# DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## PROPOSED CHANGES TO REGULATIONS

### Methodology and Criteria for Additional Payments as a Disproportionate Share Hospital.

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**PUBLIC REVIEW DRAFT**

**May 15, 2013**

**COMMENT PERIOD ENDS: June 19, 2013**

**Please see public notice for details about how to comment on these proposed changes.**

**Notes to reader:**

1. Except as discussed in note 2, proposed new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line states that a new section, subsection, paragraph, subparagraph, or clause is being added, or that an existing section, subsection, etc. is being repealed and readopted (replaced), the new (or replaced) text is not bolded or underlined.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is proposed to be deleted.

4**.** When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

## Title 7. Health and Social Services.

7 AAC 105.260(f) is amended by adding a new paragraph to read:

(f) This section does not apply to

(1) actions under 7 AAC 105.400 - 7 AAC 105.490, or bankrupt or out-of-business providers;

(2) recoupment that is based solely on a prospective payment rate under 7 AAC 150;

(3) recoupment actions identified in an audit under 7 AAC 160.100 – 7 AAC 160.130**;**

**(4) recoupment actions identified in an independent certified audit under 7 AAC 150.180(n) with respect to a hospital receiving payments as a disproportionate share hospital DSH**.

(Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am 5/11/2012, Register 202; am__/__/____, Register ____)

**Authority:** AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.200

7 AAC 150.180(b)(4)(B) is amended to read:

(B) Medicaid reporting forms for the qualifying year from the *Medicaid Hospital and Long-Term Care Facility Reporting Manual*, adopted by reference in 7 AAC 160.900**, including the audited financial statements for the facility**;

7 AAC 150.180(b)(4)(C) is amended to read:

(C) **an uninsured care** [A] log for the qualifying year for each patient having uninsured care; the log must be prepared **and submitted in electronic spreadsheet format** using the *Medicaid Log of Uninsured Care Reporting Form*, adopted by reference in 7 AAC 160.900; the hospital must certify the log as accurate **in an electronic attachment with the submission of the uninsured care log**; the log must specify, in sufficient detail for the department to verify **the following information concerning** uninsured care**;**[,]

(i) **total** charges;

(ii) **each admission date** [ADMISSIONS];

(iii) **number of** patient days;

(iv) any payments made by the patient, or on behalf of the patient by a third party, for services; [AND]

(v) **each discharge date** [DATES OF SERVICE]**;**

**(vi) each service type;**

**(vii) each payment designation; and**

**(viii) each date service was provided for outpatient hospital services**.

The lead-in language of 7 AAC 150.180(e) is amended to read:

(e) For the classifications in (d)(1) and (2) of this section, the department will make **a** [AN ANNUAL] pediatric outlier payment in the disproportionate share payment, if the **qualifying** hospital **in the qualifying year**

7 AAC 150.180(m) is repealed:

(m) Repealed___/___/2013 [IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES,

(1) "ADJUSTED INPATIENT DAYS" MEANS PATIENT DAYS CALCULATED AS THE PRODUCT OF PATIENT DAYS MULTIPLIED BY TOTAL HOSPITAL INPATIENT AND OUTPATIENT CHARGES DIVIDED BY HOSPITAL INPATIENT CHARGES;

(2) "ADMISSION" MEANS ADMISSION TO A HOSPITAL FOR INPATIENT CARE;

(3) "CASH SUBSIDIES" DOES NOT INCLUDE MONEY GENERATED UNDER THE PUBLIC HOSPITAL PROPORTIONATE SHARE PAYMENT UNDER 7 AAC 150.100;

(4) "ENCOUNTER" MEANS A UNIT OF SERVICE, VISIT, OR FACE-TO-

FACE CONTACT THAT IS A COVERED SERVICE UNDER AN AGREEMENT WITH THE DEPARTMENT AS REQUIRED UNDER (d)(3), (4), (6), (7), (8), (10), OR (11) OF THIS SECTION;

(5) "INPATIENT DAYS" MEANS PATIENT DAYS AT LICENSED HOSPITALS THAT ARE CALCULATED

(A) TO INCLUDE PATIENT DAYS RELATED TO A HOSPITALIZATION FOR ACUTE TREATMENTOF THE FOLLOWING:

(i) INJURED, DISABLED, OR SICK PATIENTS;

(ii) SUBSTANCE ABUSE PATIENTS WHO ARE HOSPITALIZED FOR SUBSTANCE ABUSE DETOXIFICATION;

(iii) SWING-BED PATIENTS WHOSE HOSPITAL LEVEL OF CARE IS REDUCED TO NURSING FACILITY LEVEL WITHOUT A PHYSICAL MOVE OF THE PATIENT;

(iv) PATIENTS HOSPITALIZED FOR REHABILITATION SERVICES FOR THE REHABILITATION OF INJURED, DISABLED, OR SICK PERSONS;

(v) PATIENTS IN A HOSPITAL RECEIVING PSYCHIATRIC SERVICES FOR THE DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS;

(vi) NEWBORN INFANTS IN HOSPITAL NURSERIES; AND

(B) NOT TO INCLUDE PATIENT DAYS RELATED TO THE TREATMENT OF PATIENTS

(i) AT LICENSED NURSING FACILITIES;

(ii) IN A RESIDENTIAL TREATMENT BED;

(iii) ON A LEAVE OF ABSENCE FROM A HOSPITAL BEGINNING WITH THE DAY THE PATIENT BEGINS A LEAVE OF ABSENCE;

(iv) WHO ARE IN A HOSPITAL FOR OBSERVATION TO DETERMINE THE NEED FOR INPATIENT ADMISSION; OR

(v) WHO RECEIVE SERVICES AT A HOSPITAL DURING THE DAY BUT ARE NOT HOUSED THERE AT MIDNIGHT;

(6) "MEDICAID-ELIGIBLE INPATIENT DAYS" MEANS PATIENT DAYS AT LICENSED HOSPITALS THAT ARE CALCULATED

(A) TO INCLUDE MEDICAID-COVERED AND MEDICAID-NONCOVERED DAYS RELATED TO A HOSPITALIZATION FOR ACUTE TREATMENT OF THE FOLLOWING:

(i) INJURED, DISABLED, OR SICK PATIENTS;

(ii) SUBSTANCE ABUSE PATIENTS WHO ARE HOSPITALIZED FOR SUBSTANCE ABUSE DETOXIFICATION;

(iii) SWING-BED PATIENTS WHOSE HOSPITAL LEVEL OF CARE IS REDUCED TO NURSING FACILITY LEVEL WITHOUT A PHYSICAL MOVE OF THE PATIENT;

(iv) PATIENTS HOSPITALIZED FOR REHABILITATION SERVICES FOR THE REHABILITATION OF INJURED, DISABLED, OR SICK PERSONS;

(v) PATIENTS IN A HOSPITAL RECEIVING PSYCHIATRIC SERVICES FOR THE DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS;

(vi) NEWBORN INFANTS IN HOSPITAL NURSERIES; AND

(B) NOT TO INCLUDE MEDICAID COVERED AND MEDICAID NON-COVERED PATIENT DAYS RELATED TO THE TREATMENT OF PATIENTS

(i) AT LICENSED NURSING FACILITIES;

(ii) IN A RESIDENTIAL TREATMENT BED;

(iii) ON A LEAVE OF ABSENCE FROM A HOSPITAL BEGINNING WITH THE DAY THE PATIENT BEGINS A LEAVE OF ABSENCE;

(iv) WHO ARE IN A HOSPITAL FOR OBSERVATION TO DETERMINE THE NEED FOR INPATIENT ADMISSION; OR

(v) WHO RECEIVE SERVICES AT A HOSPITAL DURING THE DAY BUT ARE NOT HOUSED THERE AT MIDNIGHT;

(7) "PAYMENT YEAR" MEANS THE STATE FISCAL YEAR;

(8) "QUALIFICATION DATE" MEANS JULY 1 OF EACH YEAR;

(9) "QUALIFYING HOSPITAL" MEANS A HOSPITAL THAT QUALIFIES AS A DSH UNDER THIS SECTION;

(10) "QUALIFYING YEAR" MEANS THE HOSPITAL'S FISCAL YEAR ENDING

(A) AT LEAST 11 BUT NO MORE THAN 37 MONTHS BEFORE THE BEGINNING OF THE STATE FISCAL YEAR IN WHICH THE DISPROPORTIONATE SHARE PAYMENT IS MADE; AND

(B) WITHIN THE MOST RECENT 12-MONTH REPORTING CYCLE IN WHICH ALL FACILITIES HAVE FILED A COMPLETE YEAR-END REPORT WITH THE DEPARTMENT].

7 AAC 150.180 is amended by adding new subsections to read:

(n) A hospital that receives a Medicaid payment as a DSH

(1) is subject to an independent certified audit under 42 U.S.C. 1396r-4(j)(2) and 42 C.F.R. 455.300 – 455.304 three years after the payment year to determine if an overpayment occurred; and

(2) shall furnish, in addition to other information and documents required under this chapter, any additional information and documents necessary for completion of the audit.

(o) If an independent certified audit under 42 U.S.C. 1396r-4(j)(2) and 42 C.F.R. 455.300 – 455.304 identifies an overpayment for the payment year under review, the department will immediately recoup the amount of the overpayment from the hospital. A hospital aggrieved by a recoupment under this subsection may request reconsideration by filing a request for reconsideration with the department. The department staff that oversees Medicaid payment rates may reconsider a DSH payment upon the department staff's own motion or at the facility's request. A facility seeking reconsideration must file a request for reconsideration no more than 30 days after the date of mailing the written determination to the facility. The department staff shall deny a request for reconsideration as untimely if the request was not filed 30 days or less after the date of mailing the written determination to the facility. A request for reconsideration under this subsection must be filed at the Anchorage office of the department with the staff that oversees Medicaid payment rates.

(p) In this section, unless the context otherwise requires,

(1) "adjusted inpatient days" means patient days calculated as the product of patient days multiplied by total hospital inpatient and outpatient charges divided by hospital inpatient charges;

(2) "admission" means admission to a hospital for inpatient care;

(3) "cash subsidies" does not include money generated under the public hospital proportionate share payment under 7 AAC 150.100;

(4) “encounter” means a unit of service, visit, or face-to-face contact that is a covered service under an agreement with the department as required under (d)(3), (4), (6), (7), (8), (10), or (11) of this section;

(5) "inpatient days" means patient days at licensed hospitals that are calculated

(A) to include patient days related to a hospitalization for acute treatment of the following:

(i) injured, disabled, or sick patients;

**(**ii) substance abuse patients who are hospitalized for substance abuse detoxification;

(iii) swing-bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient;

(iv) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(v) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(vi) newborn infants in hospital nurseries; and

(B) not to include patient days related to the treatment of patients

(i) at licensed nursing facilities;

(ii) in a residential treatment bed;

(iii) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

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

(v) who receive services at a hospital during the day but are not housed there at midnight;

(6) "Medicaid-eligible inpatient days" means patient days at licensed hospitals that are calculated

(A) to include Medicaid-covered and Medicaid-noncovered days related to a hospitalization for acute treatment of the following:

(i) injured, disabled, or sick patients;

(ii) substance abuse patients who are hospitalized for substance abuse detoxification;

(iii) swing-bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient;

(iv) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(v) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(vi) newborn infants in hospital nurseries; and

(B) not to include Medicaid covered and Medicaid non-covered patient days related to the treatment of patients

(i) at licensed nursing facilities;

(ii) in a residential treatment bed;

(iii) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

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

(v) who receive services at a hospital during the day but are not housed there at midnight;

(7) “payment designation” means a designation related to the source of reported payments;

(8) "payment year" means the state fiscal year plus 90 days;

(9) "qualification date" means July 1 of each year;

(10) "qualifying hospital" means a hospital that qualifies as a DSH under this section;

(11) "qualifying year" means the hospital’s fiscal year ending

(A) at least 11 but no more than 23 months before the beginning of the state fiscal year in which the disproportionate share payment is made; and

(B) within the most recent 12-month reporting cycle in which all facilities have filed a complete year-end report with the department;

(12) “service type” means a code that describes the type of service provided during an inpatient stay or the outpatient visit;

(13) “uninsured care” means inpatient and outpatient hospital services furnished by the hospital to individuals who have no health insurance or other source of third party coverage in effect at the time the service was rendered;

(Eff. 2/1/2010, Register 193; am__/__/____, Register ____)
**Authority:** AS 47.05.010 AS 47.07.070 AS 47.07.073