setting years; and

4. Utilization and payment history report (commonly known as the MR-O-14) provided by the Division of Health Care Services.

II. Allowable Costs

Allowable costs are documented costs that are ordinary and necessary in delivering a cost-effective service. Allowable costs are those directly relating to the Title XIX Medicaid program recipients. Costs include those necessary to conform with state and federal laws, regulations, and quality and safety standards.

Most of the elements of allowable Medicaid costs are defined in the Medicare Publication 15-1, and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost-finding process.

- Advertising cost is allowable only to the extent that the advertising is directly related to patient care.

The reasonable costs of the following types of advertising and marketing are allowable:

- Announcing the opening of, or change of name for, a facility;
- Recruiting for personnel;
- Advertising for the procurement or sale of items;
- Obtaining bids for construction or renovation;
- Advertising for a bond issue;
- Listing of a provider in a telephone directory for informational purposes;
- Listing a facility's hours of operation; and
- Advertising that is specifically required as part of a facility's accreditation process.

Allowable patient-related costs include wages, salaries, and employee benefits; purchased services (services contracted for and performed by a third party rather than a hospital's in-house staff); supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense.

Facilities may claim a maximum of 75% of membership dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Base year costs and rate calculations may be adjusted for regulatory changes in allowable costs that become effective after the last adjustment for inflation.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation is limited to the amounts described within the certificate of need application and other information the facility provided as a basis for the approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department considers:

A. The terms of issuance describing the nature and extent of the activities authorized by the certificate; and
B. The facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing, and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III. Specific Costs Not Allowable

- Advocacy and lobbying expenses, along with any costs related to these activities;

- Physician compensation costs and related charges associated with providing care to patients for purposes of calculating a prospective payment rate;
- Medical services that a facility or unit of a facility is not licensed to provide;
- Costs not authorized by a certificate of need when a certificate of need is required;
- Management fees or home office costs that are not reasonably attributable to the management of the facility; home office costs may not exceed those reported in the most recently audited Medicare Home Office Cost Report;
- Bad debts, charity, contractual adjustments, and discounts taken by payers; and
- Return on investment is for any facility.

Costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue, and the judgment does not include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

IV. Inflation Adjustments

The department annually adjusts the allowable base year costs for inflation. Inflation adjustments may be reduced if a facility fails to file its year-end reports with the department within the prescribed regulatory timeline. The department utilizes the most recent quarterly publication of Global Insight's "Health Care Cost Review," available 60-days before the beginning of a facility's fiscal year. The department utilizes the Global Insight Hospital Market Basket for the inflation adjustment relating to allowable non-capital costs. The department adjusts the allowable capital, and allowable home office capital, using the most recent CMS base year PPS Hospital Capital Input Price Index (IPI) reported in the Global Insight Health Care Costs and Building Cost Indexes.

V. Determination of Prospective Payment Rates

The prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per day rate reflecting costs related to patient care and attributable to the Medicaid program.

The department determines prospective payment rates under one of three methodologies – basic, optional, and new facilities.

A. Basic Prospective Payment Rate Methodology

The prospective payment rate consists of four components – (1) capital costs for routine cost centers, (2) non-capital costs for routine cost centers, (3) capital costs for ancillary cost centers, and (4) non-capital costs for ancillary cost centers. The prospective payment rates are annual rates based on the facility's fiscal year. The department rebases all facilities no less than every four years.

The department computes the prospective per day rates for inpatient acute care, specialty, and psychiatric hospitals as follows:

1. Medicaid-specific base year capital routine costs per day – The department divides the total allowable base year capital costs for each routine cost center by the total inpatient days in that cost center. The department multiplies the resulting per day cost by the allowable paid Medicaid days in that cost center to arrive at the Medicaid allowable base year routine capital costs for that cost center. The department divides the total Medicaid allowable base year capital costs for all routine cost centers by the

sum of the allowable paid Medicaid inpatient days for all routine costs centers, which results in the facility's base year Medicaid-specific capital routine cost per day.

2. Medicaid-specific base year non-capital routine costs per day – The department divides the total allowable base year costs, excluding capital costs for each routine cost center, by the total inpatient days in that cost center, and the resulting per day cost is multiplied by the allowable paid Medicaid days in that cost center to arrive at the Medicaid allowable base year routine costs for that cost center. The department divides the sum of the Medicaid allowable base year costs for all routine cost centers by the sum of the allowable paid Medicaid inpatient days for all routine cost centers, which results in the facility's base year Medicaid-specific non-capital routine cost per day.

3. Medicaid-specific base year capital ancillary cost per day – The department applies the percentage of base year capital costs in each ancillary cost center to the Medicaid ancillary costs for the cost center calculated by first dividing the allowable ancillary costs by the total inpatient days and applying the resulting per day costs to paid Medicaid inpatient days. The department divides the Medicaid allowable capital costs for all ancillary cost centers by the sum of the allowable paid Medicaid inpatient days for all ancillary cost centers, which results in the facility's base year Medicaid-specific capital ancillary cost per day.

4. Medicaid-specific base year non-capital ancillary cost per day – The department removes the total Medicaid allowable capital costs for all ancillary cost centers, determined in subsection A-3 (above), from the total base year Medicaid-specific ancillary costs, which are determined by dividing the total base year ancillary costs by the total inpatient days and applying the resulting amount to the total paid Medicaid inpatient days. The resulting base year allowable ancillary cost is divided by paid Medicaid inpatient days to arrive at the facility's base year Medicaid-specific non-capital ancillary cost per day.

The department adjusts each base year component rate for inflation per section IV and totals to arrive at the facility's prospective payment rate.

The department adjusts the capital components of the prospective payment rate for certificate of need assets placed into service if their total value is at least $5 million. This adjustment reflects the appropriate capital costs for the prospective year based on the certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

In determining the prospective payment rates, nursery days (a calendar day related to inpatient nursing care of a newborn infant in a hospital nursery) constitute inpatient days, and swing-bed days do not constitute inpatient days. The department removes costs and charges associated with swing-bed services, determined by applying the swing-bed rate in the base year to the number of swing bed days, before calculating the prospective payment rate. The Medicaid inpatient days are covered days from payment history reports (MR-O-14) generated by the Division of Health Care Services for the routine cost centers. For the ancillary cost centers, Medicaid inpatient days are covered days from the MR-O-14 payment history reports.

In the first year and the subsequent two years after the following events, the prospective payment rates for facilities calculated and paid on a per-day basis – as discussed in this section – will be no higher than the per-day rates proposed in the certificate of need application and other information provided as a basis for the review and approval of the certificate of need:

- opening of a new or modified health care facility;
- alteration of bed capacity; or
- implementation date of a change in categories of offered health services or bed capacity.

If the department grants a certificate of need for additional beds to a facility, the additional capital payment add-on to the per day rate includes the base year's inpatient days plus additional days associated with the additional beds. The department calculates the additional days as the base year's occupancy percentage multiplied by 80 percent, then multiplied by the additional beds approved in the certificate of need, and finally multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public.

Facilities licensed as Critical Access Hospitals are exempt from this provision and reimbursed at 100% of the rate calculated under the provisions of subsection V-A.

B. Optional Prospective Payment Rate Methodology and criteria for Small Facilities

A facility with 4,000 or fewer total inpatient hospital days as an acute care, specialty, or psychiatric hospital, or as a combined hospital-nursing facility during the (facility's) fiscal year ending 12 months before the beginning of its prospective payment rate year during the previous calendar year, may elect reimbursement for inpatient hospital services under provisions of this subsection. If a facility meeting this criterion does not elect to participate during its first fiscal year, the facility may not elect to participate under the provisions of this subsection until after a rebasing under the provisions of subsection V-A.

The department determines the prospective payment rate pursuant to subsection V-A until a rebasing occurs.

A facility electing reimbursement under this subsection must have an agreement with the department that will not expire, lapse, or be revoked before four fiscal years.

An agreement may be renewed after expiration if the facility still qualifies for reimbursement under this subsection. Rebasing the prospective payment rate for the renewed agreement occurs per subsection V.

For a facility that was not reimbursed under the optional payment rate methodology for small hospitals before its first fiscal year beginning after December 31, 2000, that elects to be reimbursed per subsection V-A, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires is determined per subsection V-A except that the non-capital and capital components of the payment rate are adjusted annually for inflation, except when the state implements cost containment, after the first year by 3.0 percent and 1.1 percent respectively.

1. The department allows increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement and based on this subsection if meeting the following conditions:

    a. The assets placed into service have a value of at least $5,000,000;
    b. The facility obtains one or more certificates of need for the assets placed into service; and
    c. The facility provides a detailed budget that reflects the allowance of the new assets to calculate the allowed change in the per-diem rate.

2. The administrative appeals process in subsection VIII is not available; the facility may use the "exceptional relief" process in subsection XII, except when the facility disputes a department action or decision relating to the following:

    a. The facility's eligibility to elect rate setting under this subsection;
    b. The violation of a term of the rate agreement between the facility and the department;
    c. The denial of an increase in the capital component of the prospective payment rate for new assets and a related approved certificate of need.

C. New Facility Prospective Payment Rate Methodology

The following definitions apply in this subsection:

New Facility – A new facility is a facility that has not, within the previous 36 months, provided the same or similar level of Medicaid-certified patient services within 25 miles of the facility either through present or previous ownership.

New Provider - A new provider is an actively enrolled Medicaid facility, currently receiving reimbursement for Medicaid services outside the state prospective payment system, and electing to enter the state prospective payment system.

The department calculates the rates for a new facility or a new provider, as follows:

For critical access acute care and specialty hospitals, the department establishes the inpatient per day rate at the statewide weighted average of inpatient per day rates using the most recent 12 months of permanent Medicaid rates for critical access acute care and specialty hospitals in accordance with this section; patient rates are the statewide weighted average using the base year's total patient days.

The inpatient per stay rate for acute care hospitals will be the statewide weighted average diagnosis-related groups (DRG) base rate determined during the next biennial or triennial DRG update.

For inpatient psychiatric hospitals, the department establishes the inpatient prospective payment rate at the statewide weighted average of inpatient per day rates for psychiatric hospitals, using the most recent 12 months of permanent Medicaid rates; rates are the statewide weighted average using the base year's total patient days.

The department establishes prospective payment rates for new facilities and new providers under the provisions of this section after the reporting of two full years of cost data.

VI. Sale of Facilities

Per Section 1861(v)(1)(O) of the Social Security Act (the Act), the department values an appropriate allowance for depreciation, interest on capital indebtedness, and (if applicable) return on equity capital for an asset of a facility that has changed ownership at the lesser of the allowance acquisition cost of the asset to the owner of record, or the acquisition cost of the asset to the new owner. Additionally, the provisions of Section 1861(v)(1)(O)(ii) of the Act limit the recapture of depreciation expense on the disposition of assets accommodating gains under the Medicaid program. The provisions of Section 1861(v)(1)(O)(iii) of the Act limit payment for acquisition costs associated with buying and selling of the facility.

VII. Adjustment to Rates

The department sets all rates for facilities. Facilities have the opportunity to provide additional information regarding significant changes that could impact rates.

On its own motion, or at the request of an applicant, the department may reconsider its actions within 30-days. Nothing precludes a facility from petitioning the department for additional consideration at any time during its fiscal year.

Reconsiderations are warranted only when the proper application of the methods and standards described in Attachment 4.19-A are in question or challenged.

VIII. Provider Appeals

If a party is aggrieved due to a departmental rate-setting decision, the party may appeal and request either reconsideration or an administrative hearing. Hearing officers appointed by the governor conduct all administrative hearings. A party must file an administrative appeal within 30-days of the date the department mails or otherwise transmits the notice of a decision.

The hearing officer hears a case per the administrative law of the State of Alaska. The hearing officer prepares draft findings, conclusions, and orders for commissioner review. The commissioner reviews the hearing officer's findings and may accept, reject, or modify the recommendations. If the party is dissatisfied after the administrative hearing process, the party may contest the actions of the department and the rate set via judicial review.

IX. Audit Function

The department has statutory authority to audit Medicaid prospective payment rates data. The department adopts audit findings that affect the prospective payment rates and incorporates them into future prospective rate calculations. This means that, even though an audit is not complete before the passage of the subsequent year and retroactive recoupment does not occur, the department incorporates the audit results into the rate calculations for future periods, as applicable.

X. Inappropriate Level of Care

The department reimburses for hospital patients receiving services at an inappropriate level of care, under conditions described in Section 1861(v)(l)(G) of the Act, at lower rates reflecting the level of care received, consistent with the Act. The payment rate under this scenario is the average statewide rate for swing bed days. The department uses the same methodology for skilled nursing facility (SNF) services and intermediate care facility (ICF) services; it does not differentiate between the types of services. The swing bed rate is a composite rate weighted by patient days. It is a summation of each facility's payment rate for the preceding calendar year multiplied by each facility's patient days and divided by the total patient days of all SNF and ICF facilities. The

department determines and approves the swing bed rate before the beginning of the calendar year and is based, where applicable, on estimated data.

Without exception, the department continues paying lower rates to inpatient hospitals when patients receive care at either the skilled or intermediate level nursing services.

XI. Hospitals Serving a Disproportionate Share of Low-Income Patients

A. As required by Sections 1902(a)(13)(A) and 1923(a)(l) of the Act, the Alaska Medicaid reimbursement system accounts for hospitals serving a disproportionate number of low-income patients with special needs by making a payment adjustment for qualifying hospitals. Hospitals serving a disproportionate number of low-income patients with special needs may receive a payment adjustment based on the following criteria and methods.

To be eligible for a disproportionate share payment, a hospital must:

1. Be an acute care hospital, a critical access hospital, a specialty hospital, or a psychiatric hospital;

2. Meet the obstetrical staffing requirements of 42 U.S.C 1396r-4(d) and must provide the names and Medicaid provider numbers of at least two obstetricians meeting the requirements of that section unless it qualifies for the exception set out in 42 U.S.C 1396r-4(d)(2); and

3. Have a minimum Medicaid utilization rate of not less than one percent for the qualifying year.

Disproportionate Share Hospital (DSH) payments are subject to several requirements, including federal allocation of DSH funds, legislative appropriation of DSH funds, facility-specific limits on receipt of DSH funds, and other requirements identified in the state plan. The department intends to make DSH payments to facilities satisfying the requirements related to their service to low-income patients with special needs. To accomplish this goal, the department intends to adjust DSH payments to ensure they cover, to the maximum extent permitted by the state's DSH allotment from the federal government, the costs incurred on behalf of Medicaid and uninsured patients.

B. DSH Payment Classifications

An eligible hospital may receive a DSH payment under one or more of the following classifications:

1. Medicaid Inpatient Utilization Disproportionate Share Hospital (MIU DSH)

A hospital eligible for a DSH payment may qualify for an MIU DSH payment adjustment if it has a state Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in the state.

The in-state Medicaid inpatient rate is a fraction, expressed as a percentage, for which the numerator is a hospital's Medicaid-eligible inpatient days for the qualifying fiscal year, and the denominator is the total number of the hospital's inpatient days, including the Medicaid managed care days (if any) for the qualifying year. The mean of Medicaid inpatient utilization rates for all in-state hospitals is a fraction, expressed as a

percentage, for which the numerator is the total number of Medicaid-eligible inpatient days, including Medicaid managed care days (if any) in the qualifying year for all in-state hospitals, and the denominator is the total number of inpatient days for all in-state hospitals for their qualifying year.

2. Low Income Disproportionate Share Hospital (LI DSH)

A hospital eligible for a DSH payment may qualify for an LI DSH payment adjustment if the hospital has a low-income utilization rate exceeding 25 percent.

The department calculates the low-income utilization rate as the sum of

a. A fraction expressed as a percentage, for which the numerator is the sum total of the Medicaid hospital revenue paid to the qualifying in-state hospital for patient services provided to Medicaid-eligible patients, including Medicaid managed care patients (if any) in its qualifying year and all cash subsidies received directly from the state or local governments for patient services provided in its qualifying year. The denominator is the total amount of hospital revenue for services, including cash subsidies specified in this subparagraph for the hospital's qualifying year; and
b. A fraction expressed as a percentage, for which the numerator is the total amount of the qualifying hospital's charges for inpatient services attributable to charity care for its qualifying year, less the portion of any cash subsidies received directly from the state or local governments for inpatient hospital services for its qualifying year. The denominator is the total amount of the hospital's charges for inpatient services for its qualifying year. When a state-owned qualifying hospital does not have a charge structure, the hospital's charges for charity care are equal to the cash subsidies received by the hospital from the state or local governments.

Out-of-state hospitals providing inpatient services to Alaska Medicaid beneficiaries, with a disproportionate share of Medicaid patients, may request a payment adjustment relative to the methods and standards in XI.A.1. or XI.A.2, above. If an out-of-state hospital requests a DSH adjustment, it must supply all necessary data for the department to complete the required calculations.

3. Designated Evaluation and Treatment Disproportionate Share Hospital (DET DSH)

Other than an IMD, a hospital eligible for a DSH payment may qualify for a DET DSH payment adjustment if designated by the department as an evaluation and treatment facility as specified in departmental regulations (7 AAC 72), and the hospital enters into a DET DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of DET encounters to the department to determine the appropriate distribution of DET DSH funds amongst all qualifying hospitals.

4. Designated Evaluation and Stabilization Disproportionate Share Hospital (DES DSH)

Other than an IMD, a hospital eligible for a DSH payment may qualify for a DES DSH payment adjustment if designated by the department as an evaluation services facility as specified in department regulations, and the hospital enters into a DES DSH agreement with the department. Under the agreement, the hospital commits to

reporting the number of DES encounters to the department to determine the appropriate distribution of DES DSH funds amongst all qualifying hospitals.

5. Single Point of Entry Psychiatric Disproportionate Share Hospital (SPEP DSH)

   Other than an Institute of Mental Disease (IMD), a hospital eligible for a DSH payment may qualify for a SPEP DSH payment adjustment if it enters into a SPEP DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of SPEP encounters to the department to determine the appropriate distribution of SPEP DSH funds amongst all qualifying hospitals.

6. Institution for Mental Disease Disproportionate Share Hospital (IMD DSH)

   If designated to receive involuntary commitments under state law, a psychiatric hospital eligible for a DSH payment may qualify for an IMD DSH payment adjustment. Legislative appropriation and the percentage of federal DSH funding allowed by IMD payments limit the total funds available for IMD DSH payments.

7. Children's Medical Care Disproportionate Share Hospital (CMC DSH)

   Other than an IMD, a hospital eligible for a DSH payment may qualify for a CMC DSH payment adjustment if it enters into a CMC DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of CMC encounters to the department to determine the appropriate distribution of CMC DSH funds amongst all eligible hospitals.

8. Institutional Community Health Care Disproportionate Share Hospital (ICHC DSH)

   Other than an IMD, a hospital eligible for a DSH payment may qualify for an ICHC DSH payment adjustment if the hospital enters into an ICHC DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of ICHC encounters to the department to determine the appropriate distribution of ICHC DSH funds amongst all eligible hospitals.

9. Rural Hospital Clinic Assistance Disproportionate Share Hospital (RHCA DSH)

   Other than an IMD, a hospital eligible for a DSH payment may qualify for an RHCA DSH payment adjustment if it enters into an RHCA DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of RHCA encounters to the department to determine the appropriate distribution of RHCA DSH funds amongst all eligible hospitals.

10. Mental Health Clinic Assistance Disproportionate Share Hospital (MHCA DSH)

    Other than an IMD, a hospital eligible for a DSH payment may qualify for an MHCA DSH payment adjustment if it enters into an MHCA DSH agreement with the department. Under the agreement, the hospital commits to reporting the number of MHCA encounters to the department to determine the appropriate distribution of MHCA DSH funds amongst all eligible hospitals.**

11. Substance Abuse Treatment Provider Disproportionate Share Hospital (SATP DSH)

    Other than an IMD, a hospital eligible for a DSH payment may qualify for a SATP DSH payment adjustment if it enters into a SATP DSH agreement with the department.

Under the agreement, the hospital commits to reporting the number of SATP encounters to the department to determine the appropriate distribution of SATP DSH funds amongst all eligible hospitals.**

*** Mental Health Clinic Assistance and Substance Abuse Treatment Provider DSH are agreements to provide services through freestanding clinics; their costs are not included in the hospital facility-specific limit (FSL) for DSH payments.*

C. Distribution of DSH Payments

The department distributes DSH payments to qualified hospitals according to the following methods.

1. IMD DSH

The department calculates each disproportionate share payment for the IMD DSH classification based on the qualifying hospital's Medicaid inpatient days divided by the total Medicaid inpatient days for all qualifying IMD DSHs in the qualifying year. The department multiplies the resulting percentage by the total allocation of DSH funds attributable to the IMD DSH classification. Payments are subject to the hospital's FSL, the federal IMD DSH cap for the federal fiscal year in which the department makes the payment, and the allocation of the department's legislative appropriations.

2. MIU DSH and LI DSH Payments

Each qualifying hospital within the MIU DSH classification, and each qualifying hospital within the LI DSH classification, receives a minimum payment of $10,000 per payment year and per classification. Payment is subject to the hospital's FSL, the federal IMD DSH cap for the federal fiscal year in which the department makes the payment, and the allocation of the department's legislative appropriations.

The department calculates each payment for the MIU DSH classification based on the qualifying hospital's SDM**, divided by the total SDMs for all qualifying hospitals in the qualifying year. The department multiplies the resulting percentage by the total allocation of DSH funds attributable to the MIU DSH classification.

***SDM means the Medicaid inpatient utilization rate over at least one standard deviation above the mean for Medicaid inpatient utilization rates for all hospitals in the state.*

The department calculates each DSH payment for the LI DSH classification based on the qualifying hospital's LUR**, divided by the total LURs for all qualifying LI DSHs in the qualifying year. The department multiplies the resulting percentage by the total allocation of DSH funds attributable to the LI DSH classification.

***LUR means the amount above a low-income utilization rate exceeding 25 percent*.

3. Encounter-Based Classification Payments

The department bases each disproportionate share payment for the DET DSH, DES DSH, SPEP DSH, CMC DSH, ICHC DSH, RHCS DSH, MHCA DSH, and SATP DSH classifications on the number of encounters to be performed by the qualifying hospital as specified in the agreement required for that classification.

D. Payment Limits

Each qualifying hospital's total annual disproportionate share payment is subject to a facility-specific limit (FSL) calculated for its qualifying year, and the federal requirements in 42 USC 1396r-4(g). The department calculates the FSL as the cost of services provided to Medicaid beneficiaries, minus the amount paid to the hospital under the non-DSH provisions of the state plan, plus the costs of services provided to patients without health insurance or other third-party resources applying to services rendered during the qualifying year, less any payments made by those patients without insurance or another third-party resource for those services. For this calculation, the hospital's cost of services is the total allowable hospital costs, as defined in the state plan, divided by the hospital's total adjusted inpatient days. The department multiplies the hospital's cost of services by the hospital's total adjusted inpatient days not covered by insurance or third-party payment and the adjusted Medicaid inpatient days. The cost of services includes the cost of services excluded from an insurance policy. The cost of services does not include amounts not reimbursed to the hospital by the patient's health insurance or other sources of third-party payments because of per diem maximums, coverage limitations, or unpaid patient co-payments of deductibles. For the purposes of this paragraph, third-party payments do not include state payments to hospitals from the department's programs for General Relief Medical Assistance or Chronic and Acute Medical Assistance.

The department determines inpatient days not covered by insurance using a hospital-submitted log it reviews and accepts before making a DSH payment. The log must include, in sufficient detail, for the department to verify uninsured care: charges, admissions, patient days, payments made by the patient for the services provided, payments made on behalf of the patient by a third party for the services provided, and dates of service. A hospital must, whenever possible, bill insurance and other third-party sources. The department accepts a log entry reflecting zero payments from the insurance company for a person with insurance as demonstrating no insurance coverage for the services provided. However, such a log entry is reduced by $1,000 to ensure it excludes non-payment resulting from an insurance policy deductible. If the hospital attaches an explanation of benefits or other documentation from the insurance company demonstrating the company excludes the services provided under the patient's insurance policy, the department accepts the entire amount of the log entry subject to the other requirements in this paragraph when determining the amount of uninsured care.

A disproportionate share payment is not subject to the 100 percent of charge limitation.

E. Hospital Notification and Reconsideration

Each year, the department notifies eligible hospitals and provides an opportunity for eligible hospitals to participate in each DSH classification for which they qualify. Eligible hospitals choosing to participate must notify the department in writing before the qualification date of their choice to participate and include the DSH classification(s) for which they choose to participate. The department's determination regarding participation by an eligible hospital is contingent upon the hospital administrator or CFO attesting via a log of uninsured care form provided by the department, the data submitted is accurate and correct, prepared from the books and records of the health facility for the qualifying year and a departmental determination that the hospital's FSL permits the receipt of DSH payments.

The department’s determination is its final administrative action unless a request for reconsideration is filed as required within compliance with the department’s regulations.

F. Monitoring and Recouping

The department routinely monitors DSH encounters throughout the year, with the provider submitting reports as required and specified in the agreement. The department determines providers eligible for reimbursement at the rate established in the signed agreement. The department makes DSH payments at least once each state fiscal year and bases the DSH payment(s) on the reconciliation of the total number of encounters. The department monitors any DSH payment(s) on a quarterly basis via a scheduled report. Each quarter the department receives a report containing the amount, and recipient, of each DSH payment. The department reviews expenditures under the report to ensure hospitals receiving DSH payments do not exceed their FSLs for the qualifying year. The department stops DSH payments if a hospital reaches its FSL. The department recoups the excess DSH payments when a hospital exceeds its FSL in the following order: SATP DSH, MHCA DSH, RHCA DSH, ICHC DSH, CMC DSH, SPEP DSH, DES DSH, DET DSH, LI DSH, MUI DSH, and IMD DSH. For example: If a hospital receiving payments in all DSH classifications exceeds its FSL, the department makes the over-payment adjustment in SATP DSH to the extent possible before adjusting the RHCA DSH payments. Similarly, if the DSH statewide allotment is exceeded, the department makes appropriate adjustments in the payment order shown above.

If disproportionate share eligibility and payments for any hospital require recalculation, the state recalculates and reallocates the disproportionate share eligibility and payments for all hospitals and recoups payments from all hospitals. This may occur due to a final commissioner's decision in an administrative appeal or a court decision causing the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year of the DSH payments.

The total disproportionate share payments to all hospitals (in the aggregate) are limited to the federal disproportionate share cap established for Alaska. A comparison of the federal cap to the state's estimated total disproportionate share payments for the federal fiscal year occurs before distributing payments to qualifying hospitals.

G. Definitions

1. Encounter – means a unit of service, visit, or face-to-face contact for a covered service under an agreement with the department required under XI.B.3-5 and XI.B.7-11 of this section.

2. Institution for Mental Disease (IMD) – means a facility of more than 16-beds, primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. A determination regarding IMD status relies on a determination regarding its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental disease, whether or not the facility holds a license as such.

3. Inpatient Days – are patient days at licensed hospitals calculated

    a. To include patient days related to hospitalization for acute treatment of the following:

        (1) Patients who are injured, disabled, or sick;

(2) Patients with a substance use disorder, hospitalized for substance abuse detoxification;

(3) Patients hospitalized for services intended for the rehabilitation of injured, disabled, or sick persons;

(4) Patients hospitalized and receiving psychiatric services intended for the diagnosis and treatment of mental illness; and

(5) Newborn infants in hospital nurseries.

a. Not to include patient days related to the treatment of patients:

(1) At licensed nursing facilities;

(2) In a residential psychiatric treatment bed;

(3) On a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

(4) Who are in a hospital for observation to determine the need for inpatient admission; or

(5) Receiving services at a hospital during the day but are not in the hospital at midnight.

4. Medicaid Eligible Inpatient Days – are patient days at licensed hospitals calculated

a. To include Medicaid covered and Medicaid non-covered days related to hospitalization for acute treatment of the following:

(1) Patients who are injured, disabled, or sick;

(2) Patients with a substance use disorder, hospitalized for substance abuse detoxification;

(3) Patients hospitalized for services intended for the rehabilitation of injured, disabled, or sick persons;

(4) Patients hospitalized and receiving psychiatric services intended for the diagnosis and treatment of mental illness; and

(5) Newborn infants in hospital nurseries.

a. Not to include Medicaid covered and Medicaid non-covered patient days related to the treatment of patients:

(1) At licensed nursing facilities;

(2) In a residential psychiatric treatment bed;

(3) On a leave of absence from a hospital, beginning with the day the patient begins a leave of absence;

(4) Who are in a hospital for observation to determine the need for inpatient admission; or

(5) Receiving services at a hospital during the day but are not in the hospital at midnight.

5. Payment Year – is the state fiscal year.

6. Qualifying Hospital – is a hospital qualifying for one or more DSH payments under this section.

7. Qualifying Year – is the hospital's most recent fiscal year, ending at least 11 months but not more than 37 months before the state fiscal year in which the department makes the disproportionate share payment and within the most recent 12-month reporting cycle for which all facilities filed a complete year-end report with the department.

XII. Exceptional Relief to Rate Setting

A. A facility may apply to the department's deputy commissioner for exceptional relief from the rate-setting methodology when the methodology results in a permanent rate that impedes reasonable access to quality patient care from an efficiently and economically managed facility. This provision applies when a facility closes or dramatically reduces the quality of care to residents due to the inadequacy of its payment rate. A facility's application for exceptional relief should include:

1. The amount of the facility's requested rate increase it estimates necessary for the provision of reasonable access to quality patient care provided by an efficiently managed facility;

2. The rationale supporting the requested relief, including any resolution by the facility's governing body supporting the request, and the reason a rate increase cannot occur through the established rate-setting process;

3. A description of the facility's management actions in response to the underlying scenario for the request for exceptional relief;

4. The facility's audited financial statement for the most recently completed facility fiscal year and financial data, including:

   a. a statement of income and expenses;
   b. a statement of assets, liabilities, and equities; and
   c. a monthly facility cash flow analysis for the fiscal year for which the facility requests relief;

5. A detailed description of the facility's recent efforts to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. An analysis of community needs for the service on which the facility bases its request for relief;

7. A detailed analysis of the facility's options in the event the department denies the requested relief;

8. An analysis demonstrating the facility's projections regarding the expected loss of Medicaid beneficiaries' access to covered services available to the general public in the same geographic area in the event the department does not grant the requested relief;

9. The facility's plan for future actions related to the problem leading to the request for relief; and

10. Any other information requested by the deputy commissioner to evaluate the request for relief.

B. If the deputy commissioner finds clear and convincing evidence that the rate established under section V of Attachment 4.19-A does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility and that the requested relief is in the public interest, they may increase the rate in an amount equal to the facility's requested rate or they may grant a partial rate increase. In determining whether the requested relief is in the public interest, the deputy commissioner may consider at least:

1. Whether a rate increase is necessary to facilitate reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility in support of the request for relief;

2. An assessment of the continued community need for the facility's services;

3. Whether the facility took effective steps to respond to the crisis and adopted effective management strategies to alleviate or avoid a future need for exceptional relief;

4. The availability of other resources to the facility, to respond to the crisis;

5. Whether relief should have occurred under the existing rate methodology;

6. Other factors relevant to the assessment of reasonable access to quality patient care provided by an efficiently and economically managed facility;

C. The deputy commissioner imposes conditions on the receipt of exceptional relief, including, but not limited to the following:

1. The facility shares the cost of the rate exception granted;

2. The facility takes effective steps in the future to alleviate the need for future exceptional relief requests;

3. The facility provides documentation of the continuing need for the rate exception;

4. The maximum amount of exceptional relief granted to the facility under this section.

The department does not include the amounts of exceptional relief granted as part of the base costs on which it determines future prospective rates. Exceptional relief is effective prospectively from the date of the exceptional relief decision and may not extend beyond the facility's rate-setting year. A facility may apply for and receive exceptional relief in the following year. A party aggrieved by the

deputy commissioner's determination concerning exceptional relief may submit a request for an administrative hearing to the commissioner.

XIII. Public Process

The department's public process complies with Section 1902(a)(13)(A) of the Social Security Act.

XIV. State Hospital Proportionate Share Incentive Payments

A. The department recognizes that many state-owned hospitals provide basic community and regional health care support to clients who are otherwise unable to access needed inpatient hospital services readily. The department may provide State Hospital Proportionate Share (SHPS) incentive payments to an in-state state-owned hospitals to ensure continued access for this population per 42 CFR § 447.272.

B. A qualified state-owned hospital is

1. Enrolled as a Medicaid provider of inpatient hospital services;

2. Located within the state of Alaska; and is

3. A state-owned or operated facility.

C. The department makes SHPS payments annually on or before September 30th. If needed, the state may make one additional payment per year to reconcile the federal fiscal year with state fiscal year expenditures. State fiscal year payments require money from two federal fiscal years. The department may hold the second payment until monies are available in the following federal fiscal year.

The state establishes a reasonable estimate of how much Medicare would reimburse state-owned hospitals by calculating the Medicare upper payment limit in the following way:

1. For each fiscal year it calculates the upper payment limit, the department utilizes the most recent as filed Medicare Cost Report data for each hospital's total Medicare costs and total Medicare charges to calculate a cost-to-charge ratio (CCR).

2. The department applies the CCR calculated in #1 (above) to the most recent MMIS MR-O-14B inpatient Medicaid charges to arrive at the Medicare equivalent costs.

3. The department subtracts the most recent MMIS MR-O-14B inpatient Medicaid payments and any other adjustments from the Medicare equivalent costs calculated in #2 (above) to identify variances between the upper payment limit and the estimated Medicaid payments (the upper payment limit gap).

4. The department determines the amount available for SHPS distribution by calculating the Medicare upper payment limit for all hospitals in the SHPS group in the base year, less any Medicaid and supplemental payments made to the hospitals. The aggregate difference is the upper limit total and represents the total available in the SHPS program.

5. The department determines the SHPS payment by comparing the charges and payments in the most recent MMIS MR-O-14B to the upper limit total. The lower of the two figures is the amount paid to the SHPS facility.

D. Apportionment of available SHPS funds among qualifying hospitals occurs according to the number of Medicaid inpatient days reported for each hospital, expressed as a percentage of the total Medicaid inpatient days at all state-owned hospitals.

INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 YEARS OF AGE

The department reimburses accredited residential psychiatric facilities for treating individuals under 21 years of age at daily rates established by the department. The department reimburses for therapeutically appropriate, medically necessary diagnostic and treatment services, including the following services: individual psychotherapy, group psychotherapy, family psychotherapy, group skill-development, individual skill-development, family skill-development, pharmacologic management and medication administration, crisis intervention, and intake assessment.

The department publishes the daily reimbursement rates and effective dates at: http://manuals.medicaidalaska.com/inpatient_psych_rptc/inpatient_psych_rptc.htm.

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Concerning non-payment for provider-preventable conditions, the department meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act.

The department adjusts payments for provider healthcare-acquired conditions and other provider preventable conditions using the following process. After the QIO's post-payment review of medical records, the department reduces the provider payment via a recoupment process for dates of service that were a direct result of a provider-preventable condition (PPC).

I. In compliance with 42 CFR 447.26(c), the department assures

A. It does not impose a payment reduction for a PPC when the condition defined as a PPC for a particular patient existed before the initiation of treatment by that provider.

B. It limits reductions in provider payment to the extent that the following apply:

1. The identified PPCs would otherwise result in an increase in payment;

2. It can reasonably isolate for non-payment, the portion of the payment directly related to the treatment for, and related to, the PPC.

C. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

II. Health Care Acquired Conditions

The department identifies the following healthcare-acquired conditions for non-payment under Section 4.19-A

☒ Hospital-acquired conditions as identified by Medicare other than deep vein thrombosis (DVT) or pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

III. Other Provider-Preventable Conditions

The department identifies the following Other Provider-Preventable conditions for non-payment under Section 4.19-A.

☒ The wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and the specific service type and provider type to which the provision is applied. For example, the plan's 4.19-D nursing facility services or 4.19-B physician services.

INPATIENT PROSPECTIVE PAYMENT SYSTEM BASED ON DIAGNOSIS-RELATED GROUPS

Notwithstanding any other provisions in the state plan, the department reimburses inpatient hospital services provided by general acute care hospitals on a per-stay basis using All Patient Refined Diagnosis Related Groups (APR DRG) classification system, updated as necessary (DRG) payment methodology. The DRG payment methodology applies to inpatient hospital services provided on or after this section's effective date described in II.A. and applies only to the hospitals described in II.B. below.

I. Definitions

A. Designated Border Hospitals – Out-of-state hospitals with high Alaska Medicaid claims volume. Specific criteria are included in the provider billing manual.
B. Diagnosis Related Groups (DRG) – An inpatient classification system that assigns inpatient stays to a DRG based on information contained in the inpatient claim, including diagnosis codes, procedure codes, discharge state codes, and patient characteristics.
C. DRG Base Payment – The department calculates the base payment by multiplying the DRG base rate by the DRG relative weight. The department calculates the base payment before applying the transfer payment adjustment and/or outlier payments.
D. DRG Base Rate – The rate per discharge before applying the DRG relative weight or policy adjustors.
E. DRG Relative Weight – A value reflecting a given inpatient stay's average cost and resource usage.
F. Policy Adjustor – A multiplier to the DRG base rate or DRG relative weight. The multiplier is applied to the DRG Base Payment when the department determines that an adjustment to the base payment is appropriate to achieve policy objectives.
G. Service Category – A classification of service type determined by the department based on the APR DRG assignment.
H. Outlier Payment: A payment made in addition to the DRG payment for cases exceeding the department's cost thresholds.
I. Transfer Payment Adjustment: A payment adjustment for cases where a patient is transferred to another hospital before completing the expected course of treatment. A payment adjustment will not exceed the standard non-transfer DRG payment. The department does not make a transfer payment adjustment for patients transferred to or from a unit of the same hospital.
J. Add on: An additional payment for specific services not reimbursed elsewhere.

II. Applicability

A. Effective Date – The DRG payment methodology is effective for discharges on or after January 1, 2024, for inpatient hospital services provided by hospitals subject to the DRG payment methodology.
B. Included Hospitals –

1. Alaska hospitals – Acute care hospitals in Alaska are subject to DRG reimbursement. DRG reimbursement does not apply to critical access hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals. Tribally owned and operated general acute care hospitals not paid under the state payment methodology are exempt from the DRG payment methodology unless they formally notify the department of a desire to opt into the payment methodology.

2. Out-of-state hospitals – The DRG reimbursement methodology applies to all out-of-state hospitals providing inpatient services to Alaska Medicaid beneficiaries. The department designates certain out-of-state hospitals with a high volume of Alaska Medicaid beneficiaries as border hospitals for reimbursement purposes.

III. DRG Reimbursement

Components of the DRG payment methodology are as follows:

A. The department determines DRG base rates for three classes of hospitals, acute care hospitals in Alaska, designated border hospitals, and all other out-of-state hospitals. The department assigns Alaska hospitals subject to the DRG payment methodology and designated border hospitals hospital-specific DRG base rates and assigns all other out-of-state hospitals a single DRG base rate.
B. The department uses the All Patient Refined Diagnosis Related Groups (APR DRG) grouper to assign inpatient stays to a DRG. The APR DRG system classifies each inpatient stay based on the Medicaid inpatient claim information, including diagnosis codes, procedure codes, discharge status codes, and patient characteristics.
C. DRG relative weights derive from the APR DRG national hospital-specific relative value (HSRV) weight set for the grouper version in place. The DRG relative weight values may be scaled to represent the Alaska Medicaid claims experience. The department publishes the DRG relative weights on the Alaska Medicaid website at https://health.alaska.gov/Commissioner/Pages/RateReview/default.aspx.
D. Average lengths of stay are derived from the APR DRG national weight set for the grouper version in place.
E. The department uses the Healthcare Acquired Conditions (HAC) utility to remove HACs from consideration in APR DRG assignments.
F. To increase or decrease reimbursement, the department may multiply the DRG relative weights by policy adjustors based on patient age and/or APR DRG assignment. The department assigns each APR DRG to a service category. Additionally, the department determines each policy adjustor's criteria and specific values and publishes this information on the Alaska Medicaid website at https://health.alaska.gov/Commissioner/Pages/RateReview/default.aspx.
G. Calculation of the DRG base payment before the application of other payment adjustments is as follows

*DRG Base Rate * APR DRG Relative Weight * Policy Adjustor = DRG Base Payment Rate*

H. Transfer payment adjustments based on discharge status codes and length of stay prorate payments in cases where a patient transfers to another hospital before completing the expected course of treatment, as determined by the national average length of stay for the APR DRG assigned to a case. The transfer payment policy applies to the hospital making the transfer (transferring hospital). The hospital receiving the patient is not subject to the transfer payment policy. APR DRGs specifically applied to transferred patients are exempt from transfer payment adjustments.

In the transfer adjustment calculation, one day is added to the actual length of stay to reflect the higher costs of care that typically occur on the first day of an inpatient stay. The discharge status codes triggering a transfer payment are discharge status codes 02, 05, 62, 63, 65, 66, 82, 85, 90, 91, 93, and 94. In cases where the actual length of stay plus one is less than the national average length of stay and the discharge status code on the claim is one specified by the department to trigger the transfer adjustment, the transfer adjustment calculation is:

*(DRG Base Payment/National Average Length of Stay) * (Actual Length of Stay +1) = Transfer-Adjusted Allowed Amount*

I. The department makes outlier payments for high-cost cases. To receive an outlier payment, the estimated financial loss to a hospital must exceed a threshold, calculated by the department, that aims to result in outlier payments between five percent and 15 percent of total payments; the department multiplies amounts exceeding the threshold by a marginal cost percentage to calculate outlier payments.

1. The calculation for estimated cost is

   *Charges * Cost-to-charge Ratio = Estimated Cost*

2. The calculation for estimated gain/loss is

   DRG Base Payment (or Transfer-Adjusted Allowed Amount if Applicable) – Estimated Cost = Estimated Gain/Loss

3. The claim qualifies for an outlier payment if the estimated loss exceeds the cost outlier threshold. The department publishes the cost outlier threshold value on the Alaska Medicaid website at https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Manuals/Institutional_Claims_Management.pdf.

4. The calculation for outlier payments is

   *(Estimated Loss – Cost Outlier Threshold) * Outlier Payment Percentage = Cost Outlier Payment*

5. The department adds outlier payments to the DRG base payment, or transfer-adjusted allowed amount, if applicable.

J. The department uses a cost-to-charge ratio (CCR) in calculating outlier payments. In-state acute care hospitals and designated border hospitals are assigned a hospital-specific cost-to-

charge ratio. All other out-of-state hospitals are assigned the in-state average cost-to-charge ratio.

K. The department adjusts the DRG base rate for an in-state teaching hospital for direct medical education costs reported on the Medicare hospital cost report. The specific criteria and methodology for teaching hospital base rate adjustments are described in the provider billing manual at https://extranetsp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Manuals/Institutional_Claims_Management.pdf.

L. The department calculates the APR DRG base payment rate by multiplying the hospital's base rate by the relative weight and policy adjustor(s). Transfer adjustments and outlier payment calculations follow this initial calculation.

M. The department reimburses all services, supplies, and devices provided during an inpatient stay through the DRG payment. However, the department may make a separate payment in addition to the DRG payment for a quality incentive program or another initiative adopted by regulation under the Administrative Procedure Act (AS 44.62).

N. The department assigns a new in-state acute care hospital or designated border hospital the in-state average base rate and cost-to-charge ratio until it determines a hospital-specific base rate and cost-to-charge ratio during the next biennial or triennial DRG rate update.

O. The department periodically updates DRG base rates and other DRG system parameters. Updates occur on a biennial or triennial basis as determined by the department. If DRG base rate updates occur triennially, the department adjusts base rates between years two and three using the most recent quarterly publication of the IHS Markit *Healthcare Cost Review*, Hospital Market Basket inflationary index, available 60 days before the beginning of a facility's fiscal year. The department determines border hospital classification during the DRG update process.