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State District of Columbia

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

1. Fee structures are established and designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the State plan at least to the extent that they are available to the general population.

2. Participation in the program by non-State providers[1] of services will be limited to those who:

   a. Give signatory agreement to conform with the applicable "Conditions of Participation" which are established by the State Agency for all non-State-operated services included in the State plan;

   b. Are accepted by the State Agency as being both qualified and authorized to provide such service;

   c. Evidence, to the continuing satisfaction of the State Agency, their compliant-in-fact with all terms of these conditions, and

   d. Accept, as payment in full, the amounts paid in accordance with fee structures included in these "Conditions of Participation."

3. The systems are provided by the State Agency to govern the establishment and maintenance of fee structures, and the payment for care and services, thereunder will be designed to assure that:

   a. Methods and procedures are consistent with simplicity of administration, in keeping with the requirement of Sec. 1902(a)(19) of the Social Security Act, and

[1]A private "medical-vendor" or any other provider not a facility or employee of the D.C. Government.

b. Payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care keeping with the requirement of Section 1902 (a) (30) of that Act.

4. The rates of payment are included in the fee structures for types of care or services (other than inpatient hospital services) listed in Section 1905 (a) of the Act. The rates are established and included in the program under the plan as follows:

a. Non-State-operated services will be reimbursed at rates established by the State Agency and included as a part of the "Condition of Participation" for non-State providers of services under this State plan.

b. State-operated services will be reimbursed at rates established by the State and subject to revaluation, and adjustment where indicated, by the State Agency at least once a year. These services include emergency ambulance service provided by the D.C. Fire Department. These rates are designed to meet as reasonably as practicable, but not to exceed the actual cost of the services provided, and are charged to those individuals who are required to pay for such services.

5. Drugs

a. In selecting the drugs to be used, there must be standards for quality, safety, and effectiveness under the supervision of physician and/or pharmacist.

b. The Medicaid agency restricts payment to only those drugs supplied from manufacturers that have signed a national agreement, or have an approved existing agreement, as specified in Section 1927(a). Methods for determining costs of prescribed multiple source drugs are:

(1) The allowable cost for multiple source drugs designated by the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services and included in its listings shall be the lower of the following:

(a) The upper limit established by CMS;

(b) The estimated acquisition cost, as determined by the Department of Health Care Finance based upon information from drug manufacturers and local wholesale price data;

(c) The Maximum Allowable Cost; and

(d) The pharmacy's usual and customary charge to the general public.

(2) The CMS upper limit for a drug price shall not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular patient.

(3) The handwritten phrase "Medically Necessary" or "Brand Necessary" shall appear on the face of the prescription form. If the prescription is for a nursing facility resident a handwritten phrase "Medically Necessary" or "Brand Necessary" shall be documented in the resident's medical record accompanied by a copy of the physician's order and plan of care.

(4) Neither a dual line prescription form, check-off box on the prescription form, nor check off-box on the physician's orders and plan of care shall satisfy the certification requirement.

(5) A generic drug may be considered for MAC pricing if there are two (2) or more therapeutically equivalent, multiple source drugs with a price difference. The Maximum Allowable Cost (MAC) will be based on drug status (including non-rebatable, rebatable, obsolete, therapeutic equivalency ratings) marketplace availability and cost. The obsolete drug status will be taken into account to ensure that the MAC pricing is not influenced by the prices listed for obsolete drugs. The MAC will be based on drug prices obtained from nationally recognized comprehensive data files maintained by a vendor under contract with DHCF.

(6) The Department shall supplement the CMS listing by adding drugs and their prices which meet the following requirements:

(a) The formulation of the drug approved by the U.S. Food and Drug Administration (FDA) has been evaluated as therapeutically equivalent in the most current edition of its publication, Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or in successor publications); and

(b) At least two (2) suppliers list the drug (which has been classified by the FDA as category "A" in its publication, Approved Drug Products with Therapeutic Equivalence Evaluations, including supplements or in successor publications) based on listing of drugs which are locally available.

(7) Each pharmacy that participates in the Medicaid program shall be notified by the Department of Health Care Finance (DHCF) of the establishment of a maximum allowable cost program for the selected multiple source drugs listed pursuant to this section.

c. Methods for determining costs of **single source drugs** are:

(1) Costs for prescribed drugs shall not exceed the wholesale acquisition cost (WAC), plus three percent (3%), if available. Drugs that do not have a WAC, will be priced based on the direct price benchmark plus three percent (3%)as evaluated by DHCF using a national standard database.

(2) The WAC shall be the price, at the time of service, obtained from nationally recognized comprehensive data files maintained by a vendor under contract with DHCF.

d. Methods established for determining prescription reimbursement are:

(1) Pharmacy claims for a retail pharmacy provider shall be reimbursed at the lower of the following:

(a) The allowable cost, established pursuant to sections 5b, 5c, or 5e of this Attachment, as appropriate, plus a dispensing fee of four dollars and fifty cents ($4.50) per prescription; or

(b) The pharmacy's usual and customary charge to the general public.

(2) Pharmacy claims for a nursing home pharmacy provider shall be reimbursed at the lower of the following:

(a) The allowable cost, established pursuant to section 5b, 5c, 5d.3 or 5e, as appropriate, plus a dispensing fee of four dollars and fifty cents ($4.50) per non-IV (intravenous) prescription or seven dollars and twenty-five cents ($7.25) for cassette, TPN (total parenteral nutrition) or container-related prescriptions); or

(b) The pharmacy's usual and customary charge to the general public.

(3) The allowable cost for drugs purchased by a nursing home pharmacy provider who is also a federally approved 340-B (Public Health Service) provider for Medicaid shall not exceed the actual acquisition cost for each 340-B purchased drug. Pharmacy claims for 340-B providers shall be excluded from any manufacturer's rebate.

(4) Drugs covered by Medicare for persons who are dually eligible for Medicare and Medicaid shall be billed to Medicare under the Medicare Prescription Drug Benefit Part D, effective January 1, 2006.

(5) An additional supply of medications may be dispensed for use by a nursing facility resident during a short-term medically approved trip away from the facility during holidays or family trips.

(6) Prescribed drugs for purposes of nursing homes pharmacy reimbursement shall not include over-the-counter medications, syringes for diabetic preparations, geriatric vitamin formulations and senna extract.

e. Payment for the cost of multiple source drugs shall be the lesser of:

(1) The Federal Upper Limit (FUL) of the drug for multiple source drugs other than those brand name drugs for which a prescriber has certified in writing as "Medically Necessary" or "Brand Necessary";

(2) The Maximum Allowable Cost (MAC). A MAC may be established for any drug for which two or more A-rated therapeutically equivalent, multiple source drugs with a significant cost difference exist. The MAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department of Health Care Finance. Data accessed to determine MAC may include the Average Wholesale Price, and the Wholesale Acquisition Cost (WAC), when available, or any current equivalent pricing benchmark, applying necessary multipliers to ensure reasonable access by providers to the drug at or below the MAC rate.

(a) Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors such as First Data Bank, and pharmaceutical manufacturers.

(b) The estimated acquisition cost for each product is maintained in a MAC pricing file database.

(c) Products are then sorted into drug groups by Generic Code Sequence Number (GSN), which denotes the same generic name, strength, and dosage form.

(d) A filter is applied to remove all drug products that are obsolete, are not therapeutically equivalent, or are not available in the marketplace.

(e) The acquisition cost for the remaining drug products are analyzed to produce the estimated acquisition cost for the drug group giving consideration to lower cost products (which means analyzing utilization and availability of the drug in the marketplace to ensure Medicaid eligibles will have access to the drug) for lower cost products.

(f) The resulting estimated acquisition cost is used to produce a MAC rate.

(g) The MAC rate will then be applied to all brand and generic drug products in that specific GSN.

(3) The pharmacy's usual and customary charge to the general public.

(4) The estimated acquisition cost, as determined by the Department of Health Care Finance based upon information from drug manufacturers and local wholesale price data.

DEFINITIONS

For the purposes of Section 5 in this State Plan Amendment, the following terms and phrases shall have the meanings ascribed:

Brand - any registered trade name commonly used to identify a drug.

Container - A light resistant receptacle designed to hold a specific dosage form which is or maybe in direct contact with the item and does not interact physically or chemically with the item or adversely affect the strength, quality, or purity of the item.

Department of Health Care Finance (DHCF) - The executive department responsible for administering the Medicaid program within the District of Columbia.

FUL - The Federal Upper Limit established by CMS.

Multiple source drug - a drug marketed or sold by two (2) or more manufacturers or labelers.

Prescribed drugs - legend drugs approved as safe and effective by the U.S. Food and Drug Administration and those over-the-counter medications which fall into the following categories:

(a) Oral analgesics with a single active ingredient (e.g., aspirin, acetaminophen, ibuprofen, etc);
(b) Ferrous salts (sulfate, gluconate, etc.);
(c) Antacids with up to three active ingredients, (e.g., Aluminum, magnesium, bismuth, etc.);

(d) Diabetic preparations (e.g., Insulin, syringes, etc.);
(e) Pediatric, prenatal and geriatric vitamin formulations;
(f) Family planning drugs and supplies; and
(g) Senna extract, single dose preparations when required for diagnostic radiological procedures performed under the supervision of a physician.

6. Physician and Specialty Services

(a) For service where the procedure code falls within the Medicare (Title XVIII) fee schedule, payment will be the lesser of the Medicare rate; the actual charges to the general public; or the rate listed in DHCF's fee schedule. Effective January 1, 2011, DHCF will use the Medicare rates to determine the Medicaid rates for services on or after that date. Beginning January 1, 2011, physician and specialty services rates will be reimbursed at eighty percent (80%) of the Medicare rate. All rates will be updated annually pursuant to the Medicare fee schedule. Except as otherwise noted in the Plan, the DHCF developed fee schedule rates are the same for both governmental and private. Effective January 1, 2015 through September 30, 2015, the state reimburses for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine using enhanced rates as authorized in Supplement 3 to Attachment 4.19B.

(b) Effective January 1, 2011, for services where the procedure code does not fall within the Medicare fee schedule, DHCF will apply the lowest of the following: (1) usual and customary charges; (2) rates paid by the surrounding states of Maryland and Virginia; or (3) rates set by national benchmark compendiums when available.

(c) DHCF shall provide a one-time, supplemental payment for physician and specialty services for each provider participating in the District's Medicaid program between January 1, 2011, and February 29, 2012. For each provider participating in the District's Medicaid program between January 1, 2011 and February 29, 2012, DHCF will establish a pool of funds that shall be equal to and shall not exceed the difference between one hundred percent (100%) of the Medicare rate in effect for that period and eighty percent (80%) of the Medicare rate in effect for that period (the Medicaid payment rate) for all claims paid to that provider between January 1, 2011 and February 29, 2012. Each provider participating in the District's Medicaid program between January 1, 2011 and February 29, 2012 shall receive a provider-specific supplemental payment based on the claims submitted to DHCF during the three month period beginning with

the effective date of this state plan provision (May 1, 2013), (hereinafter the "payment period"). The supplemental payment will be calculated as to the total of each provider's pool, divided by the paid claims submitted for the payment period by each provider and added proportionately to the fee-for-service rate paid to that provider during the payment period. All payments shall be made as a lump sum adjustment at the end of the defined three month payment period.

7. Nursing Home Services
(See attachment 4.19D)

8. OUTPATIENT HOSPITAL SERVICES

a. Reimbursement Methodology Overview

1) This section establishes payment rates for hospital outpatient care defined in accordance with 42 CFR § 440.20 (a). In accordance with 42 CFR § 447.321, the reimbursement methodology to establish payment rates for outpatient hospital services shall not exceed the upper payment limits for similar services under comparable circumstance paid by the Medicare program to hospital providers. The district is using a Cost Based Upper Payment Limit for its Outpatient Services demonstration. Base Cost for the UPL was derived from 2013 Cost Reports, and then inflated to 2015 values, using Health Care specific inflation factors derived by Global Insight. The method for determining cost entailed applying Cost to Charge Ratios (CCRs) from the as filed 2013 2552-10, utilizing Worksheet B, Col. 21, 22, & 26 and Worksheet C, Part I, Col. 6 and 7. CCRs were applied to MMIS Charges from the same base year of 2013. For comparison to the Cost Based 2013 UPL, which was inflated to 2015 values, prospective payments under the newly implemented EAPG methodology were utilized. As the EAPG Outpatient methodology was not implemented until after the base year of 2013, using existing 2013 MMIS data was not as accurate, as those payments were made under a reimbursement method that was obsolete in 2015. Prospective 2015 EAPG payments, developed by Xerox, were used for all but Specialty Hospitals of Washington and Psychiatric Institute of Washington. As those two facilities were not included in the Xerox analysis, 2013 MMIS payments were used, which were proportionally inflated to 2015. Other details associated with this UPL are that out-of--state charges, crossover claims and physician services were excluded.

2) All hospitals, with the exception of Maryland outpatient hospital services, that deliver outpatient services and are enrolled as providers under the Department of Health Care Finance's (DHCF) Medicaid program shall be reimbursed for outpatient services by a prospective payment system (PPS) under the Enhanced Ambulatory Patient Grouping (EAPG) classification system for dates of services beginning on October 1, 2014. Except as otherwise noted in the plan, rates are the same for both governmental and private providers.

3) EAPG is a visit-based patient classification system designed by 3M Health Information Systems (HIS), which uses grouper/pricer software or a grouping algorithm for outpatient services, to characterize the amount and type of resources used during a hospital outpatient visit for patients with similar clinical characteristics. The use of the EAPG classification system shall result in higher payments for higher intensity services and lower payments for lower intensity services.

4) There is no cost settlement for the PPS EAPG system. Prospective payments using the EAPG classification system are considered final. There shall be no retrospective cost settlements after the claim is paid.

5) Maryland hospitals shall be reimbursed in accordance with the Health Services Cost Review Commission (HSCRC)'s All-Payer Model Contract with Centers for Medicare and Medicaid Innovation, or its successor. Under this model Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland will limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent. For more information, please visit http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/.

b. Reimbursement of Outpatient Services Applicable to In-District General Hospitals and Specialty Hospitals

1) **Grouper version and quarterly updates**

a) For dates of services beginning on October 1, 2014, DHCF shall use version 3.8 of the EAPG grouper/pricer software.

b) DHCF shall use an updated EAPG grouper/pricer software version every two (2) years, or when necessary, with an effective date of October 1. The first update shall be implemented in FY 2017, beginning on October 1, 2016.

c) DHCF shall update the EAPG grouper/pricer software on a quarterly basis to accommodate changes in the national Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code sets.

2) **EAPG Relative Weights**

a) For dates of services beginning October 1, 2014, DHCF shall use the national relative weights calculated by 3M for version 3.8 of the EAPG grouper/pricer software.

b) DHCF shall update the EAPG relative weights at a minimum of every two (2) years to coincide with the grouper version upgrades, or more frequently as needed.

3) **Calculating EAPG Conversion Factor:**

a) DHCF shall apply one of three conversion factors to calculate payment:

i. In-District rehabilitation hospitals factor;

ii. District-wide conversion factor for other in-District and out-of-District hospitals (except Maryland hospitals); or

iii. A factor that is two percent (2%) higher than the District-wide conversion factor for hospitals whose primary location is in an area identified as an Economic Development Zone and certified by the District's Department of Small and Local Business Development as a Developmental Zone Enterprise (DZE) pursuant to D.C. Code § 2-218.37.

b) The conversion factors are dependent upon DHCF's budget target, and are calculated using outpatient hospital paid claims data from DHCF's most recent available fiscal year.

i. The base year data for the conversion factors effective FY 2015, beginning on October 1, 2014, shall be historical claims data for outpatient hospital services from the DHCF's FY 2013 (dates of services beginning on October 1, 2012 through September 30, 2013). The budget target for FY 2015 is based on 77% of FY13 costs (average for all hospitals combined) that are inflated forward to FY15 using the CMS Inpatient Prospective Payment System (IPPS)

Hospital Market Basket rate. The base year shall change when the EAPG payment system is rebased and recalibrated with a grouper version and relative weights update every other year.

ii. The budget target for FY15, beginning on October 1, 2014 through September 30, 2015, will be reduced by a 5% coding improvement factor due to the expectation that hospitals will improve coding above 77% of cost. During rate setting simulations, conversion factors were adjusted as necessary to attain the DHCF's overall budget target.

iii. The budget target is subject to change each year. Initially, DHCF shall monitor claim payments at least biannually during DHCF fiscal years 2015 and 2016 to ensure that expenditures do not significantly exceed or fall short of the budget target and will make adjustments to conversion factors. DHCF will provide written notification to the hospitals of the initial conversion factors and any future adjustments to the conversion factors.

iv. DHCF shall analyze claims data annually thereafter to determine the need for an update of the conversion factors. The conversion factors in subsequent years shall be based on budget implications and/or other factors deemed necessary by DHCF. Future changes in the calculation, or reimbursement methodology, of the EAPG conversion factors shall be contingent upon the approval of a state plan amendment.

v. New hospitals shall receive the District-wide conversion factor on an interim basis until the conversion factor annual review during which conversion factors for all hospitals are analyzed and potentially updated. Any changes in rates shall be effective on October 1 of each year.

4) **Calculating Final EAPG Payments**

Payment based on the EAPG method shall be determined using the following formula:

EAPG payment
=
Adjusted EAPG relative weight x policy adjustor (if applicable)
x
Conversion factor

a) Each CPT/HCPCS procedure code on a claim line is assigned to the appropriate EAPG at the line level.

b) Each EAPG has an assigned national relative weight. This relative weight is adjusted by the applicable payment mechanisms including discounting, packaging, and/or consolidation. The adjusted relative weight is then multiplied by the conversion factor to yield the EAPG payment amount for each claim line. The total reimbursement rate for an outpatient hospital claim is the sum of all claim lines.

c) DHCF may also utilize policy adjustors, as appropriate, to ensure that Medicaid beneficiaries maintain access to outpatient services, and ensure adequate provider networks. Effective October 1, 2014, a pediatric policy adjustor will be applied to the national weight for all outpatient visits for children under the age of 21.

d) The amount and type of policy adjustors shall be published in the District of Columbia Municipal Regulations. Any future changes in the types of policy adjustors will be included in state plan amendments and published in the District of Columbia Municipal Regulations.

c. **Reimbursement of Outpatient Services applicable to Out-of-District Hospital Providers**

1) With the exception of Maryland hospitals, outpatient hospital services provided at all out-of-District hospitals shall be paid under the reimbursement methodology based on the EAPG classification system.

2) EAPG relative weights and conversion factors that apply to out-of-District hospitals shall be the same relative weights and conversion factors utilized for in-District hospitals.

d. Coverage and Payment for Specific Services under the EAPG Reimbursement System

1) Laboratory and radiology shall be processed and paid by EAPG, subject to consolidation, packaging, or discounting.

2) Physical therapy, occupational therapy, speech therapy, and hospital dental services shall be processed and paid by EAPGs, subject to consolidation, packaging or discounting.

3) Services with an observation status may be paid under the EAPG payment method. In order to receive reimbursement under the EAPG, claims must include at least eight (8) consecutive hours (billed as units of service). Observation hours in excess of forty-eight (48) shall not be covered.

e. Prior authorizations

DHCF policies for services requiring prior authorization shall apply under the EAPG classification system reimbursement methodology.

f. Exceptions to Reimbursement Under the EAPG Classification System

1) Vaccines for children shall not be payable under EAPG if they are currently paid under the federal government's Vaccine for Children (VFC) program. Vaccines for adults shall be covered and paid under the EAPG pricing.

2) Professional services provided by physicians are not included in the EAPG payment method and shall be billed separately. Payment for physicians' services shall be made in accordance with the DHCF's Medicaid fee schedule.

3) Claims originating from Maryland hospitals, St. Elizabeths Hospital, and managed care organizations shall be excluded from EAPG pricing.

g. Three-day Payment Window

1) Outpatient diagnostic services provided by a hospital one (1) to three (3) days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay.

2) All hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are considered part of the inpatient stay and are not separately payable.

3) This policy applies to general hospitals, both in-District and out-of-District, with the exception of specialty hospitals (described in Part II of Attachment 4.19-A) and Maryland hospitals.

h. Payment Adjustment for Provider Preventable Conditions Policy

Medicaid payment adjustments for Provider Preventable Conditions set forth in Chapter 92 of Title 29 of the District of Columbia Municipal Regulations shall be processed and paid in accordance with the criteria for payment adjustment for provider preventable conditions described under Attachment 4.19-B of the State Plan and corresponding rules.

i. Cost Reports and Audits

An in-District hospital shall be required to submit cost reports and shall comply with audits in accordance with the requirements described under Part V, Attachment 4.19-A of the State Plan.

j. Record Maintenance and Access to Records

All in-District and out-of-District hospitals that provide outpatient services shall maintain records in accordance with the requirements described under Part V, Attachment 4.19-A of the State Plan.

k. Appeals

All in-District and out-of-District hospitals that provide outpatient services shall be subject to the appeal and administrative review requirements described under Part V, Attachment 4.19–A of the State Plan.

Definitions

For purposes of this section, the following terms shall have the meanings ascribed:

1. Base year – The standardized year on which rates for all hospitals for outpatient hospital services are calculated to derive a prospective payment system.

2. Budget target- The total amount of claims payment that DHCF anticipates spending on all hospital outpatient claims during its fiscal year.

3. Conversion Factor – The dollar value which is dependent upon the District's budget target and multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable payment for a visit.

4. Consolidation – Collapsing multiple significant procedures into one EAPG during the same visit which is then used to determine payment under the EAPG classification system reimbursement methodology.

5. Discounting - The reduction in payment for an EAPG when significant procedures or ancillary services are repeated during the same visit or in the presence of certain CPT/HCPCS modifiers.

6. Department of Health Care Finance – The single state agency responsible for the administration of the District of Columbia's Medicaid program.

7. DHCF Fiscal year – The period between October 1st and September 30th; used to calculate the District's annual budget.

8. Enhanced Ambulatory Patient Grouping (EAPG) – A group of outpatient procedures, encounters, and/or ancillary services reflecting similar patient characteristics and resource use; incorporates the use of diagnosis codes Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes, and other outpatient data submitted on the claim.

9. EAPG Grouper/Pricer Software – A system designed by 3M Health Information Systems to process HCPCS/CPT and diagnosis code information in order to assign patient visits at the procedure code level to the appropriate EAPG and apply appropriate bundling, packaging, and discounting logic to calculate payments for outpatient visits.

10. EAPG Relative Weight -The national relative weights calculated by 3M Health Information Systems.

11. EAPG Adjusted Relative Weight – The weight assigned to the patient grouping after discounting, packaging, and/or consolidation.

12. General Hospital- A hospital that has the facilities and provides the services that are necessary for the general medical and surgical care of patients, including the provision of emergency care by an Emergency Department in accordance with 22-B DCMR § 2099.

13. New Hospital- A hospital without an existing Medicaid provider agreement that is enrolled to provide Medicaid outpatient hospital services, after September 30, 2014.

14. In-District Hospital- Any hospital that is located within the District of Columbia in accordance with 22-B DCMR§ 2099.

15. Observation Status – Services rendered after a physician writes an order to evaluate the patient for services and before an order for inpatient admission is prescribed.

16. Outpatient Hospital Services – Preventative, diagnostic, therapeutic, rehabilitative, or palliative services rendered in accordance with 42 C.F.R. § 440.20(a).

17. Out-of-District Hospital- Any hospital that is not located within the District of Columbia. The term does not include hospitals located in the State of Maryland and specialty hospitals identified at 22-B DCMR § 2099.

18. Packaging – Including or wrapping payment for certain services in the EAPG payment, along with services that are ancillary to a significant procedure or medical visit.

19. Pediatric Policy Adjustor - A policy adjustor that is based upon the age of the beneficiary and will adjust payment levels based upon a targeted population. The value of the adjustor is determined by comparing payment levels for pediatric visits versus adult visits. The adjustor is a percentage increase of the total payment for the outpatient visit. The value of the policy adjustor will be determined annually during the rate setting process and may be adjusted year to year to ensure necessary access to outpatient hospital services. During claim adjudication, the dollar amount of the adjustor will be calculated as a percent of the EAPG payment and added to the total claim payment. The increased EAPG payment will only be applied to claims for beneficiaries under the age of 21.

20. Specialty Hospital - A hospital that meets the definition of "special hospital" as set forth in 22-B DCMR § 2099 as follows:

    (a) Defines a program of specialized services, such as obstetrics, mental health, orthopedics, long term acute care, rehabilitative services or pediatric services;

    (b) Admits only patients with medical or surgical needs within the defined program; and

    (c) Has the facilities for and provides those specialized services

21. Visit – A basic unit of payment for an outpatient prospective payment system.

9. Clinic Services

a. General Provisions

1. Clinic services shall be provided by or under the direction of a physician and may be provided in either public or private facilities.

2. Reimbursement for induced abortions is provided in cases where the life of the mother, due to a physical condition/disorder in the pregnancy woman, would be endangered if the fetus were carried to term, or the pregnancy occurred as a result of rape of incest, and when the claim is accompanied by the following documentation:

   i. Documentation that services were performed by a provider licensed to provide such services; and

   ii. Written documentation from the treating physician that the life of the mother would be endangered if the fetus were carried to term; or

   iii Documentation that the pregnancy occurred as a result of rape or incest. For the purposes of this requirement, documentation may consist of official reports; a written certification from the patient that the pregnancy occurred as a result of rape or incest; or certification from the physician that in his or her professional opinion, the pregnancy resulted from rape or incest.

b. Private Clinics

1. Reimbursement for private clinic services will be based on a two-tier system using the following methodology:

   i. Physician and specialty services rates will be reimbursed pursuant to Attachment 4.19B(6), page 4; and

   ii. Rates provided by non-physicians for Medicaid services will be reimbursed at eighty percent (80%) of the physician and specialty services rate.

c. Public Clinics

1. The term "public clinic" includes all clinics owned, operated, managed or leased by the District of Columbia. Medicaid services will include:

   i. Preventive Services
   ii. Diagnostic Services
   iii. Therapeutic Services
   iv. Rehabilitative Services
   v. Palliative Services

   Providers will be reimbursed interim rates for Clinic Services, per unit of service, at the lesser of the provider's billed charges or statewide enterprise interim rate. On an annual basis, a District of Columbia cost reconciliation and cost settlement for all over and under payments will be processed based on yearly filed provider cost reports.

   The units of service are defined by each Health Insurance Portability and Accountability Act (HIPPA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

2. Reimbursement for medical services in a public clinic is 100% of the reasonable costs of providing services to Medicaid beneficiaries as reported on the CMS-approved Public Clinic and Clinic Laboratory Cost (PCCLC) Report.

   i. Direct costs include, but are not limited to, unallocated payroll and other costs that can be charged to direct medical services. Direct payroll costs that include total compensation (i.e., salaries and benefits and contract compensation) of direct personnel listed in the description of covered Medicaid services delivered by public clinics. Costs are directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs will be calculated on a Medicaid provider-specific level and reduced for any federal payments for these costs, resulting in adjusted direct costs. Allowable provider costs related to Direct Medical Services include: salaries; benefits; medically-related purchased or contracted services; and medically-related supplies and materials.

   ii. Indirect costs are determined by applying the public clinic unrestricted indirect costs rate to its adjusted direct costs. Providers are permitted

only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect rate. Indirect costs include overhead and other costs common to an operational clinic, including but not limited to, administration, financial; public relations; legal; data processing; housekeeping; public relations; maintenance; security; insurance; utilities; transportation; depreciation; training, seminars, conferences and meetings.

3. Statistical or other evidence is used as the basis for allocating costs to public clinic services and determining the Medicaid eligibility rate. The Medicaid eligibility rate is based on the percentage of Medicaid beneficiaries receiving service in each individual clinic relative to the entire population receiving service in each individual clinic.

4. The cost reconciliation process will be conducted for the reporting period covered by the annual PCCLC Report. Interim payments to public clinics will be compared to Medicaid reimbursable costs at the FFP level to compute the amount due to or from the program.

5. Each public clinic will certify on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition each public clinic certified on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share. Public clinics are only permitted to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are not included on the cost report.

6. Each public clinic will complete the annual PCCLC Report for all clinic services delivered during the fiscal year covering October 1 through September 30. The cost report is due on or before June 30 of the following year, with the cost reconciliation and settlement process completed by September 30 of the subsequent year. The cost report will:

   i. Document the public clinic's total Medicaid allowed costs for delivering public clinic services, including direct and indirect costs.
   ii. Reconcile interim payments to total Medicaid allowed costs and determine amounts due to/from public clinic.

DHCF will use the PCCLC Report for purposes of clinic cost reporting. The annual PCCLC Report includes:

i. attestations regarding the completeness and correctness of the data presented;
ii. delineation of total public clinic costs associated with the clinic and related clinic laboratory services;
iii. separation of such costs into indirect and direct components with allocation of the indirect costs based on direct costs prior to allocation;
iv. determination of program costs and the statistical or other basis used to make such determinations; and
v. application of the appropriate Federal Medical Assistance Percentage to determine federal financial participation and reconcile interim payments to allowed costs.

All filed annual PCCLC Reports are subject to a review by the DHCF or its designee.

10. Intermediate Care Facilities

See Attachment 4.19D

11. Prepayment Organizations

a. Health Maintenance Organizations will be reimbursed for services at a negotiated per capita rate per enrolled individual to be established by the State Agency.

b. The premium rate will be reasonable in relation to the amount, duration, and scope of services provided, and will not exceed the costs of providing services on a fee for service basis.

c. The payment of services provided on a prepaid capitation basis are actuarially sound in accordance with the regulations in 42 CFR 438.6(c).

12.

a. Rural Health Clinic Services

The District of Columbia does not have any rural areas.

b. Federally Qualified Health Centers

(1) The District of Columbia reimburses federally qualified health centers (FQHCs) based on the approved costs identified in the FQHC's Title XVIII audited costs report. The Department accepts Title XVIII's determination of reasonable costs in lieu of its own definition.

13. Payment for Medical Assistance Furnished to an Alien with an Emergency Medical condition who is not Lawfully Admitted for Permanent Residence or otherwise Permanently Residing under Color of Law

a. Emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

b. Payment for medical assistance under this provision shall be determined by the type of care provided and shall be in accordance with the methods and standards or reimbursement outlined in this Attachment.

14. Reimbursement Methodology: Hospice Care for services performed between 10/1/92 through 3/1/2013

    1. The Program shall pay a hospice care provider at one (1) of four (4) prospective rates for each day that a recipient is under the provider's care. The daily payment rates for a provider for routine home, continuous home care, inpatient respite care, and general inpatient care shall be in accordance with the amounts established by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services for hospice care under the Medicare Program.

    2. The four (4) daily rates are prospective rates, and there will be no retrospective adjustment other than a limitation on payment for inpatient care.

    3. Total reimbursement to a participating hospice for hospice care shall be limited to the cap amount established by Medicare regulations.

    4. The following services performed by hospice physicians are included in the rates paid to the hospice care provider:

        a. General supervisory services of the medical director; and

        b. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

    5. In addition to the daily rates for the hospice care, the Program will make separate payment to the hospice care provider for the services subject to the following requirements:

        a. <u>Physician Services</u>

            For services not described in number (4) above, the payment shall be made in accordance with the usual Program reimbursement policy and fee schedule for physicians' services.

            Reimbursements for these physician services are not included in the amount subject to the hospice payment limit.

            The services must be direct patient care services furnished to a recipient under the care of the provider.

14. Reimbursement Methodology: Hospice Care for services provided on or after 3/2/2013

1. The Program shall pay a hospice care provider at one (1) of four (4) prospective rates for each day that a recipient is under the provider's care. The Medicaid Hospice rates are set prospectively by the Centers for Medicare and Medicaid Services (CMS) based on the methodology used in setting Medicare hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through the Centers for Medicare and Medicaid memorandum titled *Annual Change in Medicaid Hospice Payment Rates – ACTION* issued by the Director of the Disabled and Elderly Health Programs Group in the Center for Medicaid and CHIP Services. Rates and fees can be found by accessing the DHCF website at www.dc-medicaid.gov. The DHCF hospice rates were set by CMS and are effective for services provided on or after the CMS publication date. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

2. The four (4) daily rates are prospective rates, and there will be no retrospective adjustment other than a limitation on payment for inpatient care.

3. Total reimbursement to a participating hospice for hospice care shall be limited to the cap amount established by Medicare regulations.

4. The following services performed by hospice physicians are included in the rates paid to the hospice care provider:

   a. General supervisory services of the medical director;

   b. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

5. In addition to the daily rates for the hospice care, the Program will make separate payments to the hospice care provider for the services subject to the following requirements:

   a. Physician Services

      For services not described in number (4) above, the payment shall be made in accordance with the usual Program reimbursement policy and fee schedule for physicians' services. Reimbursements for these physician services are not included in the amount subject to the hospice payment limit. The services must be direct patient care services furnished to a recipient under the care of the provider.

The services must be furnished by an employee of the provider or under the arrangements made by the hospice provider;

Payment shall be paid directly to the physician in accordance with the usual program reimbursement policy and fee schedule for physician services and not subject to the hospice cap;

The services furnished voluntarily by physicians are not reimbursable.

b. Pharmacy Services - Quality of Life Prescriptions

The drugs must be a part of the therapeutic regimen for a chronic condition unrelated to the terminal illness, such as diabetes or hypertension.

6. When a recipient resides in a nursing facility, the program will pay a per diem reimbursement for room and board to the hospice care provider in addition to the routine home care rate or continuous home care rate.

   a. The amount will be the per diem reimbursement rate of an individual facility.

   b. The amount will be paid only when the provider and the facility have written agreement under which the provider is responsible for the professional management of the recipient's hospice care and the facility agrees to provide room and board to the participant.

7. For recipients residing in a nursing facility, the Department of Human Services shall determine the application of a recipient's resources to the cost of hospice care pursuant to Section 1924 (d) of the Social Security Act, D.C. Law 9-70 and CFR 435.725 and 435.726.

8. The personal needs allowance for persons or families institutionalized in a hospice program and maintenance standards for community spouse and other dependent family members will be based upon Attachment 2.6A pages 4 through 5a of the District's State Plan. Also see 42 CFR 435.733.

9. Request for payment for hospice care rendered will be submitted according to procedures established by the Department. Payment requests which are not properly prepared or submitted may not be processed, but returned unpaid to the provider.

10. Requests for payment will be submitted on the invoice form specified by the Department.

15. Reimbursement Methodology for Case Management Services

1. Requests for payment of case management services shall be submitted by an approved provider according to the "Conditions of Participation" established by the State Agency.

2. The provider shall submit a request for reimbursement on claim form HCFA-1500. A separate invoice shall be submitted for each participant. Payment requests which are not properly prepared or submitted may not be processed and will be returned unpaid to the provider.

3. Clients shall be assigned to CMHS to case managers who require case management services or intensive case management services.

   a. Case management services are targeted to clients who have been identified as having obtainable goals of physical survival, personal growth, community participation and recovery from or adaptation to mental illness;

   b. Intensive case management services are targeted to clients who have minimal social skills for negotiating in the community and/or resist traditional forms of mental health and other treatment.

4. Payments shall be limited to one reimbursement unit per day even though the case manager may have more than one face-to-face contact with the client on the same day. This includes at least one visit to the participant's home or another suitable site at least every 90 days.

5. The reimbursement rate shall be on a fee for service basis.

   a. Payment for case management services shall not exceed 50 units per year unless prior authorized.

   b. Payment for intensive case management shall not exceed 100 units per year unless prior authorized.

   c. Rate changes when appropriate, shall be published in the District of Columbia Register.

Reimbursement Methodology

6. The number of units shall be listed in the individual service plan. When a determination is made by CMHS that a client requires more than the upper limit of units per year, as started in 5a and 5b, a written request including documentation supporting the medical necessity for the additional units shall be submitted to CHCF for approval.

7. Reimbursement rate for assessment or reassessment shall be on a fee for service basis. After an initial assessment the CMSH will conduct a reassessment every 180 days. The assessment and reassessment shall incorporate input from the individual, family members, friends and community service providers. Rate changes when appropriate, shall be noted in the District of Columbia's Register.

8. The provider shall accept, as payment in full, the amount paid in accordance with the established fee for service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE District of Columbia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item 16 - Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	___ limited to State plan rates*	___ limited to State plan rates*	___ limited to State plan rates*
	X full amount	X full amount	X full amount
Part A Coinsurance	___ limited to State plan rates*	___ limited to State plan rates*	___ limited to State plan rates*
	X full amount	X full amount	X full amount
Part B Deductible	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	___ full amount	___ full amount	___ full amount
Part B Coinsurance	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	___ full amount	___ full amount	___ full amount

* For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) 17.

STATE District of Columbia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

The policy and method to be used in establishing payment rates for each type of care or services listed in 1905 (a) of the Social Security Act, other than inpatient hospital care and care provided in skilled nursing and intermediate facility care, and included in the District's State Plan of Medical Assistance are described below:

17. Reimbursement and payment criteria shall be established which are designed to enlist participation of a sufficient number of providers such that services are available to eligible persons at least to the extent that such services are available to the general population.

18. Participation in the program shall be limited to providers of services who agree to accept the District's payment plus any co-payment required under the State Plan as payment in full.

19. Payments for services shall be based on reasonable allowable costs following the standards and principles applicable to the Title XVIII program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility-by-facility basis in accordance with 42 CFR 447.325. In no instance, however, shall charges for services provided to beneficiaries of the program exceed charges for private patients receiving care from the provider. The professional component for emergency room physicians shall continue to be included as a component of the payment to the facility.

20. Emergency Hospital Services

    a. Definitions. The following terms shall have the following meaning when applied to emergency services unless the context clearly indicates otherwise:

       "All inclusive" shall mean all emergency room and ancillary service charges claimed in association with the emergency room visit.

"Department" shall mean the Department of Health.

"Emergency hospital services" shall mean services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

"Recent injury" shall mean an injury that occurred less than 72 hours prior to the emergency room visit.

b. Scope. The Department shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in the emergency room. The differentiation shall be between (1) "emergency care" as defined above under "emergency hospital services" and (2) "urgent (non-emergency) care", which does not meet the above-cited definition of "emergency hospital services". The Department publishes a list of primary diagnosis codes that meet the definition of emergency care as well as a list of primary diagnosis codes that meet the definition of urgent (or non-emergency) care.

1. The Department shall reimburse at reduced all inclusive reimbursement rate for all services rendered in emergency rooms which the Department determines were non-emergency care. For services provided in emergency rooms that do not meet the definition of emergency care on or after September 1, 1996, the all inclusive facility rate shall be fifty dollars ($50).

2. Services determined by the physician's primary diagnosis to be emergencies are reimbursed at the facility specific, all-inclusive outpatient rate described in paragraph 8 (b) of page 5 of Attachment 4.19B except that for services on or after September 1, 1996, the all-inclusive outpatient rate described in paragraph 8 (b)(4) is inflated by 40% for the purpose of reimbursing hospital emergency room services.

3. Services performed by the attending physician which may be emergency services will be manually reviewed. If these services meet certain criteria, they shall be reimbursed under the methodology for 2 above. Services not meeting these criteria shall be reimbursed under the methodology for 1 above.

i. The initial treatment for medical emergencies including indications of severe chest pains, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered to be life threatening.

ii. The initial treatment following a recent injury resulting in a need for emergency hospital services as defined in "a" above.

iii. Treatment related to an injury sustained more than 72 hours prior to the visit in which the patient's condition has deteriorated to the point of requiring medical treatment for stabilization.

iv. A visit in which the patient's condition requires immediate hospitalization or the transfer to another facility for further treatment or a visit in which the patient dies.

v. Acute vital sign changes indicating a deterioration of the patient's health requiring emergency hospital care.

vi. Severe pain would support an emergency need when combined with one or more of the other guidelines.

21. Fee-for-Service Providers

i. The DHCF fee schedule is effective for services provided on or after the date of publication, occurring annually in January. All rates are published on the state agency's website at www.dc-medicaid.com.

ii. Except as otherwise noted in the Plan, DHCF-developed fee schedule rates are the same for both governmental and private individual practitioners.

iii. Payment for the following services shall be at lesser of the state agency fee schedule; actual charges to the general public; or, the Medicare (Title XVIII) allowance for the following services:

a. Physician's services
b. Dentist and Orthodontist's services
c. Podiatry
d. Mental health services, including community mental health services, services of licensed clinical psychologists, and mental health services provided by a physician, except for mental health services listed in Supplement 2, Attachment 4.19-B, pages 1 and 1a, which shall be reimbursed based on the methodology outlined on those pages.

21. (Continued) Fee for Service Providers

e. Durable medical equipment
f. Laboratory services
g. Optometry services
h. Home health services
i. Medical supplies and equipment
j. X-Ray services
k. Targeted case management services
l. Transportation services
m. Nurse practitioner services which include, but are not limited to, services provided by the Advanced Practice Registered Nurse, nurse midwife, nurse anesthetist, and clinical nurse specialist. The nurse practitioner may choose to be reimbursed either directly by the State Medicaid agency through an independent provider agreement or through the employing provider.

22. For Title XVIII services not covered under Title XIX in the State Plan of Medical Assistance the payment rate shall be the lower of:

a. The provider's charge for the services, or;

b. The District's fee for the service or;

c. Eighty percent (80%) of the prevailing reasonable allowable charge for the same service under Medicare at the time the service is provided.

23. Tuberculosis-Related Services

a. Medically necessary tuberculosis-related services provided on an inpatient basis shall be reimbursed in accordance with provisions of 4.19A of the State Plan of Medical Assistance.

b. Medically necessary tuberculosis-related services provided in an outpatient hospital department or in a free-standing clinic shall be reimbursed in accordance with the provisions of 4.19B of the State Plan Medical Assistance that refer to the appropriate provider type.

24. Personal Care Services

a. Payment for Personal Care Aide services shall be provided at an hourly rate established by the State Medicaid Agency. The hourly rate for services provided in an individual setting will be distinct from the rate for services provided to multiple beneficiaries at the same address.

b. Payment will not be made for more than eight (8) hours of service per day, or one thousand and forty (1,040) hours in any twelve (12) month period, without prior authorization from the Medicaid agency.

c. Reimbursement will be the lesser of the amount established by the Medicaid agency or the amount charged by the provider.

25. Rehabilitative Services

1. Mobile Community Outreach Service Teams (MCOTT)

1. MCOTT providers shall be reimbursed at a flat rate for each day on which at least one face-to-face service for the client is provided. This rate will be established by the Medicaid agency. An example follows:

Direct service yearly cost	=$1,753,700.00
Fringe Benefits & Administration (*overhead which is 33% of direct service total costs*)	=$ 578,721.00
Total Costs	=$2,332,421.00

Hypothetical number of clients = 100

Rate Calculation: ($2,332,421.00/100)/365 days =$ 63.90
(this is a per person ,per day rate)

2. Services must be medically necessary and prior authorized.

3. Reimbursement will not be made for services provided during a client's inpatient hospitalization

26. Case Management Services

Target Group
This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Children and Family Services Administration (CFSA).

An interim rate will be established. In order to ensure that such rate is reasonable for all providers, it will be based on - and continue to be bound to - the actual cost of CFSA in providing case management services to the target population. To the extent that payments will be made to governmental service providers, in accordance with Federal Office of Management and Budget Circular No. A-87 requirements, such payments shall not exceed the costs of providing such services.

These interim rates will be established for every twelve month period beginning October 1 and ending September 30th. After the actual costs for the period has been determined, all claims paid during this period will be adjusted to the actual rate. A new interim rate will be determined as described above. This will be repeated every twelve months to adjust claims paid at the interim rate to actual cost.

The Medicaid Targeted Case Management unit rate will be determined as follows:

	Compute the actual cost of providing targeted case management (TCM) services through CFSA during its most recently completed twelve month period for which actual costs data exists, which includes case managers, their direct supervisory and support staff, and their indirect administrative staff. This cost includes salaries and benefits; other operating costs including travel, supplies, telephone and occupancy cost; and indirect administrative costs in accordance with Circular A-87.
Multiplied by	Percentage of time spent by CFSA Family Service Workers in performing case management work on behalf of children in the care or custody of CFSA. This percentage will be taken from the current Random Moment Time Study (RMTS), which is performed quarterly by CFSA. The RMTS is currently used to allocate worker time to various functions so as to properly allocate and claim funds from the appropriate programs.
Multiplied by	Percentage of Medicaid recipients among number of clients serviced in the month. Taken together with the RMTS percentages, this will give the percentage of the total cost of service worker time described above that is allocable to TCM.

Equals	Total cost for Medicaid Targeted Case Management Services
Divided by	12 Months
Equals	Average monthly cost of Medicaid Targeted Case Management Services
Divided by	Number of clients in receipt of Medicaid to be served during the month
Equals	Monthly cost per Medicaid eligible client for Medicaid Targeted Case Management Services. This is the monthly case management interim unit rate, which will be billed for each Medicaid recipient in the target group each month. Documentation of case management services delivered will be retained in the service worker case files.

The monthly case management interim unit rate is that amount for which the provider will bill the Medicaid Agency for one or more case management services provided to each client in receipt of Medicaid during that month. This "monthly case management unit" will be the basis for billing. A monthly case management unit is defined as the sum of case management activities that occur within the calendar month. Whether a Medicaid client receives twenty hours or two hours or less, as long as some service is performed during the month, only one unit of case management service per Medicaid client will be billed monthly.

27. Rehabilitative Services to Children Who have Been Abused or Neglected

A. Rehabilitation services for children will be provided in the least restrictive setting appropriate to the child's assessed condition, plan of care and service. Services shall be provided to children in one or more of the following settings:

1. Services provided to children who reside in a family home setting will be provided either in the child's home, in the customary place of business of a qualified provider or in other settings appropriate to servicing Children's (schools, health clinics, etc.).

2. Services provided to children who reside outside of a family home will be provided in the customary place of business of a qualified provider or in an appropriately licensed and/or certified settings including:

(a) Emergency shelter facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates,

(b) Comprehensive residential treatment facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates,

(c) Residential treatment facilities licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates, and

(d) Therapeutic foster homes licensed and/or approved by the appropriate regulatory agency in the jurisdiction within which the facility operates.

3. Services shall not be reimbursed when provided as part of a service provided by the following facilities:

(a) Acute, general, psychiatric or pediatric hospitals,

(b) Nursing facilities,

(c) Intermediate care facilities for the mentally retarded, and

(d) Institutes for the treatment of mental diseases.

4. Rehabilitative Services to Children Who Have Been Abused or Neglected shall be reimburse through the following methods:

   (a) The eight services will be reimbursed as traditional fee-for-service claims for children who are not in residential settings.

   (b) Partial Day Treatment Programs providing a comprehensive treatment program including at least four of the covered services and provided at least four (4) hours per session will be reimbursed via a per diem rate which recognizes and combines each of the services actually provided in that setting.

   (c) Full Day Treatment Programs providing a comprehensive treatment program including at least four of the covered services and provided at least six (6) hours per session will be reimbursed via a per diem rate which recognizes and combines each of the services actually provided in that setting.

   (d) The reimbursement made in residential settings will be via a per diem rate which recognizes and combines each of the services actually provided in that setting.

5. Rehabilitative Services To Children Who Have Been Abused or Neglected shall be reimbursed through a cost based fee schedule. Documentation of the rate development methodology and fee schedule payment rates will be maintained by the Medical Assistance Administration.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

28. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

A. Reimbursement Methodology for School Based Health Services (SBHS)

School based health services are delivered by District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), herein after referred to as "providers" for this section of the State Plan. EPSDT SBHS are defined in Supplement 1, Attachment 3.1-A pages 6, 6a and 6b and include the following Medicaid services:

1. Skilled Nursing Services
2. Psychological Evaluation Services
3. Behavioral Supports (Counseling Services)
4. Orientation and Mobility Services
5. Speech-Language Pathology Services
6. Audiology Services
7. Occupational Therapy Services
8. Physical Therapy Services
9. Specialized Transportation
10. Personal Care Services
11. Nutrition Services

B. Direct Medical Payment Methodology

Providers are being paid on a cost basis for SBHS provided on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS direct medical services per unit of service at the lesser of the provider's billed charges or the statewide enterprise interim rate. On an annual basis, a District-specific cost reconciliation and cost settlement for all over and under payments will be processed based on yearly filed provider cost reports.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data sources:

    a. School Based Health Services Cost Reports received from schools
    b. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
        i. Direct medical RMTS percentage
    c. School District specific IEP Medicaid Eligibility Rates (MER)

D. Data Sources and Cost Finding Steps

The cost report identifies SBHS costs by the following cost pools: 1) Medical costs; 2) Personal care costs; and, 3) Transportation costs. Change in the number of cost pools is determined during the CMS approval of the cost report and RMTS. The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs:

Direct costs for direct medical services include unallocated payroll and other costs that can be charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by DCPS and DCPCS, excluding transportation personnel. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs will be calculated on a Medicaid provider-specific level and reduced for any federal payments for these costs, resulting in adjusted direct costs. Allowable provider costs related to Direct Medical Services include: 1) Salaries; 2) Benefits; 3) Medically-related purchased or contracted services; and, 4) Medically-related supplies and materials.

The cost report contains the scope of cost and methods of cost allocation that have been approved by the CMS. Costs are obtained from the audited Trial Balance and supporting General Ledger, Journals, and source documents. They are also reported on an accrual basis.

Indirect Costs: Indirect costs are determined by applying the DCPS and DCPCS specific unrestricted indirect costs rate to their adjusted direct costs. District of Columbia Public Schools and Public Charter Schools use predetermined fixed rates for indirect costs. The District of Columbia Public Schools, Office of the Chief Financial Officer, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by DCPS and DCPCS. Pursuant to the authorization in 34 CFR § 75.561(b), DCPS and DCPCS approves unrestricted indirect cost rates for schools, which are also considered the cognizant agencies. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate:

a. Apply the District of Columbia Public Schools and Public Charter Schools Unrestricted Indirect Cost Rate (UICR) applicable for the dates of service in the rate year.
b. The DCPS and DCPCS UICR is the unrestricted indirect cost rate calculated by the District of Columbia Public Schools, Office of the Chief Financial Officer.

2. Time Study: A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize two mutually exclusive cost pools representing individuals performing Direct Medical Services. A sufficient number of personnel for each cost pool will be sampled to ensure time study results that will have a confidence level of at least 95 percent (95%) with a precision of plus or minus five percent (5%) overall. The Direct Medical Service time study percentage is applied against the Direct Medical Service cost pool. Results will be District-wide so every school will have the same time study percentages.

   a. Fee-For-Service RMTS Percentage
      i. Direct Medical Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 1200). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.
      ii. Personal Care Service Cost Pool: Apply the PCS percentage from the Random Moment Time Study. The Personal Care Service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation

i. Direct Medical Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 3100). The Direct Medical Services costs and time study results must be aligned to assure appropriate cost allocation.

ii. Personal Care Service Cost Pool: Apply the General Administrative time applicable to Personal Care Service percentage from the Random Moment Time Study (Activity Code 3100). The Personal Care Service costs and time study results must be aligned to assure appropriate cost allocation.

3. IEP Medicaid Eligibility Rate (MER): A District-wide MER will be established that will be applied to all participating schools. When applied, this MER will discount the cost pool expenditures by the percentage of IEP Medicaid students.

   The names and birthdates of students with a health-related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator of the rate will be the students with an IEP that are eligible for Medicaid, and the denominator will be the total number of students with an IEP.

4. Total Medicaid Reimbursable Cost: The results of the previous steps will be a total Medicaid reimbursable cost for each participating provider.

   After valid time study/claims results have been produced for at least four consecutive quarters, DHCF will submit for CMS review and approval a proposed methodology for documenting prior period claims by applying the time study results for purposes of adjusting the prior period claims that CMS has deferred. Claims for all prior period quarters must meet the timeliness requirements of 45 CFR § 95.7 and any additional time requirements specified in individual CMS deferral letters. Reported expenditures must be reasonable, allowable, and allocable, and must be adjusted, if necessary, to comport with the guidelines specified in the final approved District of Columbia Random Moment Time Study. The feasibility and method for adjusting the prior period quarter claims as proposed by the District and approved by CMS shall be final and not be subject to challenge or appeal.

E. Specialized Transportation Services Payment Methodology

Providers are paid on a cost basis for effective dates of service on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS Specialized Transportation services at the lesser of the provider's billed charges or the District-wide interim rate. Federal matching funds will be available for interim rates paid by the District. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Transportation is specifically listed in the IEP as a required service;
2. The child requiring transportation in a vehicle with personnel specifically trained to serve the needs of an individual with a disability;
3. A medical service is provided on the day that specialized transportation is billed; and
4. The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Attendants
3. Mechanics
4. Substitute Drivers
5. Fuel
6. Repairs & Maintenance
7. Rentals
8. Contract Use Cost
9. Depreciation

The source of these costs will be the audited Trial Balance and supporting General Ledger, Journals and source documents kept at DCPS and DCPCS. Costs are reported on an accrual basis.

Special education transportation costs include those adapted for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school based health services delivered during the previous state fiscal year covering October 1 through September 30. The cost report is due on or before June 30 of the year following the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school based health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to a desk review by the Department of Health Care Finance (DHCF) or its designee.

H. Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four (24) months of the end of the reporting period covered by the annual SBHS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school based health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

For the purposes of cost reconciliation, the District may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS

prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. Cost Settlement Process

For services delivered for a period covering October 1 through September 30, the annual SBHS Cost Report is due on or before June 30 of the following year, with the cost reconciliation and settlement process completed by September 30 of the subsequent year.

If a provider's interim payments exceed the actual, certified costs of the provider for school based health services to Medicaid beneficiaries, the provider will return an amount equal to the overpayment.

If actual certified costs of a provider for school based health services exceed the interim Medicaid payments, DHCF will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment within 30-days of final cost settlement.

DHCF shall issue a notice of settlement that denotes the amount due to or from the provider.

Citation

42 CFR 447,434
Part 438, and 1902(a)(4),
1903 1902(a)(6), and 1903
conditions.

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and with respect to non-payment for provider preventable

Other Provider Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section(s) 4.19 B.

X_ 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.

Payments for other provider preventable conditions (OPPCs) will be adjusted accordingly:

1. Providers are mandatorily required to report OPPCs to the Agency by using diagnosis codes in the corresponding fields provided for event codes on the claims.
2. Providers are mandatorily required to also report OPPCs using corresponding CPT/HCPCS modifiers associated with the surgical procedures on all claims.
3. Claims indicating any one of the three erroneous surgeries or procedures will be reviewed and denied if appropriate.

Citation

42 CFR 447.26 (c)

Provider Guidelines relating to Provider Reimbursement

i. The Agency assures the Centers for Medicare and Medicaid Services (CMS) that non-payment for OPPCs does not prevent access to services for Medicaid beneficiaries.

29. Other Non-Institutional Services

A. Licensed or Otherwise State-Approved Freestanding Birth Centers

1. Freestanding birth centers are reimbursed utilizing a contracted facility fee. Practitioners are reimbursed utilizing a separate professional services fee. The authority to reimburse practitioners independently can be found in Attachment 4.19B, Part 1, Section 21. Practitioners providing free standing birth center services must be licensed in the District of Columbia pursuant to the following:

   (a) Physician under Chapter 46 of Title 17 of the DCMR;

   (b) Pediatric nurse practitioner under Chapter 56 of Title 17 of the DCMR;

   (c) Family nurse practitioner under Chapter 56 of Title 17 of the DCMR;

   (d) Nurse midwife under Chapter 56 of Title 17 of the DCMR; and

   (e) Lay midwife and Certified Professional Midwife under 42 CFR 440.60

   Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners.

2. The birth centers shall be paid according to the District's fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website at https://www.dcmedicaid.com/dcwebportal/home.

3. The agency's fee schedule rate was set as of January 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at https://www.dcmedicaid.com/dcwebportal/home.