

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF SECOND EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02 (2014 Repl. & 2016 Supp.)), and Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6)) (2012 Repl.), hereby gives notice of the adoption, on an emergency basis, of an amendment to Chapter 45 (Medicaid Reimbursement for Federally Qualified Health Centers) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The second emergency and proposed rules amend the Medicaid reimbursement methodology for a Federally Qualified Health Center (FQHC). Federal law authorizes Medicaid reimbursement of FQHCs on a prospective payment system (PPS) that comports with federal regulations that have been in place since 2001, or an Alternative Payment Methodology (APM) that is based on reasonable costs, subject to certain requirements. The current PPS reimbursement model has been in effect since January 1, 2001. Since that time, the number of FQHCs operating in the District, the variety of services offered and patients served have increased.

The major components of the proposed reimbursement model include: (1) an APM for primary care services, behavioral health services, preventive, diagnostic, and comprehensive dental services; (2) a limit on reimbursement for administrative costs; (3) an additional payment based upon performance of each FQHC beginning in January 2018; and (4) a new PPS reimbursement model for new providers that enroll in the Medicaid program after the effective date of the corresponding SPA. These rules set forth the standards for participation in the Medicaid program, the standards used to develop the PPS, APM, cost reporting and auditing processes, and establish the requirements for Medicaid reimbursement of FQHCs for Medicaid-reimbursable services that are outside the scope of core services that qualify for APM rates. DHCF projects an increase in aggregate expenditures of approximately \$307,000 in Fiscal Year (FY) 2016 and \$1,200,000 in FY 2017.

A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on August 5, 2016 at 63 DCR 010227. Two sets of comments were received and a number of substantive changes were made. The majority of comments received were related to the rule sections governing PPPS, the APM for Behavioral Services, Change in the Scope of Practice, and Payment for Performance. All comments received were carefully considered by DHCF, and changes were made as follows:

General Provisions

DHCF received comments regarding requirements that FQHCs complete the Medicare enrollment process before enrolling in the Medicaid program. For claims submitted for services

furnished to dually eligible beneficiaries, FQHCs must be enrolled with Medicare in order to verify that claims will be paid first by Medicare.

With regard to the requirement that FQHCs serve only “temporarily” homebound patients, DHCF proposes to include language in the rule so that FQHCs may serve beneficiaries in the home that are not necessarily homebound. The change would allow the flexibility to provide access to beneficiaries that require home visits for a variety of reasons.

Prospective Payment System

Commenters argued that “medical service or services” should be replaced by “any federally-qualified health center service or other ambulatory service included under the Medicaid FQHC benefit, as described in Section 1905(a)(2)(C) of the Social Security Act.” Commenters also requested that DHCF include language that “allowable costs shall include total reasonable costs incurred in furnishing Medicaid coverable services divided by total visits, as determined by Medicare Reasonable Cost Principles as set forth in 42 CFR Part 413,” in order to reflect the total cost/total visits methodology used to calculate PPS.” DHCF cannot retroactively enact changes to the original provisions on the PPS methodology or reset rates that were set in 2001, which includes the above definition.

Commenters proposed a more specific definition behind a change in scope, including changes in the type, intensity, duration, or amount of services. DHCF agrees to the proposed language except for the addition of ambulatory services. In addition, DHCF proposes adding a new provision in Section 4509.

Commenters made the point that the rule should clarify that a claim can be eligible for wraparound even if the Managed Care Organization (MCO) did not make a payment on the claim. In light of the federal court’s holding in a U.S. Court of Appeals, Third Circuit case, DHCF will include more specificity on the process for appeals from MCO’s coverage denials in a subsequent proposed rule. However, revisions are made to the provisions on PPS and APM rates to include the requirement that FQHCs shall receive wrap-around supplemental payments.

Commenters contend that the adjustment to the PPS should be determined by dividing the incremental allowable cost attributable to a change in the scope of services by the number of encounters affected by the scope change event during the corresponding time period, with a corresponding allocation of overhead. The proposed language calculates the PPS rate adjustment by multiplying the current PPS rate by the percentage change in the allowable cost attributable to the change in scope; and the percentage change would be calculated as the total allowable cost including the change in scope for a twelve (12) month period, minus the total allowable cost stated in the FQHC's prior year’s cost report; divided by the total allowable cost stated in the FQHC's prior year’s cost report; and multiplied by one hundred percent (100%).

Additionally, the proposed language calculates the APM rate increase by dividing the total allowable cost plus the incremental allowable cost attributable to a change in the scope by the total number of encounters plus the encounters affected by the scope change. Overhead is

already accounted for, hence no need to add additional overhead when calculating the rate increase.

Commenters also requested that the PPS be adjusted for the year in which the change took place. DHCF does not intend to apply the revised rate retrospectively, as it is not administratively feasible for DHCF to recalculate rates retrospectively by recycling claims.

Commenters felt that the adjustment to the PPS should be granted if the change in scope of services results in at least a three percent (3%) increase or decrease in the FQHC's allowable costs, instead of the currently proposed five percent (5%). DHCF believes the five percent (5%) threshold is reasonable and a good threshold to determine whether the cost difference is substantial enough to warrant a change. Further, rates are rebased every three (3) years. Therefore, any increases less than five percent (5%) will be documented in cost reports and rates will be adjusted after the rebase.

With regard to the timeframe for submitting scope change requests, DHCF agrees that an FQHC should submit a written request to DHCF within ninety (90) days after the close of one (1) year of operation of the service that has resulted in a change of the scope of service, and has included this language in the rule.

In regard to the provisions on PPS rate adjustments based on changes in scope of services, DHCF removed all subsections from Section 4502 and revised Section 4509 to address adjustments to both PPS and APM rates based on scope of service changes.

APM for Behavioral Health Services

Commenters requested that the new behavioral health APM rate be applicable for all services in 2016, but DHCF is unable to make changes applicable retrospectively, and the effective date for these provisions must be consistent with the general effective date for these provisions. For these reasons, DHCF cannot make the behavioral health APM effective earlier.

Another commenter expressed concern that the one-fifth (1/5) reimbursement methodology for group therapy services will serve as a disincentive to the provision of group therapy in FQHCs and requested that group therapy be reimbursed at one third (1/3) of the individual behavioral health service APM rate. DHCF finds the proposed payment rate of one-fifth (1/5) to be fair and reasonable based on a review of other states' reimbursement of group therapy. For example, Massachusetts reimburses at one-eighth (1/8) of an FQHC encounter rate, and New York is another state that does not reimburse at the full PPS rate. New York's FQHCs are reimbursed a flat fee of \$35.16 per person for a group visit, which is not the full PPS rate. In addition, DHCF plans to rebase all rates based on more robust cost reports in 2018, which will provide more accurate rate data to inform future rates.

One commenter requested that DHCF remove the requirement that an FQHC which at the time of an audit has been operating as an FQHC, or an FQHC look-alike as determined by Health Resources Services Administration (HRSA), for fewer than five (5) years, receive the lesser of the average APM rate calculated for similar facilities. DHCF disagrees with this

proposed change. DHCF believes this provision is needed in order to ensure reasonable rates are paid to new FQHCs that are less than five (5) years old. During the initial years of operation, FQHCs have higher direct and indirect costs as they build up their network. Therefore, setting ongoing rates based on actual costs during that period could result in unreasonably high rates. Paying these newly established FQHCs comparable rates to established FQHCs will allow DHCF to establish a facility-specific APM based on actual cost experience that more accurately reflects ongoing experience.

One commenter requested that the rule be revised to allow FQHCs to bill for both individual and group therapy behavioral health service encounters in a single day. DHCF does not agree to the proposed change. DHCF is concerned that allowing FQHCs to bill for up to four (4) encounters per day may invite abuse. While keeping in mind a more patient-centric approach, DHCF proposes to clarify that FQHCs with beneficiaries receiving both group therapy and individual behavioral health services should request reimbursement at the individual therapy rate.

With regard to scope of behavioral health services, one commenter believed that FQHCs should be required to obtain separate National Provider Identifiers (NPIs) and bill in a non-FQHC capacity only for services that are fully outside the FQHC benefit. DHCF agrees in part; however, DHCF proposes to include a provision that reimbursement pursuant to these rules be within the scope of primary care services, behavioral health services, and dental as described in these rules. DHCF also proposes a provision that addresses the requirements for a FQHC to bill for services outside the scope of the four (4) core service categories, which includes obtaining a separate NPI.

Primary Care Services

With regard to the definition of “primary care services,” one commenter offered an alternate definition for consideration based on concern that the definition proposed in the initial rule was out of compliance with the federal laws concerning the scope of the FQHC benefit. In fact, the currently proposed definition by DHCF is consistent with FQHC services described in Section 1905(l)(2) of the Social Security Act, and DHCF already allows reimbursement pursuant to the fee schedule for any other ambulatory services covered under the State Plan.

One commenter requested that DHCF add nurse practitioners and licensed nutritionists to the list of primary care providers and remove the requirement to “work under the supervision of a physician.” DHCF disagrees. The DOH scope of practice regulations (17 DCMR § 5908.1) regarding nurse practitioners (NPs) require that NPs practice in accordance with the statute governing advanced practiced registered nurses (APRNs) (D.C. Official Code §§ 2-3306.4 – 7). In connection to physician assistants (PAs), Chapter 49 of Title 17 DCMR requires that PAs practice under a supervising physician. Regarding licensed nutritionists, Sections 1905(l)(2) and 1861(aa) the Social Security Act do not include licensed nutritionists among the providers of FQHC services. Additionally, nutritionist services may fit under allowable costs as an enabling service rather than covered primary care services.

Behavioral Health Services

A commenter made a similar request to add NPs to the list of covered behavioral health service providers was included under Subsection 4508.2(b) detailing which providers MCOs will credential, but the DOH regulations outlined above still stands. The same commenter requested that DHCF ensure MCOs credential all providers included in Subsection 4503.2; DHCF will work with MCOs to streamline the credentialing process.

Changes in the Scope of Services

One commenter proposed that DHCF add new language clarifying what constituted a change in type, intensity, duration or amount of service. DHCF agreed that additional language would clarify intent and adopted most of the proposed language.

One commenter requested that language be added so that a change in the scope of services may be triggered by an increase in the number of encounters or in the number of an FQHC's clinical staff. In fact, any increase in the number of clinicians or encounters is already included as constituting a change in intensity. Because this is already addressed, no change is needed.

One commenter proposed that the entirety of Subsection 4509.4 be stricken. That provision states, "A change in the scope of services shall not be based on a change in the number of encounters, or a change in the number of staff that furnish the existing service." In fact, the change in scope adjustment must specify parameters for which scope of change adjustments will be made. Therefore, DHCF cannot strike this section.

With regard to the change in scope threshold for APM rate changes, a commenter asked to update the provision allowing for an adjustment to the APM if the change in scope of services results in at least a three percent (3%) increase or decrease in the FQHC's allowable costs, instead of the currently proposed five percent (5%). DHCF believes the five percent (5%) threshold is reasonable and a good threshold to determine whether the change is substantial. Further, rates are rebased every three (3) years, so any increases less than three percent (3%) will be captured during the rebase year.

Commenters recommended a revision to require the health center provide a written notification to DHCF within ninety (90) days after the close of the year in which the change in the scope of services occurred, and that the deadline for the health center to file a cost report demonstrating the increase in cost per encounter should be one (1) year after the close of the year in which the scope change occurred. DHCF agrees to this suggestion and has proposed revised language. Additionally, DHCF will add the same provisions that were added to PPS adjustments based on scope changes.

Commenters also proposed that the timeframe for change in scope for APM rates to take effect be stricken altogether, and that a rate adjustment relating to a change in the scope of services should take effect as of the first date of the fiscal period when the scope change event occurred. DHCF does not intend to apply the revised rate retroactively and will only apply it prospectively as it is not administratively feasible or practical for DHCF to recalculate rates.

Allowable Costs

Under the definition of allowable costs, one commenter suggested adding “staff cost related to quality improvement, data analytics, and compliance.” DHCF agrees with the proposed change, and proposes a new subparagraph under incidental services.

Similarly, one commenter proposed to add “IT infrastructure” under the capital and facility cost definition. DHCF agrees with the intention of ensuring FQHCs are reimbursed for their IT infrastructure costs, but these costs are already included to support patient care under incidental costs or to support patient record keeping under administrative costs. In this rule, DHCF is proposing changes to existing language covering costs for hardware and software systems, under incidental costs in Subsection 4510.2(f)(8) and administrative costs under Subsection 4510.9(i), to clarify that services related to implementation of hardware and software systems will be included.

Under the administrative costs listed, a commenter suggested striking “training” from the list. DHCF proposes new clarifying language to include training of administrative personnel for the provision of health care services.

Commenters requested that DHCF remove the twenty percent (20%) cap on Medicaid reimbursement for administrative cost in the initial proposed rule. DHCF feels the cap is reasonable since many FQHCs reported unusually and unreasonably high administrative costs in cost reports DHCF reviewed in developing this rule. The cap is only applicable to administrative expenses, and would not apply to small-sized FQHCs during the first year of implementation. Additionally, DHCF did not include a cap/ceiling for capital- and facility-related expenditures, which will enable FQHCs to invest in needed facility and operational improvements.

Exclusions from Allowable Costs

One commenter proposed to strike “transportation costs” from the list of expenses excluded from allowable costs, but in fact, costs related to patient care should be addressed under enabling services. However, DHCF has revised incidental services and enabling services under Subsections 4507.1(b) and (c) and included the costs related to both services under allowable costs.

One commenter proposed that the section which would require that cost paid for by locally funded grants or other local services be offset against expenses in determining an FQHC’s allowable costs be removed. The intention of the offset is to avoid District sister agencies from paying the same cost twice, since the locally funded grant was already considered by DHCF during the rate development process.

Reimbursement for Out of State Providers

One commenter proposed that FQHCs located outside of the District of Columbia should be reimbursed at the DC PPS rate for DC patients seen at the FQHCs. DHCF took into account other states’ approaches, and DHCF finds this reimbursement requirement to be fair and reasonable if beneficiaries are going to out-of-state facilities.

Performance Payment

All comments related to this section are appreciated, and DHCF will provide proposed changes to this section in a subsequent rule.

Cost Reporting and Record Maintenance

One commenter expressed concern that FQHCs may not have completed their audits within the one hundred fifty (150) day timeframe. In fact, the stated provision allows FQHCs to provide unaudited financial statements if they do not have audited financial statements.

Regarding the requirement to submit “the annual HRSA application submitted to the federal government,” DHCF agrees with the suggestion to replace this requirement with “its annual HRSA Uniform Data System (UDS) report.”

Appeals

DHCF agrees with the commenter that DHCF needs an appeals process for wrap denials, and commits to including more specificity on the process for appeals in a subsequent proposed rule.

General

One commenter expressed concern regarding the eventual reconciliation between the interim rate and the APM rate projected to be retroactive to September 1, 2016, recommending that DHCF allow either billing methodology beginning September 1, 2016 at the discretion of the health centers. Unfortunately, DHCF does not have authority to pay the APM rate on September 1, 2016 without CMS approval.

Lastly, one commenter shared that while the rule does not explicitly address this topic, DHCF has made a commitment to address procedures and payment for those beneficiaries dually eligible for full Medicaid and Medicare in 2017. DHCF agrees with this sentiment, and included a provision that DHCF would pay an amount that is equal to the difference between the payment received from Medicare and any other payers (if the individual is enrolled in any other form of insurance) and the FQHC’s payment rate.

In addition to the substantive changes based on comments received, DHCF is also proposing substantive changes to conform with the corresponding State Plan Amendment (SPA). The proposed changes are as follows: (1) the rule deletes “Healthcare Effectiveness Data and Information Set (HEDIS)” from the list of quality measures in Subsection 4500.5 because this is already included as an National Committee for Quality Assurance (NCQA) measure and inclusion would be redundant; (2) the rule revises Sections 4503, 4504, 4505, and 4506 to clarify that the APM rates will not be adjusted based on increases to the Medicare Economic Index (MEI) during years that the APM is being rebased; (3) the rule adds a new requirement in Section 4504 that FQHC providers that deliver substance abuse services must be certified by DBH in accordance with Chapter 63 of Title 22-A DCMR; (4) the rule adds language in Sections 4502, 4505, and 4506, to clarify that FQHCs must bill all services related to a single course of treatment as part of a single encounter; (5) the rule proposes to include clarifying

language in Section 4502 to address the process for wrap-around supplemental payments, and omit redundant language in Sections 4503, 4504, 4505, and 4506; (6) the rule updates the language regarding services provided pursuant to EPSDT requirements (in Section 4507) to clarify that it will include the full scope of services, not just “well-child” care, and also to allow reimbursement for these services provided outside the clinic, for example in mobile units or in the home; (7) the rule clarifies in Section 4510 that costs incurred in furnishing dental services will be included among administrative and capital costs; (8) the rules clarifies, through non-substantive edits, Sections 4502, 4503, 4504, 4505, 4506, 4509, 4511, 4513, 4515, and 4516 and (9) the rule includes additional language in the definition of “Encounter” to include a telemedicine visit which will enable FQHCs to be reimbursed for telemedicine encounters in accordance with District requirements.

Further substantive changes were made to the rule in light of discussions on implementation of the rule with FQHCs, and to clarify certain requirements. Subsection 4500.2 is revised to include the requirement that the FQHCs meet requirements set forth by CMS under Title XVIII of the Social Security Act, including but not limited to meeting the requirements established by the federal Health Resource Services Administration (HRSA). Additional revisions are made to Sections 4502, 4503, 4504, 4505, and 4506 to address the requirements regarding wrap-around supplemental payments to FQHCs that receive global payments from MCOs, and FQHCs that have sub-capitation arrangements with MCOs. Revisions are also made to Sections 4503, 4504, 4505, 4506 to specify that the rate for FQHCs or FQHC look-alikes that have been in operation for less than five (5) years will be calculated as of the first day of the fiscal year. Section 4511 is revised to include marketing and lobbying expenses as exclusions to allowable costs. Section 4512 is revised to clarify that PPS rates for new FQHCs shall be calculated as of the first day of the District fiscal year that the FQHCs commence operations. A new provision is added to Section 4509 to include a calculation for PPS rate adjustments based on scope of change requests. Section 4513 is revised to require that FQHCs located out of state must comply with application and enrollment requirements set forth under Section 4500, and to clarify that the PPS or APM rate set by the District will be compared with the rate set by the Medicaid agency in which the FQHCs are located. Section 4513 is amended to specify that for Medicaid beneficiaries that are enrolled out of state, the FQHCs must seek reimbursement from the state in which the beneficiary is enrolled. Definitions for “capitation payments,” “global payments,” and “single course of treatment” are added in order to provide clarification. Lastly, other existing language was clarified in order to simplify interpretation.

Continued emergency action is necessary for the immediate preservation of the health, safety and welfare of persons receiving primary care, behavioral health, and dental services from FQHCs. FQHCs deliver primary care, behavioral health, and dental services to some of the District’s most physically and economically vulnerable residents. In order to ensure that the District’s FQHCs maintain adequate resources to continue their role as safety net providers within the public health care delivery system, these rules must be published on an emergency basis to preserve the health, safety and welfare of individuals receiving health care from the FQHCs.

This Notice of Second Emergency and Proposed Rulemaking was adopted on November 18, 2016 and became effective on the date, subject to approval by the federal Centers for Medicare and Medicaid (CMS) on the corresponding State Plan Amendment. The Council of the District

of Columbia approved the corresponding State Plan amendment through the Fiscal Year 2016 Budget Support Act of 2015, effective October 22, 2015 (D.C. Law 21-36; 62 DCR 10905 (August 14, 2015)). The corresponding State Plan amendment is awaiting approval from CMS.

The emergency rules shall remain in effect for one hundred and twenty (120) days from the date of adoption, until March 18, 2017, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director also gives notice of the intent to adopt this proposed rule not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Chapter 45, MEDICAID REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS of Title 29 DCMR, PUBLIC WELFARE, is deleted in its entirety and replaced with a new Chapter 45 to read as follows:

**CHAPTER 45 MEDICAID REIMBURSEMENT FOR FEDERALLY
QUALIFIED HEALTH CENTERS**

- 4500 General Provisions
- 4501 Reimbursement
- 4502 Prospective Payment System
- 4503 Alternative Payment Methodology For Primary Care Services
- 4504 Alternative Payment Methodology For Behavioral Health Services
- 4505 Alternative Payment Methodology For Preventive And Diagnostic Dental Services
- 4506 Alternative Payment Methodology For Comprehensive Dental Services
- 4507 Primary Care Services
- 4508 Behavioral Health Services
- 4509 Change in the Scope Of Services
- 4510 Allowable Costs
- 4511 Exclusions From Allowable Costs
- 4512 Reimbursement For New Providers
- 4513 Reimbursement For Out Of State Providers
- 4514 Performance Payment
- 4515 Rebasing For APM
- 4516 Cost Reporting And Record Maintenance
- 4517 Access to Records
- 4518 Appeals
- 4599 Definitions

4500 GENERAL PROVISIONS

- 4500.1 The rules set forth in this chapter establish the conditions of participation for a Federally Qualified Health Center (FQHC) in the Medicaid program. These rules also establish the reimbursement methodology for services rendered to Medicaid beneficiaries by an FQHC.
- 4500.2 Prior to seeking Medicaid reimbursement each FQHC must:

- (a) Be approved by the federal Centers for Medicare and Medicaid Services (CMS) and meet the requirements set forth in the applicable provisions of Title XVIII of the Social Security Act and implementing regulations, which shall include but not be limited to meeting the requirements governing federal Health Resources Services Administration (HRSA) approval of FQHCs and FQHC Look-Alikes;
- (b) Be screened and enrolled in the Medicaid program pursuant to the requirements set forth in Chapter 94 of Title 29 of the District of Columbia Municipal Regulations (DCMR); and
- (c) Obtain a National Provider Identifier (NPI) for each site operated by an FQHC.

4500.3 Medicaid reimbursable services provided by an FQHC shall be furnished in accordance with Section 4231 of the State Medicaid Manual and provided in a setting that is within the scope of project approved by HRSA.

4500.4 Services may be provided at other sites including mobile vans, intermittent sites such as a homeless shelter, a seasonal site, or a beneficiary's place of residence, provided the sites and activities are within the FQHC's Scope of Project approved by HRSA and the claims for reimbursement are consistent with the services described in Sections 4502 and 4505 through 4508.

4500.5 All services provided by an FQHC shall be subject to quality standards, measures and guidelines established by National Committee for Quality Assurance (NCQA), HRSA, CMS and the Department of Health Care Finance (DHCF).

4500.6 Services for which an FQHC seeks Medicaid reimbursement pursuant to this chapter shall be delivered in accordance with the corresponding standards for service delivery, as described in relevant sections of the District of Columbia State Plan for Medical Assistance and implementing regulations.

4501 REIMBURSEMENT

4501.1 Medicaid reimbursement for primary care, behavioral health, and dental services furnished by an FQHC shall be made under:

- (a) A Prospective Payment System (PPS) as described in Section 4502; or
- (b) An Alternative Payment Methodology (APM) as described in Sections 4503 through 4506.

4501.2 Each FQHC that is enrolled in the District's Medicaid program as of the effective date of the corresponding State Plan Amendment (SPA) that elects to be

reimbursed for services under an APM shall sign an agreement with the DHCF.

- 4501.3 The APM referenced in Subsection 4501.2 shall become effective on or after the date of an executed agreement between DHCF and the FQHC, or the effective date of the corresponding State Plan amendment, whichever is later.
- 4501.4 The APM shall comply with all requirements set forth in federal law and rules.
- 4501.5 Any FQHC that elects not to be reimbursed under an APM shall be reimbursed under the PPS methodology described in Section 4502.
- 4501.6 The FQHC may only be reimbursed for services that are within the scope of services described in Sections 4502, 4505, 4506, 4507, and 4508.
- 4501.7 Each encounter for a Medicaid enrollee who is enrolled in Medicare or another form of insurance (or both) shall be paid an amount that is equal to the difference between the payment received from Medicare and any other payors and the FQHC's payment rate calculated pursuant to these rules.
- 4501.8 The payment received by an FQHC from Medicare, any other payor and Medicaid shall not exceed the Medicaid reimbursement rate.
- 4501.9 If an FQHC seeks Medicaid reimbursement outside scope of services described in Sections 4502, 4505, 4506, 4507, and 4508, the FQHC shall:
- (a) Obtain a separate D.C. Medicaid identification number in accordance with Chapter 94 of Title 29 DCMR;
 - (b) Obtain a separate NPI;
 - (c) Ensure that all individuals providing the service are authorized to render the service and meet the requirements governing the service; and
 - (d) Be subject to the limitations set forth in the State Plan for Medical Assistance and any governing rules and regulations.
- 4501.10 Each FQHC shall ensure that a service that requires multiple procedures, and which may be performed as part of a single course of treatment under general standards of care, shall be completed as a single encounter unless multiple visits are medically required to complete the treatment plan and the medical necessity is documented in the clinical record.

4502 PROSPECTIVE PAYMENT SYSTEM

- 4502.1 Medicaid reimbursement for services furnished on or after January 1, 2001 by an FQHC shall be a Prospective Payment System (PPS) rate consistent with the

requirements set forth in Section 1902(bb) of the Social Security Act.

- 4502.2 The PPS rate shall be paid for each encounter with a Medicaid beneficiary when a medical service or services are furnished. The PPS for services rendered beginning on or after January 1, 2001 through and including September 30, 2001, shall be calculated as follows:
- (a) The sum of the FQHC's audited allowable costs for the FYs 1999 and 2000 shall be divided by the total number of patient encounters in FYs 1999 and 2000;
 - (b) The amount established in Subsection 4502.2(a) shall be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during FY 2001. Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change. The amount of the adjustment shall be negotiated between the parties. The adjustment shall be implemented not later than ninety (90) days after establishment of the negotiated rate; and
 - (c) Allowable costs shall include reasonable costs that are incurred by the FQHC in furnishing Medicaid coverable services to Medicaid eligible beneficiaries, as determined by Medicare Reasonable Cost Principles set forth in 42 C.F.R. Part 413.
- 4502.3 For services furnished beginning FY 2002 and each fiscal year thereafter, an FQHC shall be reimbursed at a rate that is equal to the rate in effect the previous fiscal year, increased by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during the fiscal year.
- 4502.4 Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change, consistent with the requirements established in Section 4509.
- 4502.5 In any case in which an entity first qualifies as an FQHC after FY 2000, the prospective rate for services furnished in the first year shall be equal to the average of the prospective rates paid to other FQHCs located in the same area with a similar caseload, effective on the date of application. For each fiscal year following the first year in which the entity first qualified as an FQHC, the prospective payment rate shall be computed in accordance with Subsection 4502.3. This section shall not apply to a new provider. Reimbursement for a new provider is set forth in Section 4512.
- 4502.6 An FQHC that furnishes services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in

Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a global payment) from such entity is less than the amount the FQHC would be entitled to receive under Subsections 4502.2 through 4502.5 will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF.

4502.7 The amount of the wrap-around supplemental payment identified in Section 4502.6 shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC PPS rate calculated pursuant to this section. If an FQHC receives a global payment from an MCO and has a capitation payment arrangement with the MCO, the amount payable to the FQHC shall be offset by the capitation payment. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider.

4503 ALTERNATIVE PAYMENT METHODOLOGY FOR PRIMARY CARE SERVICES

4503.1 The APM rate for primary care services rendered beginning the effective date of the corresponding SPA by an FQHC shall be determined as described in this section. The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for primary care services described in Section 4507.

4503.2 The APM rate for primary care services shall be calculated by taking the sum of the FQHC's audited allowable costs for primary care services and related administrative and capital costs and dividing it by the total number of eligible primary care encounters.

4503.3 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4503.4 An FQHC which has been in operation as an FQHC, or an FQHC look-alike as determined by HRSA, for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4503.2 or the APM rate based on costs reported by the FQHC or FQHC look-alike.

4503.5 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate for primary care services shall not be lower than the Medicare PPS rate in FY 2016. If, an FQHC's APM rate for primary care services is less than the Medicare PPS rate, the APM rate shall be adjusted up to the Medicare PPS rate for the applicable time period.

4503.6 Except as described in Subsection 4503.4, for services rendered beginning

January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for primary care services as follows:

- (a) The APM rate for primary care services shall be determined under Subsection 4503.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.

- 4503.7 Except as described in Subsection 4503.4, the APM rate for primary care services rendered on or after January 1, 2019, shall be determined as described in Subsection 4503.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.
- 4503.8 The APM rate established pursuant to Subsection 4503.7 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4515.
- 4503.9 An FQHC that furnishes primary care services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a global payment) from such entity is less than the amount the FQHC would be entitled to receive under this section will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF.
- 4503.10 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC APM rate calculated pursuant to this section. If an FQHC receives a global payment from an MCO and has a capitation payment arrangement with the MCO, the FQHC shall receive an offset equal to the amount of the capitation payment. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider.
- 4503.11 Reimbursement shall be limited for each beneficiary to one primary care encounter per day. The FQHC shall document each encounter in the beneficiary's medical record.
- 4503.12 The APM rate established pursuant to this section may be subject to adjustment to take into account any change in the scope of services as described in Section 4509.

4503.13 Each FQHC shall include the Current Procedural Terminology (CPT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement.

4503.14 If an FQHC seeks Medicaid reimbursement for services that are outside the scope of primary care services described in Section 4507, such as prescription drugs, labor and delivery services, or laboratory and x-ray services that are not office based, the FQHC shall follow the requirements set forth in Subsection 4501.9.

4504 ALTERNATIVE PAYMENT METHODOLOGY FOR BEHAVIORAL HEALTH SERVICES

4504.1 The APM rate for behavioral health services rendered beginning the effective date of the corresponding SPA by an FQHC shall be determined as described in this section. The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available per encounter with a D.C. Medicaid beneficiary for behavioral health services described in Section 4508.

4504.2 Except for group therapy as described in Subsection 4504.3 and reimbursement to certain FQHCs as described in Subsection 4504.5, the APM rate for behavioral health services shall be calculated by taking the sum of the FQHC's audited allowable costs for behavioral health services and related administrative and capital costs and dividing it by the total number of eligible behavioral health encounters.

4504.3 The APM rate for group therapy shall be equal to one fifth (1/5) of the APM rate for behavioral health service calculated pursuant to Subsection 4504.2.

4504.4 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4504.5 An FQHC which has been in operation as an FQHC, or an FQHC look-alike as determined by HRSA for fewer than five (5) years, at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4504.2 or the APM rate based on costs reported by the FQHC or FQHC look-alike.

4504.6 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate for behavioral services shall not be lower than the Medicare PPS in FY 2016. If, an FQHC's APM rate for behavioral health services is less than the Medicare PPS rate, the APM rate shall be adjusted up to the Medicare PPS rate for the applicable time period.

4504.7 Except as described in Subsection 4504.5, for services rendered beginning

January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for behavioral health services as follows:

- (a) The APM rate for behavioral health services shall be the amount determined under Subsection 4504.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report; and
- (b) Group therapy shall be determined as described in Subsection 4504.3.

- 4504.8 Except as described in Subsection 4504.5, the APM rate for behavioral health services rendered on or after January 1, 2019, shall be determined as described in Subsection 4504.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.
- 4504.9 The APM rate established pursuant to Subsection 4504.8 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act except for the years the APM rate is rebased as described in Section 4515.
- 4504.10 An FQHC that furnishes behavioral health services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a global payment) from such entity is less than the amount the FQHC would be entitled to receive under this section will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF.
- 4504.11 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC APM rate calculated pursuant to this section. If an FQHC receives a global payment from an MCO and has a capitation payment arrangement with the MCO, the FQHC shall receive an offset equal to the amount of the capitation payment. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider.
- 4504.12 For services furnished on or after the effective date of the corresponding SPA, reimbursement shall be limited for each beneficiary to one behavioral service encounter per day. If a beneficiary participates in individual therapy and group therapy on the same day, the FQHC shall receive the individual therapy rate. The FQHC shall document each encounter in the beneficiary's medical record.

- 4504.13 The APM rate established pursuant to this Section may be subject to adjustment to take into account any change in the scope of services as described in Section 4509.
- 4504.14 Each FQHC shall include the Current Procedural Terminology (CPT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement.
- 4504.15 If an FQHC seeks Medicaid reimbursement for services that are outside the scope of behavioral health services described in Section 4508, such as rehabilitative services, including Mental Health Rehabilitative Services, prescription drugs, or laboratory and x-ray services that are not office-based, the FQHC shall comply with the requirements set forth under Subsection 4501.9.
- 4504.16 Each FQHC that delivers substance abuse services must be certified by the Department of Behavioral Health in accordance with Chapter 63 of Title 22-A DCMR.
- 4505 ALTERNATIVE PAYMENT METHODOLOGY FOR PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES**
- 4505.1 The APM rate for preventive and diagnostic dental services rendered beginning the effective date of the corresponding SPA by an FQHC shall be determined as described in this section. The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available per encounter with a D.C. Medicaid beneficiary for preventive and diagnostic dental services described in Subsection 4505.5.
- 4505.2 The APM rate for preventive and diagnostic dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for preventative and diagnostic dental services and administrative and capital costs and dividing it by the total number of eligible preventive and diagnostic dental service encounters.
- 4505.3 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.
- 4505.4 Except as described in Subsection 4505.16, for services rendered beginning January 1, 2018 through December 31, 2018, the APM rate for preventive and diagnostic dental services shall be determined as described in Subsection 4505.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- 4505.5 Except as described in Subsection 4505.16, the APM for preventive and

diagnostic dental services rendered on or after January 1, 2019 shall be determined as described in Subsection 4505.2 except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.

- 4505.6 The APM rate established pursuant to Subsection 4505.5 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4515.
- 4505.7 Subject to the limitations set forth in the section, covered preventive and diagnostic dental services provided by the FQHC may include the following procedures:
- (a) Diagnostic-American Dental Association (ADA) dental procedure codes (D0100-D0999) representing clinical oral examinations, radiographs, diagnostic imaging, tests and examinations; and
 - (b) Preventive-ADA dental procedure codes (D1000-D1999) representing dental prophylaxis, topical fluoride treatment (office procedure), space maintenance (passive appliances and sealants).
- 4505.8 Only procedure codes listed in Subsection 4505.7 that are included on the D.C. Medicaid Fee for Service schedule as covered benefits shall be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at <http://www.dc-medicaid.com>.
- 4505.9 An FQHC that furnishes preventive and diagnostic dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a global payment) from such entity is less than the amount the FQHC would be entitled to receive under this section will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF.
- 4505.10 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the amount of the FQHC APM rate calculated pursuant to this section. If an FQHC receives a global payment from an MCO and has a capitation payment arrangement with the MCO, the FQHC shall receive an offset equal to the amount of the capitation payment. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider.
- 4505.11 Reimbursement shall be limited for each beneficiary to one preventive and diagnostic encounter per day. The FQHC shall document each encounter in the

beneficiary's dental record.

- 4505.12 If an encounter comprises both a preventive and diagnostic service and a comprehensive dental service as described in Section 4506, the FQHC shall bill the encounter as a comprehensive dental service.
- 4505.13 All preventive and diagnostic dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Section 964 (Dental Services) of Title 29 DCMR.
- 4505.14 Each FQHC shall include the Current Dental Terminology (CDT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement with associated tooth number, quadrant, and arch if applicable for the dental procedure.
- 4505.15 Each provider of preventive and diagnostic dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2015 Supp.)), or consistent with the applicable professional practices act within the jurisdiction where services are provided.
- 4505.16 An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4505.2 or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

4506 ALTERNATIVE PAYMENT METHODOLOGY FOR COMPREHENSIVE DENTAL SERVICES

- 4506.1 The APM rate for comprehensive dental services rendered by the FQHC on or after the effective date of the corresponding SPA by an FQHC shall be determined in accordance with this section. .
- 4506.2 The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for comprehensive dental services described in Subsection 4506.8.
- 4506.3 The APM rate for comprehensive dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for comprehensive dental services and related administrative and capital costs and dividing it by the total number of eligible comprehensive dental service encounters.

- 4506.4 For services rendered beginning on or after the effective date of the corresponding SPA, through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.
- 4506.5 Except as described in Subsection 4506.17, for services rendered from January 1, 2018 through December 31, 2018, the APM rate for comprehensive dental services shall be determined as described in Subsection 4506.3, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- 4506.6 Except as described in Subsection 4506.17, the APM for comprehensive dental services rendered on or after January 1, 2019, the twenty percent (20%) administrative cap described in Subsection 4506.5 shall apply in determining the APM rate for all FQHCs, including those with less than ten thousand (10,000) annual encounters.
- 4506.7 The APM rate established pursuant to Subsection 4506.6 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4515.
- 4506.8 Subject to the limitations set forth in this section, covered comprehensive dental services provided by the FQHC may include the following procedures:
- (a) Restorative - ADA dental procedure codes (D2000-D2999) representing amalgam restoration, resin-based composite restorations, crowns (single restorations only), and additional restorative services;
 - (b) Endodontic - ADA dental procedures codes (D3000-D3999) representing pulp capping, pulpotomies, endodontic therapy of primary and permanent teeth, endodontic retreatment, apexification/recalcification procedures, apicoectomy/periradicular services, and other endodontic services;
 - (c) Peridontic - ADA dental procedure codes (D4000-D4999) representing surgical services, including usual postoperative care), nonsurgical periodontal services, and other periodontal services;
 - (d) Prosthodontic - ADA dental procedure codes (D5000-D5899) representing complete and partial dentures treatment including repairs and rebasing, interim prosthesis, and other removable prosthetic services;
 - (e) Maxillofacial Prosthetics - ADA dental procedure code (D5982) representing the surgical stent procedure;

- (f) Implants Services - ADA dental procedure codes (D6000-D6199) representing Pre-surgical and surgical services, implant-supported prosthetics, and other implant services;
- (g) Oral and Maxillofacial Surgery - ADA dental procedure codes (D7000-D7999) representing treatment and care related to extractions, alveoloplasty, vestibuloplasty, surgical treatment of lesions, treatment of fractures, repair traumatic wounds including complicated suturing;
- (h) Orthodontics - ADA dental procedure codes (D8000-D8999) representing orthodontic treatments and services; and
- (i) Adjunctive General Services - ADA dental procedure codes (D9000-D9999) representing unclassified treatment, anesthesia, professional consultation, professional visits, drugs and miscellaneous.

4506.9 Only procedure codes listed in Subsection 4506.8 that are included on the D.C. Medicaid Fee for Service schedule as covered benefits shall be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at <http://www.dc-medicaid.com>.

4506.10 An FQHC that furnishes comprehensive dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a global payment) from such entity is less than the amount the FQHC would be entitled to receive under this section will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF.

4506.11 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the managed care entity as determined on a per encounter basis and the FQHC APM rate calculated receive pursuant to this section. If an FQHC receives a global payment from an MCO and has a capitation payment arrangement with the MCO, the FQHC shall receive an offset equal to the amount of the capitation payment. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap submission. This amount shall be offset against total amounts otherwise payable to the provider.

4506.12 Reimbursement shall be limited for each beneficiary to one comprehensive dental service encounter per day. The FQHC shall document each encounter in the beneficiary's dental record.

4506.13 If an encounter comprises both a preventive and diagnostic service as described in Section 4505 and a comprehensive dental service, the FQHC shall bill the encounter as a comprehensive dental service.

- 4506.14 All comprehensive dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Section 964 (Dental Services) of Title 29 DCMR.
- 4506.15 Each FQHC shall include the CDT code(s) that correspond to the specific services provided on each claim submitted for reimbursement with associated tooth number, quadrant, surface, and arch if applicable for the dental procedure.
- 4506.16 Each provider of comprehensive dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2015 Supp.)), or consistent with the applicable professional practices act within the jurisdiction where services are provided.
- 4506.17 An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4506.3 or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

4507 PRIMARY CARE SERVICES

- 4507.1 Covered primary care services provided by the FQHC shall be limited to the following services:
- (a) Health services related to family medicine, internal medicine, pediatrics, obstetrics (excluding services related to birth and delivery), and gynecology which include but are not limited to:
- (1) Health management services and treatment for illness, injuries or chronic conditions (examples of chronic conditions include diabetes, high blood pressure, etc.) including but not limited to health education and self-management training;
 - (2) Services provided pursuant to the Early and Periodic Screening, Diagnostic and Treatment benefit for Medicaid eligible children under the age of twenty-one (21);
 - (3) Preventive fluoride varnish for children, provided the service is furnished during a well-child visit by a physician or pediatrician who is acting within the scope of practice authorized pursuant to District of Columbia Health Occupations Revision Act of 1985,

effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2015 Supp.)) (“HORA”).

- (4) Preventive and diagnostic services, including but not limited to the following:
- (i) Prenatal and postpartum care rendered at an FQHC, excluding labor and delivery;
 - (ii) Lactation consultation, education and support services if provided by a certified nurse mid-wife licensed in accordance with HORA and certified by the International Board of Lactation Consultant Examiners (IBLCE) or a registered lactation consultant certified by IBLCE;
 - (iii) Physical exams;
 - (iv) Family planning services;
 - (v) Screenings and assessments, including but not limited to, visual acuity and hearings screenings, and nutritional assessments and referrals;
 - (vi) Risk assessments and initial counseling regarding risks for clinical services;
 - (vii) PAP smears, breast exams and mammography referrals when provided as part of an office visit; and
 - (viii) Preventive health education.

4507.2 Primary care services set forth in this Subsection 4507.1(a) shall be delivered by the following health care professionals who are licensed in accordance with HORA:

- (a) A physician;
- (b) An Advanced Practiced Registered Nurse (APRN);
- (c) A physician assistant working under the supervision of physician; or
- (d) A nurse-mid-wife.

4508 BEHAVIORAL HEALTH SERVICES

4508.1 Covered behavioral health services provided by an FQHC shall be limited to

ambulatory mental health and substance abuse evaluation, treatment and management services identified by specific Current Procedural Terminology (CPT) codes. Such codes include psychiatric diagnosis, health and behavioral health assessment and treatment, individual and group psychotherapy, family therapy and pharmacologic management. DHCF shall issue a transmittal to the FQHCs which shall include the specific CPT codes including any billing requirements for covered behavioral health services.

4508.2 Covered behavioral health services set forth in this section shall be delivered by the following health care professionals who shall be licensed in accordance with HORA:

- (a) A physician, including a psychiatrist;
- (b) An APRN;
- (c) A psychologist;
- (d) A licensed independent clinical social worker;
- (e) A licensed independent social worker (LISW);
- (f) A graduate social worker, working under the supervision of an LISW;
- (g) A licensed professional counselor;
- (h) A certified addiction counselor;
- (i) A licensed marriage and family therapist; and
- (j) A licensed psychologist associate, working under the supervision of a psychologist or psychiatrist.

4509 CHANGE IN THE SCOPE OF SERVICES

4509.1 An FQHC may apply for an adjustment to its PPS rate or its APM rate (in any of the following four (4) service categories: (1) primary care; (2) behavioral health, (3) preventive and diagnostic dental services; and (4) comprehensive dental services) during any fiscal year after the effective date of the corresponding SPA, based upon a change in the scope of the services provided by the FQHC subject to the requirements set forth in the section.

4509.2 For services furnished on or after the effective date of these rules, a change in the scope of services shall only relate to services furnished on or after the effective date of the corresponding SPA and shall consist of a change in the type, intensity duration or amount of service as described below:

- (a) Type: for FQHCs adopting either the PPS or APM payment rate, the addition of a new service not previously provided by the FQHC, which has been approved by HRSA within the FQHC's Scope of Project and is consistent with the services described in Section 4505 through 4508;
- (b) Intensity: for FQHCs adopting the either the PPS or APM payment rate, a change in quantity or quality of a service demonstrated by an increase or decrease in the total quantity of labor and materials consumed by an individual patient during an average encounter or a change in the types of patients served;
- (c) Duration: for FQHCs adopting the either the PPS or APM payment rate, a change in the average length of time it takes FQHC providers to complete an average patient visit due to changing circumstances such as demographic shifts or the introduction of disease management programs;
- (d) Amount: for FQHCs adopting either the PPS or APM payment rate, an increase or decrease in the amount of services that an average patient receives in a Medicaid-covered visit such as additional outreach or case management services or improvements to technology or facilities that result in better services to the FQHC's patients.

4509.3 A change in the cost of a service, in and of itself, is not considered a change in the scope of services.

4509.4 A change in the scope of services shall not be based on a change in the number of encounters, or a change in the number of staff that furnish the existing service.

4509.5 DHCF shall review the costs related to the change in the scope of services. Rate changes based on a change in the scope of services provided by an FQHC shall be evaluated in accordance with the Medicare reasonable cost principles set forth in 42 C.F.R., Part 413.

4509.6 The adjustment to the PPS rate shall only be granted if the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC's allowable costs in the core service category for the fiscal year in which the change in scope of service became effective. The PPS rate adjustment for a change in scope shall be determined as the current PPS rate multiplied by the percentage change in the allowable cost attributable to the change in scope. The percentage change shall be calculated as follows:

- (a) The total allowable cost including the change in scope for a twelve (12) month period, minus the total allowable cost stated in the FQHC's prior year's cost report;

- (b) Divided by the total allowable cost stated in the FQHC's prior year's cost report; and
 - (c) Multiplied by one hundred percent (100%).
- 4509.7 Subject to the limitation set forth in Subsection 4509.8, the adjustment to the APM rate shall be determined by dividing the total allowable cost plus the incremental allowable cost attributable to a change in the scope, by the total number of encounters including the encounters affected by the scope change during the corresponding time period.
- 4509.8 The adjustment to the APM rate shall only be granted if the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC's allowable costs in the core service category for the fiscal year in which the change in scope of service became effective. This percentage shall be calculated by comparing the FQHC's APM rate at the beginning of the fiscal year in question with the cost per encounter as calculated by a completed Medicaid cost report using data from the same fiscal year.
- 4509.9 For services furnished on or after the effective date of the corresponding SPA, an FQHC shall submit a written notification to DHCF within ninety (90) days after a change of the scope of service, and the FQHC shall file a cost report demonstrating the increase in cost per encounter no later than 90 days after the close of one year of operation in which the scope change occurred. The FQHC shall submit documentation in support of the request.
- 4509.10 DHCF shall provide a written notice of its determination to the FQHC within one hundred eighty (180) days of receiving all information related to the request described in Subsections 4509.9.
- 4509.11 If approved, the PPS or APM rate calculated pursuant to Sections 4502 or 4503 through 4506 shall be adjusted to reflect the adjustment for the change in the scope of service. The adjustment shall be effective on the first day of the first full month after DHCF has approved the request. There shall be no retroactive adjustment.
- 4509.12 DHCF shall review or audit the subsequently filed annual cost report to verify the costs that have a changed scope. Based upon that review DHCF may adjust the rate in accordance with the requirements set forth in this section.
- 4509.13 For services furnished on or after the effective date of the corresponding SPA, a request for a rate adjustment based on change in scope of services shall be limited to one (1) request per year, per FQHC.

4510 ALLOWABLE COSTS

- 4510.1 The standards established in this section are to provide guidance in determining whether certain cost items will be recognized as allowable costs incurred by a FQHC in furnishing primary care, behavioral health, diagnostic and preventive dental services, and comprehensive dental services regardless of the applicable payment methodology. In the absence of specific instructions or guidelines, each FQHC shall follow the Medicare reasonable cost principles set forth in 42 C.F.R. Part 413 and instructions set forth in the Medicare Provider Reimbursement Manual.
- 4510.2 Allowable costs, to the extent they are reasonable, necessary and related to patient care shall include but are not limited to the following:
- (a) Compensation for the services rendered by each health care professional listed in Subsections 4507.2, 4508.2, 4505.15 and 4506.16 and other supporting health care professionals including but not limited to registered nurses, licensed practical nurses, nurse aides, medical assistants, physician's assistants, technicians, etc.;
 - (b) Compensation for services for supervising health care professionals described in Subsections 4507.2, 4508.2, 4505.15 and 4506.16;
 - (c) Costs of services and supplies incident to the provision of services as described in paragraph (f) of this subsection;
 - (d) Administrative and capital costs that are incurred in furnishing primary care, behavioral health services, diagnostic and preventive dental services, and comprehensive dental services, including clinic administration, subject to the limitation set forth in this section;
 - (e) Enabling services that support an individual's management of his or her health and social service needs or improve the FQHC's ability to treat the individual, including:
 - (1) Health education and promotion services including assisting the individual in developing a self-management plan, executing the plan through self-monitoring and management skills, educating the individual on accessing care in appropriate settings and making healthy lifestyle and wellness choices; connecting the individual to peer and/or recovery supports including self-help and advocacy groups; and providing support for improving an individual's social network. These services shall be provided by health educators, with or without specific degrees in this area, family planning specialists, HIV specialists, or other professionals who provide information about health conditions and guidance about appropriate use of health services;

- (2) Translation and interpretation services during an encounter at the FQHC. These services are provided by staff whose full time or dedicated time is devoted to translation and/or interpretation services or by an outside licensed translation and interpretation service provider. Any portion of the time of a physician, nurse, medical assistant, or other support and administrative staff who provides interpretation or translation during the course of his or her other billable activities shall not be included;
- (3) Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services). Such services shall not be reimbursed separately as enabling services where such referrals are provided during the course of other billable treatment activities;
- (4) Eligibility assistance services designed to assist individuals in establishing eligibility for and gaining access to Federal, State and District programs that provide or financially support the provision of medical related services;
- (5) Health literacy;
- (6) Outreach services to identify potential patients and clients and/or facilitate access or referral of potential health center patients to available health center services, including reminders for upcoming events, brochures and social services;
- (7) Care coordination, which consists of services designed to organize person-centered care activities and information sharing among those involved in the clinical and social aspects of an individual's care to achieve safer and more effective healthcare and improved health outcomes. These services shall be provided by individuals trained as, and with specific titles of care coordinators, case managers, referral coordinators, or other titles such as nurses, social workers, and other professional staff who are specifically allocated to care coordination during assigned hours but not when these services are an integral part of their other duties such as providing direct patient care;
- (8) Staff cost related to quality improvement, data analytics, and compliance; and
- (9) Training for health care professionals for the provision of health care services-

- (f) Incidental services and supplies that are integral, although incidental, to the diagnostic or treatment components of the services described in Subsections 4505.7, 4506.8, 4507.1(a), and 4508.1 which shall include but are not limited to the following:
- (1) Lactation consultation, education and support services that are provided by health care professionals described in Subsection 4507.1(4)(ii);
 - (2) Medical services ordinarily rendered by an FQHC staff person such as taking patient history, blood pressure measurement or temperatures, and changing dressings;
 - (3) Medical supplies, equipment or other disposable products such as gauze, bandages, and wrist braces;
 - (4) Administration of drugs or medication treatments, including administration of contraceptive treatments, that are delivered during a primary care visit, not including the cost of the drugs and medications;
 - (5) Immunizations;
 - (6) Electrocardiograms;
 - (7) Office-based laboratory screenings or tests performed by FQHC employees in conjunction with an encounter, which shall not include lab work performed by an external laboratory or x-ray provider. These services include but are not limited to stool testing for occult blood, dipstick urinalysis, cholesterol screening, and tuberculosis testing for high-risk beneficiaries; and
 - (8) Hardware and software systems, including implementation services, used to facilitate patient record-keeping and related services to support implementation.

4510.3 For the purposes of determining allowable and reasonable costs in the purchase of goods and services from a related party, each FQHC shall identify all related parties.

4510.4 A related party is any individual, organization or entity who currently or within the previous five (5) years has had a business relationship with the owner or operator of an FQHC, either directly or indirectly, or is related by marriage of birth to the owner or operator of the FQHC, or who has a relationship arising from common ownership or control.

- 4510.5 The cost claimed on the cost report for services, facilities and supplies furnished by a related party shall not exceed the lower of:
- (a) The cost incurred by the related party; or
 - (b) The price of comparable services, facilities, or supplies generally available.
- 4510.6 Administrative and capital costs shall be allocated and included in determining the total allowable costs for primary care services and behavioral health services.
- 4510.7 Administrative and general overhead costs shall consist of overhead facility costs as described in Subsection 4510.8 and administrative costs as described in Subsection 4510.9.
- 4510.8 Capital and facility costs shall include but not be limited to:
- (a) Rent;
 - (b) Insurance;
 - (c) Interest on mortgages or loans;
 - (d) Utilities;
 - (e) Depreciation on buildings;
 - (f) Depreciation on equipment;
 - (g) Maintenance, including janitorial services;
 - (h) Building security services; and
 - (i) Real estate and property taxes.
- 4510.9 Administrative costs shall include but not be limited to:
- (a) Administrative Salaries (*i.e.*, salary expenditures related to the administrative work of a FQHC);
 - (b) Fringe benefits and payroll taxes of personnel described in (a) of this subsection;
 - (c) Depreciation on office equipment;

- (d) Office supplies;
- (e) Legal expenses;
- (f) Accounting expenses;
- (g) Training costs of administrative personnel for the provision of health care services;
- (h) Telephone expense; and
- (i) Hardware and software, including implementation costs, not related to patient record keeping.

4510.10 Administrative costs shall be subject to a ceiling of twenty percent (20%) as described in Sections 4503, 4504, 4505 and 4506. Costs in excess of the ceiling shall not be included in allowable costs.

4511 EXCLUSIONS FROM ALLOWABLE COSTS

4511.1 The costs that shall be excluded from allowable costs for purposes of calculating the APM rate shall include, but not be limited to, the following:

- (a) Cost of services provided in settings that are not included in the FQHC's Scope of Project that is approved by HRSA;
- (b) Cost of services that are outside the scope of services described in Sections 4505 through 4508;
- (c) Graduate Medical Education costs; and
- (d) Expenses incurred by the FQHC that are unrelated to the delivery of primary care, behavioral health and dental services as defined in Sections 4505 through 4508, which shall include but are not limited to the following:
 - (1) Staff educational costs, including student loan reimbursements, except for training and staff development, required to enhance job performance;
 - (2) Marketing and public relations expenses;
 - (3) Community services that are provided as part of a large scale effort, such as a mass scale community wide immunization program or any other community wide service

- (4) Environmental activities;
- (5) Research;
- (6) Transportation costs;
- (7) Indirect costs allocated to unallowable direct health service costs;
- (8) Entertainment including costs for office parties and other social functions, retirement gifts, meals, and lodging;
- (9) Board of Director fees;
- (10) Federal, state and local income taxes;
- (11) Excise taxes;
- (12) All costs related to physicians and other professional's private practices;
- (13) Donations, services and goods and space, except for those that are allowable pursuant to the Office of Management and Budget Circular No. A-122 and the Medicare Provider Reimbursement Manual;
- (14) Fines and penalties;
- (15) Bad debts, including losses arising from uncollectible accounts receivable and other claims, related collection and legal costs;
- (16) Advertising, except for recruitment of personnel, procurement of goods and services, and disposal of medical equipment and supplies;
- (17) Contributions to a contingency reserve or any similar provision made for an event, the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of the event taking place;
- (18) Over-funding of contributions to self-insurance funds that do not represent payments based on current liabilities;
- (19) Fundraising expenses;
- (20) Goodwill;

- (21) Political contributions, lobbying expenses or other related expenses;
 - (22) Costs attributable to the use of a vehicle or other company equipment for personal use;
 - (23) Other personal expenses not related to patient care for the core services; and
 - (24) Charitable contributions.
- 4511.2 Costs reimbursed or otherwise paid for by locally funded grants or other locally funded sources, shall be offset against expenses in determining allowable cost.
- 4511.3 An FQHC shall identify each grant by name and funding source in the supplemental data submitted with the cost report.
- 4511.4 Revenues related to the following categories shall be offset against expense.
- (a) Investment Income: Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs;
 - (b) Refunds and rebates for expenses;
 - (c) Rental income for building and office space;
 - (d) Related organization transactions pursuant to 42 C.F.R. § 413.17;
 - (e) Sale of drugs to other than patient;
 - (f) Vending Machines
- 4511.5 Enabling services described in Subsection 4510.2 shall not include any services that may be or are included as a part of a patient encounter, administrative, facility or other reimbursable cost described in these rules. The costs of enabling services shall be reasonable as determined in accordance with the Medicare reasonable cost principles set forth in 42 C.F.R. Part 413.
- 4512 REIMBURSEMENT FOR NEW PROVIDERS**
- 4512.1 Each new provider seeking Medicaid reimbursement as an FQHC shall meet all of the requirements set forth in Section 4500.
- 4512.2 Reimbursement for services furnished by a new provider shall be determined in

accordance the PPS methodology set forth in this section.

- 4512.3 The PPS rate for services furnished during the first year of operation shall be calculated as of the first day of the District's fiscal year in which the FQHC commences operations, and shall be equal to the average of the PPS rates paid to other FQHCs located in the same geographical area with a similar caseload.
- 4512.4 After the first year of operation, the FQHC shall submit a cost report to DHCF. DHCF shall audit the cost report in accordance with the standards set forth in Sections 4510 and 4511 and establish a PPS for each of the following four categories:
- (a) Primary care services as described in Section 4507;
 - (b) Behavioral health services as described in Section 4508;
 - (c) Preventive and diagnostic dental services as described in Subsection 4505.7; and
 - (d) Comprehensive dental services as described in Subsection 4506.7.
- 4512.5 The PPS shall be calculated for each category described in Subsections 4512.4(a) through 4512.4(d) by taking the sum of the FQHC's audited allowable cost for the applicable category, including related administrative and capital costs, and dividing it by the total number of eligible encounters for that category. Administrative costs shall not exceed twenty percent (20%) of total allowable costs.
- 4512.6 The PPS rate described in Subsection 4512.5 shall remain in effect until all provider rates are rebased in accordance with Section 4515. After rebasing the FQHC shall be have the option of electing an APM rate in accordance with the procedures set forth in Section 4501.
- 4512.7 In addition to the PPS rate described in this section, the FQHC shall be entitled to receive a supplemental wrap-around payment as described in Subsections 4502.6 through 4502.7.
- 4512.8 Each new FQHC provider seeking Medicaid reimbursement shall:
- (a) Obtain a separate National Provider Identification number; and
 - (b) Be screened and enrolled in the Medicaid program pursuant to the requirements set forth in Chapter 94 of Title 29 DCMR.
- 4512.9 Each new FQHC shall only seek Medicaid reimbursement for services provided in settings that are consistent with the services described in Sections 4505 through

4508.

- 4512.10 If an FQHC discontinues operations, either as a facility or at one of its sites, the FQHC shall notify DHCF in writing at least ninety days (90) prior to discontinuing services.
- 4512.11 The new provider will be allowed one encounter on the same day for each of the categories described in Subsection 4512.4(a), (b), and either (c) or (d), consistent with the requirements set forth under Subsections 4505.12 and 4506.13.

4513 REIMBURSEMENT FOR OUT OF STATE PROVIDERS

4513.1 An FQHC located outside of the District of Columbia that seeks reimbursement for services furnished to District of Columbia Medicaid beneficiaries shall comply with the requirements set forth under 4500.2 and shall be reimbursed:

- (a) The lesser of the District of Columbia's PPS rate or the amount of reimbursement determined by the Medicaid agency in the state the FQHC is located; or
- (b) The lesser of the District of Columbia's APM rate or the amount of reimbursement determined by the Medicaid agency in the state the FQHC is located.

4513.2 For Medicaid beneficiaries that are enrolled out of state, the FQHC shall seek reimbursement from the state in which the beneficiary is enrolled. The FQHC shall not seek reimbursement from DHCF.

4514 PERFORMANCE PAYMENT

4514.1 Beginning January 1, 2018, and annually thereafter, each FQHC that elects the APM reimbursement may be eligible to receive an additional payment based upon performance as described in this section.

4514.2 For 2018, the amount of the performance bonus pool available for distribution to all FQHCs shall be the difference between the FQHCs uncapped administrative cost and the capped administrative cost based on 2013 audited cost reports.

4514.3 The performance bonus pool established pursuant to Subsection 4514.2 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act.

4514.4 To participate in the pay-for-performance incentive program, each FQHC shall submit to DHCF by December 31st of each year the following information:

- (a) HRSA approved quality improvement plan;

- (b) Written policies and procedures that describe the FQHC’s twenty-four (24) hours, seven (7) days a week access to clinical advice. These policies and procedures shall comply with DHCF-issued guidance describing standards for twenty-four (24) hours, seven (7) days a week access; and
- (c) Proof of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level 2 recognition or proof that the FQHC has begun the application process as demonstrated by either of the following:
 - (i) An emailed confirmation from NCQA indicating the FQHC’s submission of the application; or
 - (ii) An NCQA score of the FQHC’s PCMH submitted application.

4514.5 Each FQHC shall also submit to DHCF on a quarterly basis, its performance on the following measures of care delivery to participate in the pay-for-performance incentive program:

Measure Name	NQF #	Steward	Description
Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	National Committee for Quality Assurance (NCQA)	Percentage of FQHC patients 18-75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c >9.0% during the measurement year.
Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) testing	0057	NCQA	Percentage of FQHC patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.
Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Control (<8.0%)	0575	NCQA	Percentage of FQHC patients 18 - 75 years of age with diabetes (type 1 and type 2) whose had a HbA1c <8.0% during the measurement year.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents WCC): Body Mass Index (BMI) Percentile Assessment for Children/ Adolescents	0024	NCQA	Percentage of FQHC patients 3-17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and who had evidence of a BMI percentile assessment during the measurement year.

Measure Name	NQF #	Steward	Description
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0421	Centers for Medicare and Medicaid Services (CMS)	Percentage of FQHC patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.
Cervical Cancer Screening (CCS)	0032	NCQA	Percentage of FQHC patients (women) 21-64 years of age, who were screened for cervical cancer.
Colorectal Cancer Screening (COL)	0034	NCQA	Percentage of FQHC patients 50-75 years of age who had appropriate screening for colorectal cancer.
Controlling High Blood Pressure (CBP)	0018	NCQA	Percentage of FQHC patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. <ul style="list-style-type: none"> • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. <i>Note: Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.</i>
Linkage to HIV Medical Care	NA	HRSA - HIV/AIDS Bureau	Percentage of FQHC patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis.
Percentage of Low Birthweight Births	1382	Centers for Disease Control and Prevention (CDC)	Percentage of FQHC births with birthweight <2,500 grams during the measurement year.
Trimester of Entry into Prenatal Care	NA	HRSA-Bureau of Primary Health Care	Percentage of prenatal care patients who entered treatment during their first trimester.
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0418	CMS	Percentage of FQHC patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND a follow up plan is documented.

4514.6 DHCF shall review these measures annually and may update them as needed. If changes are warranted, DHCF shall notify FQHCs of proposed changes through transmittals to the FQHCs describing any changes to the measures set forth in Subsection 4514.5.

4514.7 Each participating FQHC’s maximum annual bonus payment shall be based on the number of unique Medicaid beneficiaries that received primary care services from the FQHC within the measurement year, divided by the total number of Medicaid patients that received primary care services within the measurement year, from all

FQHCs participating in the pay-for-performance incentive program. The resulting percentage is each participating FQHC’s market share.

4514.8 DHCF shall use each participating FQHC’s market share for categorization into four (4) distinct bonus payment groups. Each bonus payment group shall be determined by dividing by four (4) the total number of Medicaid patients that received primary care services from the participating FQHCs within the measurement year (*i.e.*, descriptive statistic quartiles). The description statistic quartiles separate the aggregate number of primary care patients served into twenty-five percent (25%) intervals. The market share of each FQHC shall be summed to calculate each quartile’s aggregate market share percentage.

4514.9 The aggregate market share percentage described in Subsection 4514.8 shall be multiplied by the total available pay-for-performance incentive program funding pool to determine the maximum bonus payment amount for each quartile. The maximum bonus amount for each quartile shall be distributed evenly among the number of FQHCs in each quartile.

4514.10 Beginning January 1, 2018, in addition to meeting the requirements set forth in Subsections 4514.4 and 4514.5, each qualifying FQHC shall achieve a three percent (3%) reduction on one of the following three (3) key measures to qualify for a pay-for-performance incentive payment:

Measure Name	NQF #	Steward	Description
Plan All-Cause Readmission	1768	NCQA	For FQHC patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data is reported in the following categories: 1. Count of Index Hospital Stays (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average adjusted Probability of Readmission
Potentially Preventable Hospitalization	Not Applicable	AHRQ	Percentage of inpatient admissions among FQHC participants for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.
Low-Acuity Non-Emergent Emergency Department Visits	Not Applicable	DHCF	Percentage of avoidable low-acuity non-emergent ED visits.

4514.11 DHCF shall review the baseline performance annually and may adjust the reduction targets for calendar year 2019 and future years. DHCF shall notify FQHCs of any necessary reduction target adjustments at least one year in advance of their application.

4514.12 Beginning January 1, 2018, the pay-for-performance incentive payment amount each qualifying FQHC shall be eligible to receive shall not exceed the amount that is available for distribution to each FQHC as described in Subsection 4514.7 and shall be subject to the following limitations:

- (a) An FQHC shall receive one third (1/3) of their pay-for-performance incentive payment for a three percent (3%) reduction in one (1) key measure;
- (b) An FQHC shall receive two-thirds (2/3) of their pay-for-performance incentive payment for a three percent (3%) reduction in two (2) key measures; or
- (c) An FQHC shall receive one hundred percent (100%) of their pay-for-performance incentive payment for a three percent (3%) reduction in all three (3) key measures.

4515 REBASING FOR APM

4515.1 Not later than January 1, 2018 and every three (3) years thereafter, the cost and financial data used to determine the APM rate shall be updated based upon audited cost reports that reflect costs that are two (2) years prior to the base year and in accordance with the methodology set forth in Sections 4503, 4504, 4505, and 4506.

4516 COST REPORTING AND RECORD MAINTENANCE

4516.1 Each FQHC shall submit to DHCF a Medicaid cost report, prepared based on the accrual basis of accounting, in accordance with Generally Accepted Accounting Principles. In addition FQHCs are required to submit their audited financial statements and any supplemental statements as required by DHCF no later than one hundred and fifty days (150) days after the end of each FQHC's fiscal year, unless DHCF grants an extension or the FQHC discontinues participation in the Medicaid program as a FQHC. In the absence of audited financial statements, the FQHC may submit unaudited financial statements prepared by the FQHC.

4516.2 Each FQHC shall also submit to DHCF its FQHC Medicare cost report that is filed with its respective Medicare fiscal intermediary, if submission of the Medicare cost report is required by the federal Centers for Medicare and Medicaid Services.

4516.3 Each FQHC shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the FQHC's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and

any other original documents which pertain to the determination of costs.

4516.4 Each FQHC shall maintain the records pertaining to each cost report for a period of not less than ten (10) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

4516.5 DHCF reserves the right to audit the FQHC's Medicaid cost reports and financial reports at any time. DHCF may review or audit the cost reports to determine allowable costs in the base rate calculation or any rate adjustment as set forth in these rules.

4516.6 If a provider's cost report has not been submitted to DHCF within hundred and fifty (150) days after the end of the FQHC's fiscal year as set forth in Subsection 4516.1, or within the deadline granted pursuant to an extension, DHCF reserves the right not to adjust the FQHC's APM rate or PPS rate for services as described in Subsection 4502.3, 4503.7, 4504.8, 4505.4 and 4506.4.

4516.7 Each FQHC shall submit to DHCF a copy of the annual HRSA Uniform Data System (UDS) report within thirty (30) calendar days of the filing.

4517 ACCESS TO RECORDS

4517.1 Each FQHC shall grant full access to all records during announced and unannounced audits and reviews by DHCF personnel, representatives of the U.S. Department of Health and Human Services, and any authorized agent(s) or official(s) of the federal or District of Columbia government.

4518 APPEALS

4518.1 At the conclusion of any required audit, the FQHC shall receive a Notice of Audit Findings that includes a description of each audit finding and the reason for any adjustment to allowable costs or to the payment rate.

4518.2 An FQHC may request an administrative review of payment rate calculations, scope of service adjustments or audit adjustments. The FQHC may request administrative review within thirty (30) calendar days of receiving the Notice of Audit Findings by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, DHCF.

4518.3 The written request for administrative review shall identify the specific audit adjustment or payment rate calculation to be reviewed, and include an explanation of why the FQHC views the adjustment or calculation to be in error, the requested relief, and supporting documentation.

4518.4 DHCF shall mail a formal response to the FQHC not later than sixty (60) calendar

days from the date of receipt of the written request for administrative review.

- 4518.5 Within thirty (30) calendar days of receipt of DHCF's written determination relative to the administrative review, the FQHC may appeal the determination by filing a written request for appeal with the Office of Administrative Hearings (OAH).
- 4518.6 The filing of an appeal with OAH shall not stay DHCF's action to adjust the FQHCs payment rate.

4599 DEFINITIONS

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

Alternative Payment Methodology - A reimbursement model other than a Prospective Payment System Rate for services furnished by an FQHC which meets the requirements set forth in Section 1902(bb)(6) of the Social Security Act.

Capitation payment - A payment an MCO makes periodically to an FQHC on behalf of a beneficiary enrolled with the FQHC pursuant to a contract between the MCO and FQHC. In exchange for the payment, the FQHC agrees to provide or arrange for the provision of the service(s) covered under the contract regardless of whether the particular beneficiary receives services during the covered period.

Encounter - A face-to-face visit between a Medicaid beneficiary and a qualified FQHC health care professional as described in Subsections 4507.2, 4508.2, 4505.15 and 4506.16, who exercises independent judgment when providing services for a primary care, behavioral health service or dental service. An encounter may also include a visit between a Medicaid beneficiary receiving healthcare services and a provider via telemedicine in accordance with District requirements.

FQHC look-alike - A private, charitable, tax-exempt non-profit organization or public entity that is approved by the federal Centers for Medicaid and Medicare Services and authorized to provide Federally Qualified Health Center Services.

Global payments - A single payment by an MCO to an FQHC to cover multiple visits.

New Provider - An FQHC that enrolls in the District's Medicaid Program after the effective date of the corresponding SPA or after the date that the rates are rebased.

Prospective Payment System Rate – The rate paid for services furnished in a particular fiscal year that is not dependent on actual cost experience during the same year in which the rate is in effect.

Single course of treatment – A process or sequence of services that are furnished at the same time or at the same visit.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Senior Deputy/State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, N.W., Suite 900, Washington D.C. 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.