DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in 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 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) based on reasonable costs or an Alternative Payment Methodology (APM), 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 has increased as well as the variation in the services offered and patients served.

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 these rules. 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.

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 Emergency and Proposed Rulemaking was adopted on July 22, 2016 and will become effective for dates of services rendered beginning September 1, 2016, if the corresponding State Plan amendment has been approved by CMS with an effective date of September 1, 2016 or the effective date established by CMS, whichever is later. 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 emergency rules shall remain in effect for one hundred and twenty (120) days from the date of adoption, until November 19, 2016, 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 entirely 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
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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 governing FQHCs set forth in the

applicable provisions of Title XVIII of the Social Security Act and implementing regulations;

(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; 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 the federal Health Resources Services Administration (HRSA).

4500.4 Services may be provided at other sites including mobile vans, intermittent sites such as a homeless shelter, a seasonal site and a beneficiary's place of residence for beneficiaries that are temporarily homebound, 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 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), Healthcare Effectiveness Data and Information Set, 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 these rules 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, subject to approval by CMS 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.

4502 PROSPECTIVE PAYMENT SYSTEM

4502.1 Medicaid reimbursement for services furnished on or after January 1, 2001 by an FQHC shall be on a PPS consistent with the requirements set forth in Section 1902(aa) 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. The amount of the adjustment

for an increase or decrease in services shall be negotiated between the parties. The adjustment shall be implemented not later than ninety (90) days after establishment of the negotiated rate. A change in the cost of a service, in and of itself, is not considered a change in the scope of services.

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. 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 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, shall receive a wrap-around supplemental payment if the FQHC's reimbursement for services received from the managed care organization (MCO) is less than the amount the FQHC would be entitled to receive pursuant to Subsections 4502.2 through 4502.5.

4502.7 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 PPS rate calculated pursuant to this section.

4502.8 The wrap-around supplemental payment shall be processed and paid by DHCF.

4503 ALTERNATIVE PAYMENT METHODOLOGY FOR PRIMARY CARE SERVICES

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

4503.2 The APM for primary care services shall be calculated by taking the sum of the FQHC's audited allowable costs for primary care services, and 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 these rules through December 31, 2017, the APM 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 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 these rules through December 31, 2017, the APM for primary care services shall not be lower than the Medicare PPS rate in FY 2016. If, an FQHC's APM for primary care services is less than the Medicare PPS rate, the APM 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 for primary care services 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 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 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 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.

4503.9 An FQHC that furnishes primary care services 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, shall receive a wrap-around supplemental payment if the FQHC's reimbursement for primary care services received from the MCO is less than the amount the FQHC would be entitled to receive pursuant to this section.

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 calculated pursuant to this section.

4503.11 The wrap-around supplemental payment shall be processed and paid by DHCF.

4503.12 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.

4503.13 The APM 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.

4503.14 Each FQHC shall include the Current Procedural Terminology (CPT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement.

4503.15 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:

(a) Obtain a separate DC 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.

4504 ALTERNATIVE PAYMENT METHODOLOGY FOR BEHAVIORAL HEALTH SERVICES

4504.1 The APM for behavioral health services rendered beginning the effective date of these rules by an FQHC shall be determined as described in this section. The APM shall be applicable to all sites for FQHCs operating in multiple locations. The APM 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 for behavioral health services shall be calculated by taking the sum of the FQHC's audited allowable costs for behavioral health services and administrative and capital costs and dividing it by the total number of eligible behavioral health encounters.

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

4504.4 For services rendered beginning the effective date of these rules through December 31, 2017, the APM 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 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 these rules through December 31, 2017, the APM for behavioral services shall not be lower than the Medicare PPS in FY 2016. If, an FQHC's APM for behavioral health services is less than the Medicare PPS rate, the APM 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 (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 for behavioral health services 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 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 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 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.

4504.10 An FQHC that furnishes behavioral health services 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, shall receive a wrap-around supplemental payment if the FQHC's reimbursement for behavioral health services received from the MCO is less than the amount the FQHC would be entitled to receive pursuant to this section.

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 calculated pursuant to this section.

4504.12 The wrap-around supplemental payment shall be processed and paid by DHCF.

4504.13 Reimbursement shall be limited for each beneficiary to one behavioral service encounter per day. The FQHC shall document each encounter in the beneficiary's medical record.

4504.14 The APM 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.

4504.15 Each FQHC shall include the Current Procedural Terminology (CPT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement.

4504.16 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:

(a) Obtain a separate DC 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.

4505 ALTERNATIVE PAYMENT METHODOLOGY FOR PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

4505.1 The APM for preventive and diagnostic dental services rendered beginning the effective date of the rules by an FQHC shall be determined as described in this section. The APM shall be applicable to all sites for FQHCs operating in multiple locations. The APM 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 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, 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 these rules through

December 31, 2017, the APM shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4505.4 For services rendered beginning January 1, 2018 through December 31, 2018, the APM for preventive and diagnostic dental services shall be determined as described in section 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 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 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.

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 If a procedure code listed in Subsection 4505.7 is not included on the D.C. Medicaid Fee for Service schedule, the procedure code shall not 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 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, shall receive a wrap-around supplemental payment if the FQHC's reimbursement for preventative and diagnostic dental services received from the MCO is less than the amount the FQHC would be entitled to receive pursuant to this section.

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 calculated pursuant to this section.

4505.11 The wrap-around supplemental payment shall be processed and paid by DHCF.

4505.12 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.

4505.13 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.

4505.14 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.

4505.15 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.

4505.16 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.

4506 ALTERNATIVE PAYMENT METHODOLOGY FOR COMPREHENSIVE DENTAL SERVICES

4506.1 The APM for comprehensive dental services rendered by the FQHC on or after the effective date of these rules shall be determined in accordance with this section.

4506.2 The APM shall be applicable to all sites for FQHCs operating in multiple locations. The APM shall be available for each encounter with a D.C. Medicaid beneficiary for comprehensive dental services described in Subsection 4506.5.

4506.3 The APM for comprehensive dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for comprehensive dental services, 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 these rules,

through December 31, 2017, the APM shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4506.5 For services rendered from January 1, 2018 through December 31, 2018, the APM 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 The APM for comprehensive dental services rendered on or after January 1, 2019 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 all FQHCs.

4506.7 The APM 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.

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 If a procedure code listed in Subsection 4506.8 is not included on the D.C. Medicaid Fee for Service schedule, the procedure code shall not 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 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, shall receive a wrap-around supplemental payment if the FQHC's reimbursement for comprehensive dental services received from the MCO is less than the amount the FQHC would be entitled to receive pursuant to this section.

4506.11 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 calculated receive pursuant to this section.

4506.12 The wrap-around supplemental payment shall be processed and paid by DHCF.

4506.13 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.

4506.14 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.

4506.15 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.

4506.16 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.

4506.17 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.

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) Well child care 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.

(b) Incidental services and supplies that are integral, although incidental, parts of the diagnosis or treatment of the services described in Subsection 4507.1(a) and included in allowable costs as described in Section 4510. Incidental services and supplies 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 used to facilitate patient record-keeping.

(c) Enabling services are those services that support an individual's management of their health and social service needs or improve the FQHC's ability to treat the individual and shall include the following:

(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; and

(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.

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 APM 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, 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 A change in the scope of services shall consist of a change in the type, intensity, duration or amount of service as described below:

(a) 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 Sections 4505 through 4508; or

(b) The elimination of an existing service provided by the FQHC.

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 APM shall be determined by dividing the incremental Medicaid allowable costs by the number of Medicaid encounters during the corresponding time period.

4509.7 The adjustment to the APM 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 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.

4509.8 An FQHC shall 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. The FQHC shall submit documentation in support of the request.

4509.9 DHCF shall provide a written notice of its determination to the FQHC within ninety (90) days of receiving all information related to the request described in Subsection 4509.8.

4509.10 If approved, the APM calculated pursuant to Sections 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.

4509.11 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.

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 and dental services. In the absence or 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, 4505.16 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, 4505.16 and 4506.16;

(c) Costs of services and supplies incident to the provision of services as described in Subsection 4507.1(b);

(d) Administrative and capital costs that are incurred in furnishing primary care, behavioral health and dental services, including clinic administration, subject to the limitation set forth in this section; and

(e) Costs related to enabling services as described in Subsection 4507.1(c).

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;

(h) Telephone expense; and

(i) Hardware and software 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 and 4504. 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 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) 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, lobby 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 4507.1 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 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, and 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 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 4502.8.

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.

4513 REIMBURSEMENT FOR OUT OF STATE PROVIDERS

4513.1 An FQHC located outside of the District of Columbia shall be reimbursed:

(a) The lesser of the PPS or the amount of reimbursement determined by the Medicaid agency in the state the FQHC is located; or

(b) The lesser of the APM or the amount of reimbursement determined by the Medicaid agency in the state the FQHC is located.

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.

Measure Name	NQF #	Steward	Description
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.
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. • 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. *Note: Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*
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.

Measure Name	NQF #	Steward	Description
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 base year data 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 these rules.

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 or PPS 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 application submitted to the federal government 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.

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, 4505.16 and 4506.16, who exercises independent judgment when providing services for a primary care, behavioral health service or dental service.

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.

New Provider – An FQHC that enrolls in the District's Medicaid Program after the effective date of these rules 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.

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.