DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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 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 (2016 Repl.)) and Section 6(6) of the 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 an amendment to Chapter 48 (Medicaid Program: Reimbursement) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These rules establish updated methods and standards for the reimbursement of inpatient hospital services provided by specialty hospitals through the District Medicaid program. Specifically, these rules make three (3) changes to the reimbursement methodology for Medicaid reimbursement to specialty hospitals classified as rehabilitation hospitals. First, Subsections 4814.12 through 4814.14 have been amended to adjust the initial year in which reimbursement rates for rehabilitation hospitals are rebased from Fiscal Year (FY) 2019 to FY 2018. The next year in which reimbursement rates for rehabilitation hospitals will be rebased will be FY 2023, aligning with the rebasing schedule for other types of specialty hospitals. Second, Subsections 4814.3 and 4814.6 have been amended to clarify that inpatient psychiatric services provided to individuals under age twenty-one (21) and individuals age sixty-five (65) and over may be eligible for reimbursement subject to federal and District regulatory requirements. Finally, Subsection 4814.11 has been amended to clarify what is included in the Medicare inflation factor.

These rules correlate to a proposed amendment to the District of Columbia State Plan for Medical Assistance (State Plan). The corresponding State Plan Amendment (SPA) requires approval by the Council of the District of Columbia (Council) and the Centers for Medicare and Medicaid Services (CMS). The Council approved the corresponding SPA through the Fiscal Year 2017 Budget Support Act of 2016, effective October 8, 2016 (D.C. Law 21-160; 63 DCR 10775 (August 26, 2017)). These rules are contingent upon approval of the corresponding SPA by CMS, which was approved on September 15, 2017 with an effective date of October 1, 2017. The estimated impact to annual aggregate expenditures for the SPA is $1,787,071 in Fiscal Year 2018 and $1,890,415 in Fiscal Year 2019.

An initial Notice of Proposed Rulemaking was published in the *D.C. Register* on August 4, 2017 at 64 DCR 007498. No comments were received and no substantive changes have been made. The Director has adopted these rules as final on October 17, 2017 and they shall become effective on the date of publication of this rulemaking in the *D.C. Register*.

Chapter 48, MEDICAID PROGRAM: REIMBURSEMENT, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Section 4814, SPECIALTY INPATIENT SERVICES: GENERAL PROVISIONS, is amended as follows:

4814 SPECIALTY INPATIENT SERVICES: GENERAL PROVISIONS

4814.1 The District of Columbia's Medicaid program shall reimburse claims associated with discharges from specialty hospitals, occurring on and after October 1, 2014, in accordance with the methodology described in Sections 4814 through 4819 of these rules. A claim eligible for payment shall reflect an approved specialty inpatient hospital stay of at least one (1) day or more by a beneficiary who is eligible for Medicaid.

4814.2 A specialty hospital shall be reimbursed either on a per diem (PD) or a per stay (PS) basis using the All Payer Refined-Diagnostic Related Group (APR-DRG) perspective payment system. DHCF adopted the APR-DRG classification system, as contained in the 2014 APR-DRG Classification System Definitions Manual, version 31.0, for purposes of calculating rates set forth in this section. Subsequent versions representing significant changes to the APR-DRG Classification System Definitions Manual may be adopted by DHCF at a later date.

4814.3 For purposes of Medicaid reimbursement, a specialty hospital meets the definition of a "special hospital" that is set forth in 22-B DCMR § 2099. Specialty hospitals classified as psychiatric hospitals shall be eligible for reimbursement of: (1) inpatient psychiatric services for individuals under age twenty-one (21) in accordance with the requirements set forth in 42 CFR § 440.160; and (2) inpatient hospital services for individuals age sixty-five (65) or over in accordance with federal and District regulatory requirements. Specialty hospitals classified as rehabilitation hospitals or long term care hospitals (LTCHs) shall be eligible for reimbursement for services that meet the definition at 42 CFR § 440.10.

4814.4 For discharges occurring on or after October 1, 2014, the following types of specialty hospitals in the District shall be reimbursed on a PD basis as described at Section 4815:

(a) Psychiatric hospitals;

(b) Pediatric hospitals not eligible for APR-DRG payment under Sections 4800-4813; and

(c) Rehabilitation hospitals.

4814.5 For discharges occurring on or after October 1, 2014, LTCHs in the District shall be reimbursed on a PS basis as described at Section 4816.

4814.6 Out-of-District hospitals that deliver services meeting the requirements set forth in Subsection 4814.3 shall be reimbursed in accordance with the requirements set forth in Sections 4813, 4814, and 4815.

4814.7 A hospital entering the District of Columbia market after October 1, 2014 shall demonstrate substantial compliance with all applicable laws and policies, including licensure, prior to contacting DHCF to initiate the rate setting process, including classification as either a per diem or per stay hospital.

4814.8 Each hospital classified within the specialty category shall have a hospital-specific base PD rate calculated in accordance with Section 4815 or base PS rate calculated in accordance with Section 4816. For purposes of this section, the base year period shall be Fiscal Year (FY) 2013, or October 1, 2012 through September 30, 2013.

4814.9 Cost classifications and allocation methods shall be applied in accordance with the CMS Guidelines for Form CMS 2552-10 and the Medicare Provider Reimbursement Manual 15, or subsequent superseding issuances from CMS.

4814.10 The hospital-specific cost-to-charge ratio (CCR) for specialty hospitals located in the District shall be calculated annually in accordance with 42 CFR § 413.53 and 42 CFR §§ 412.1 through 412.125, as reported on cost reporting Form HFCA 2552-10, Worksheet C Part I, or its successor. For purposes of specialty hospital reimbursement, organ acquisition costs shall not be included in the CCR calculation.

4814.11 Effective FY 2016, beginning on October 1, 2015, and annually thereafter, except during a rebasing year, DHCF shall apply an inflation adjustment to the then current base per diem or per stay rate associated with each specialty hospital. The inflation adjustment factor shall be calculated by multiplying the current base rate by the Medicare inflation factor as set forth in 42 USC § 1395ww (including multifactor productivity, statutory and any other relevant adjustments to the market basket rate of increase) to equal the adjusted base rate. DHCF shall base the inflation adjustment factor on the appropriate, hospital type specific inflation factor proposed under the Medicare program, set forth in the Hospital Inpatient Prospective Payment Systems (PPS) for general hospitals and the LTCH PPS for the same federal FY in which the rates will be effective.

4814.12 Except as provided in Subsections 4814.13 and 4814.14, effective in FY 2019, which begins on October 1, 2018, and every four (4) years thereafter (*i.e.*, quadrennially), the base rate for each specialty hospital shall be rebased as follows:

(a) For rebasing occurring quadrennially on October 1, the updated base rate shall be based on each hospital's submitted cost reports for the hospital's

fiscal year that ends prior to October 1, of the prior calendar year, including case mix, claims, and discharge data; and

(b) Any hospital that enters the District of Columbia market during a non-rebasing year shall be paid a rate equal to the base rate associated with a comparable specialty hospital until the next rebasing period, provided at least twelve (12) months of data are available prior to rebasing.

4814.13 For specialty hospitals classified as rehabilitation hospitals, effective FY 2018, which begins on October 1, 2017, the base rate for each rehabilitation hospital shall be rebased using the methodology outlined in Subsection 4814.12.

4814.14 Following the FY 2018 rebasing for rehabilitation hospitals described in Subsection 4814.13, the base rate for each rehabilitation hospital shall be rebased effective FY 2023, beginning on October 1, 2022, and every four (4) years thereafter (*i.e.*, quadrennially).

4814.15 Out-of-District specialty hospitals, not located in Maryland, shall be reimbursed for inpatient discharges in the same manner as general hospitals, pursuant to Sections 4800 through 4813.

4814.16 In the event that an out-of-District hospital offers inpatient specialty services that are distinct from services offered by other hospitals, DHCF may consider alternative reimbursement for those specialty inpatient services, provided the needs of Medicaid beneficiaries cannot be met by an in-District hospital.

4814.17 Maryland hospitals shall be reimbursed for specialty inpatient hospital services in accordance with Subsection 4800.12.

4814.18 All specialty hospital inpatient stays and non-emergency transfers shall be prior authorized pursuant to Subsection 4800.5.

4814.19 A specialty hospital located in an EDZ shall receive an increased reimbursement rate pursuant to Subsection 4810.1.

4814.20 Reimbursement of same-day discharges shall occur in accordance with Subsections 4812.1 through 4812.2.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health (Department), pursuant to § 302(14) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14) (2016 Repl.)), Mayor's Order 98-140, dated August 20, 1998, and the LGBTQ Cultural Competency Continuing Education Amendment Act of 2016, effective April 6, 2016 (D.C. Law 21-95; 63 DCR 2203 (February 26, 2016)), hereby gives notice of the adoption of the following amendment to Chapter 46 (Medicine) of Title 17 (Business, Occupations, and Professionals) of the District of Columbia Municipal Regulations (DCMR).

The rulemaking is necessary to update the District of Columbia Municipal Regulations pertinent to the Board of Medicine in order to reflect additional continuing education requirements imposed by the LGBTQ Cultural Competency Continuing Education Amendment Act of 2016 for physicians. Consistent with the aim of the Health Occupations Revision Act, this rulemaking will enhance professionalism within the community and operate in support of the health and welfare of the public.

This rulemaking was published in the *D.C. Register* on August 4, 2017 at 64 DCR 007502. The Department did not receive any comments in response to the notice. No changes have been made to the rulemaking. These rules were adopted as final on September 20, 2017 and will be effective upon publication of this notice in the *D.C. Register*.

Chapter 46, MEDICINE, of Title 17 DCMR, BUSINESS, OCCUPATIONS, AND PROFESSIONALS, is amended as follows:

Section 4606, CONTINUING EDUCATION REQUIREMENTS FOR NONPRACTICING PHYSICIANS, is amended as follows:

Subsection 4606.4 is amended to read as follows:

4606.4 An applicant for renewal, reactivation, or reinstatement of a license who has not been actively practicing medicine for a period of one (1) to five (5) years shall submit proof pursuant to § 4606.7 that the applicant has completed acceptable continuing medical education for each year after December 31, 1988, that the applicant has not been actively practicing medicine as follows:

(a) Twenty-five (25) hours of credit in continuing medical education meeting the requirements of Category 1;

(b) Twenty-five (25) hours of credit in continuing medical education meeting the requirements of either Category 1 or Category 2; and

(c) Beginning with the renewal period ending December 31, 2018, two (2) AMA/PRA Category I or Category I-equivalent hours in cultural competence or appropriate clinical treatment specifically for individuals who are lesbian, gay, bisexual, transgender, gender nonconforming, queer, or questioning their sexual orientation or gender identity and expression (LGBTQ) that meets the requirement of § 4607.4, and which shall count towards the hours required under paragraphs (a) and (b). Category I-equivalent hours shall be acceptable so long as they have been prescribed by the American Academy of Family Physicians or another entity approved by the Board.

Section 4607, APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES, is amended as follows:

A new Subsection 4607.4 is added to read as follows:

4607.4 Continuing medical education hours that are completed, pursuant to § 4606.4(c) of this chapter, in cultural competence and appropriate clinical treatment specifically for individuals who are LGBTQ shall, at a minimum, provide information and skills to enable a physician to care effectively and respectfully for patients who identify as LGBTQ, which may include:

(a) Specialized clinical training relevant to patients who identify as LGBTQ, including training on how to use cultural information and terminology to establish clinical relationships;

(b) Training that improves the understanding and application, in a clinical setting, of relevant data concerning health disparities and risk factors for patients who identify as LGBTQ;

(c) Training that outlines the legal obligations associated with treating patients who identify as LGBTQ;

(d) Best practices for collecting, storing, using, and keeping confidential, information regarding sexual orientation and gender identity;

(e) Best practices for training support staff regarding the treatment of patients who identify as LGBTQ and their families;

(f) Training that improves the understanding of the intersections between systems of oppression and discrimination and improves the recognition that those who identify as LGBTQ may experience these systems in varying degrees of intensity; and

(g) Training that addresses underlying cultural biases aimed at improving the provision of nondiscriminatory care for patients who identify as LGBTQ.