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State District of Columbia

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Drugs

 a. The Medicaid agency restricts payment to only those drugs that are approved by the U.S. Federal Drug Administration (FDA) for safety and effectiveness and supplied from manufacturers that have signed a national rebate agreement, or have an approved existing agreement, as specified in Section 1927(a).

 b. Methods established for determining prescription reimbursement are as follows:

  i. The reimbursement methods for brand name drugs and multiple source drugs, set forth under sections 5.c or 5.d of this Attachment, shall apply to the following claims, as appropriate:

   A. Pharmacy claims for retail pharmacy providers;

   B. Specialty drugs primarily dispensed through the mail;

   C. Non-retail community pharmacies (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay);

   D. Clotting factors from Specialty Pharmacies Hemophilia Treatment Centers, Centers of Excellence;

c. Payment for the cost of brand name drugs shall be the lesser of:

   i. The pharmacies' usual and customary charges to the general public; or

   ii. The actual acquisition cost (AAC) plus a professional dispensing fee as established in 5.e. The AAC shall be defined as DHCF's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers. The AAC shall be based on the lesser of the National Average Acquisition Cost (NADAC) or the Wholesale Acquisition Cost plus zero percent (0%).

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

   i. The Federal Upper Limit (FUL) of the drug for multiple source drugs plus a professional dispensing fee as described in 5.e;

   ii. NADAC plus a professional dispensing fee as described in 5.e;

   iii. WAC plus zero percent (0%) plus a professional dispensing fee as described in 5.e;

   iii. The pharmacy's usual and customary charges to the general public; or

   iv. The District Maximum Allowable Cost (DMAC) plus a professional dispensing fee as described in 5.e. The DMAC shall be established and applied as follows:

      A. A DMAC may be established for any drug for which two or more A-rated therapeutically equivalent, source drugs with a significant cost difference. The DMAC will be determined taking into account drug price status (non- rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization, and availability in the marketplace.

      B. The DMAC rate shall be applied to multiple source drugs as follows:

         I. Multiple drug pricing resources are utilized to determine the pricing for multiple source drugs, applying the necessary multipliers to ensure reasonable access by

providers to the drug at or below the determined pricing benchmark;

II. The resources used to determine DMAC are maintained by a vendor under contract with DHCF, and include but are not limited to pharmacy providers, wholesalers, drug file vendors such as First Data Bank, and pharmaceutical manufacturers, or any current equivalent pricing benchmark;

C. DHCF shall supplement the CMS listing for DMAC pricing described in 5.d.iv by adding drugs and their prices which meet the following requirements:

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

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

e. The professional dispensing fee rate is $11.15 per prescription.

f. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the submitted ingredient cost shall be the 340B acquisition cost. 340B covered entity pharmacies that include Medicaid claims in the 340B Drug Pricing Program will be reimbursed at their 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee. Drugs purchased outside of the 340B program will be reimbursed using the lesser of methodology described in Section 5.c or 5.d, plus the established professional dispensing fee. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

g. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS actual acquisition cost, plus the established professional dispensing fee.

h. Drugs acquired at Nominal Price will be reimbursed at their actual acquisition cost, plus the established professional dispensing fee.

i. Effective May 1, 2016, physician-administered drugs shall be reimbursed at eighty percent (80%) of the Medicare fee schedule, with the exception of physician-administered chemotherapy drugs which shall be reimbursed at one hundred percent (100%) of the Medicare fee schedule. Rates will be updated annually pursuant to the Medicare fee schedule, and will be published on DHCF's website at www.dc-medicaid.com.

j. For physician administered drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, reimbursement shall be the 340B actual acquisition cost, but no more than the 340B ceiling price.

k. Investigational drugs shall not be Medicaid-reimbursable.

DEFINITIONS

For the purposes of Section 3 in this State Plan Amendment, the following terms and phrases shall have the meanings ascribed:

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

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

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

Federal Supply Schedule (FSS) - a multiple award, multi-year federal contract for medical equipment, supplies, pharmaceutical, or service programs that is available for use by federal government agencies that complies with all federal contract laws and regulations. Pricing is negotiated based on how vendors do business with their commercial customers.

6. Physician and Specialty Services

a. For service where the procedure code falls within the Medicare (Title XVIII) fee schedule, payment will be the lesser of the Medicare rate; the actual charges to the general public; or the rate listed in DHCF's fee schedule. Effective January 1, 2011, DHCF will use the Medicare rates to determine the Medicaid rates for services on or after that date. Beginning January 1, 2011, physician and specialty services rates will be reimbursed at eighty percent (80%) of the Medicare rate. All rates will be updated annually pursuant to the Medicare fee schedule. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.dcmedicaid.com. Effective January 1, 2015 through September 30, 2015, the state reimburses for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine using the enhanced rates in effect pursuant to the requirements of 42 C.F.R. § 447.400(a).

Effective January 1, 2016, the state reimburses for specified services provided by qualified physicians and advanced practice registered nurses (APRNs) with a primary specialty designation of family medicine, pediatric medicine, psychiatry, obstetrics and gynecology or internal medicine utilizing Evaluation and Management (E&M) Codes and Vaccine Administration Codes authorized in Supplement 3 to Attachment 4.19B. Both physicians and APRNs shall deliver services that are predicated upon their scopes of practice and are in accordance with rules and regulations promulgated by the District of Columbia Health Occupations Board.

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

7. Nursing Home Services
(See attachment 4.19D)

8. OUTPATIENT HOSPITAL SERVICES

a. Reimbursement Methodology Overview

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

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

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

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

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

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

1) **Grouper version and quarterly updates**

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

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

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

2) **EAPG Relative Weights**

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

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

3) **Calculating EAPG Conversion Factor:**

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

i. In-District rehabilitation hospitals factor;

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

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

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

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

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

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

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

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

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

4) **Calculating Final EAPG Payments**

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Prior authorizations

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

f. Exceptions to Reimbursement Under the EAPG Classification System

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

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

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

g. **Three-day Payment Window**

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

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

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

h. **Payment Adjustment for Provider Preventable Conditions Policy**

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

i. **Cost Reports and Audits**

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

j. **Record Maintenance and Access to Records**

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

k. **Outpatient Hospital Supplemental Payment**

Beginning Fiscal Year 2017, each eligible hospital shall receive a supplemental hospital access payment calculated as set forth below:

1) For visits and services beginning October 1, 2016 and ending on September 30, 2017, quarterly access payments shall be made to each eligible private hospital. Each payment shall be an amount equal to each hospital's District Fiscal Year (DFY) 2014 outpatient Medicaid payments divided by the total in District private hospital DFY 2014 outpatient Medicaid payments multiplied by one quarter (1/4) of the total outpatient private hospital access payment pool. The total outpatient private hospital access payment pool shall be equal to the total available spending room under the private hospital outpatient Medicaid upper payment limit for DFY 2017 as determined by the State Medicaid agency;

2) Applicable private hospital DFY 2014 outpatient Medicaid payments shall include all outpatient Medicaid payments to Medicaid participating hospitals located within the District of Columbia except for the United Medical Center; and

3) For visits and services beginning October 1, 2016, quarterly access payments shall be made to the United Medical Center. Each payment shall be equal to one quarter (1/4) of the total outpatient public hospital access payment pool. The total outpatient public hospital access payment pool shall be equal to the total available spending room under the District-operated hospital outpatient Medicaid upper payment limit for DFY 2017.

l. **Appeals**

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

Definitions

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

1. Available spending room – The remaining room for outpatient hospital reimbursement that when combined with all other outpatient payments made under the District's Medicaid State Plan shall not exceed the allowable federal outpatient hospital upper payment limited specified in 42 C.F.R.§ 447.321.

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

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

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

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

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

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

8. Disproportionate Share Hospital – A hospital located in the District of Columbia that meets the qualifications established pursuant to 42 U.S.C. § 1396r-4.

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

8. Disproportionate Share Hospital – A hospital located in the District of Columbia that meets the qualifications established pursuant to Section 1923(b) of the Social Security Act (42 U.S.C. 1396r-4).

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

10. Eligible Hospital – A hospital located in the District of Columbia that participates in the District of Columbia Medicaid program

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

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

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

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

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

16. Hospital-specific DSH limit – The federal requirement limiting hospital disproportionate share hospital (DSH) payments to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid and uninsured individuals, consistent with Section 8 of Attachment 4.19-A of the District's Medicaid State plan.

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

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

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

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

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

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

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

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

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

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

24. Upper payment limit – The federal requirement limiting outpatient hospital Medicaid reimbursement to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles consistent with 42 C.F.R. 447.321.

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

9. Clinic Services

a. General Provisions

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

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

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

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

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

b. Private Clinics

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

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

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

c. Public Clinics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Intermediate Care Facilities

See Attachment 4.19D

11. Prepayment Organizations

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

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

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

12.

a. Rural Health Clinic Services

The District of Columbia does not have any rural areas.

12. b. Federally Qualified Health Centers

i. General Provisions

A. Medicaid reimbursement for services provided by a Federally Qualified Health Center (FQHC) shall be either:

I. A Prospective Payment System (PPS) as described in Section 12.b.ii; or

II. For FQHCs that elect this method, an Alternative Payment Methodology (APM) as described in Sections 12.b.iii through 12.b.vi.

B. Each FQHC that is geographically located in the District of Columbia and is enrolled in the District's Medicaid program as of September 1, 2016 that elects to be reimbursed for services under an APM shall sign an agreement with the Department of Health Care Finance (DHCF).

C. The APM referenced in Subsection 12.b.i.A.II shall become effective on or after the date of an executed agreement between DHCF and the FQHC, or September 1, 2016, whichever is later.

D. The APM shall comply with 1902(bb)(6) of the Social Security Act .

E. Any FQHC that elects not to be reimbursed under the APM described in Sections 12.b iii – vi will receive payment under the PPS methodology described in Section 12.b.ii.

F. An FQHC may only be reimbursed at the PPS or APM rate for services that are within the scope of services described in Section 12.b.2, and Supplement 1 to Attachment 3.1-A, pages 36-40, Sections B.2 – 5, and Supplement 1 to Attachment 3.1-B, pages 35-39, Sections B.2 – 5 and in accordance with Section 1905(a)(2) of Social Security the Act.

G. 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 payers and the FQHC's payment rate calculated pursuant to these rules.

H. Each encounter for a qualified Medicare beneficiary for whom Medicaid is responsible for only cost-sharing payments shall be paid the amount that is equal to the difference between the payment the FQHC received from Medicare and the FQHCs' Medicare prospective payment rate.

I. The payment received by an FQHC from Medicare, any other payer and Medicaid shall not exceed the Medicaid reimbursement rate.

J. If an FQHC seeks Medicaid reimbursement for services outside the scope of services described in Section 12.b.i.F and in accordance with Section 1905(a)(2) of the Social Security Act , reimbursement shall be subject to the D.C. Medicaid Fee for Service Fee Schedule if the FQHC meets the conditions outlined in District rulemaking. The D.C. Medicaid Fee for Service Fee Schedule is available online at http://www.dc-medicaid.com

K. Each FQHC shall ensure that a service that requires multiple procedures but under general standards of care are performed as part of a single course of treatment 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.

L. At the end of each fiscal year, DHCF will review and reconcile the total payments made to each FQHC that elects the APM rate to ensure that the overall per encounter rate is at least equal to the PPS rate for that FQHC for the fiscal year. If the payments are less than the total amount that would be paid under the PPS rate methodology for that FQHC, DHCF will pay the FQHC the difference between the amount paid and the amount the FQHC would have been due under the PPS rate methodology for the total number of encounters provided. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

ii. **Prospective Payment System (PPS) Rate Methodology**

A. Medicaid reimbursement for services furnished on or after January 1, 2001 by an FQHC will be on a prospective payment system consistent with the requirements set forth in Section 1902(bb) of the Social Security Act and subject to District rulemaking.

B. 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:

I. The sum of the FQHC's audited allowable costs for FYs 1999 and 2000 shall be divided by the total number of patient encounters in FYs 1999 and 2000;

II. The amount established in 12.b.ii.B.I 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

III. Allowable costs shall include reasonable costs that are incurred by an FQHC in furnishing Medicaid coverable services to Medicaid eligible beneficiaries, as determined by Reasonable Cost Principles set forth in 42 CFR Chapter IV, Sub Chapter B, Part 413 and 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.

C. 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.

D. 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 12.b.vii.

E. 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 Section 12.b.ii.C. This section shall not apply to a new provider seeking reimbursement as an FQHC. Reimbursement for a new provider is set forth in Section 12.b.x.

F. 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 per member per month (PMPM) payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.ii.B through 12.b.ii.E will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR Section 447.45 and 45 CFR Section 95, Subpart A.

G. The amount of the wrap-around supplemental payment identified in Section 12.b.ii.F 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 PMPM 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 as part of the annual reconciliation described in Section 12.b.ii.F.

iii. **Alternative Payment Methodology for Primary Care Services**

A. The APM rate for Primary Care services rendered beginning on September 1, 2016 shall be determined as described in this section. The same APM rate shall be applicable to all sites an FQHC operates within the District of Columbia in multiple locations. The APM rate will be paid to FQHCs on a per encounter basis for Primary Care services described in Supplement 1 to Attachment 3.1-A, beginning page 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2 and in accordance with1905(a)(2) delivered to an enrolled District Medicaid beneficiary.

B. 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.

C. For services rendered beginning on September 1, 2016 through December 31, 2017, the APM shall be determined based upon each FQHC's FY 2013 audited allowable costs.

D. 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 Section 12.b.iii.B or the APM rate based on costs reported by the FQHC or FQHC look-alike.

E. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate for Primary Care services shall not be lower than the Medicaid PPS rate in FY 2016. If an FQHC's APM rate for Primary Care services is less than the Medicaid PPS rate, the APM rate shall be adjusted up to the Medicaid PPS rate for the applicable time period.

F. Except as described in Section 12.b.iii.D, 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:

I. The APM rate for Primary Care services shall be the amount determined under Section 12.b.iii.B, 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.

G. Except as described in Section 12.b.iii.D, the APM rate for Primary Care services rendered on or after January 1, 2019, shall be determined as described in Section 12.b.iii.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.

H. The APM rate established pursuant to Section 12.b.iii.G 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 12.b.xiv.

I. 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 PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.iii.A-H will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

J. 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 pursuant to Sections 12.b.iii.A - H. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. 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 as part of the annual reconciliation described in 12.b.iii.I. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

K. 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.

L. 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 12.b.vii.

M. If an FQHC seeks Medicaid reimbursement for services that are outside the scope of Primary Care services described in Section 1905(a)(2) of the Social Security Act, Supplement 1 to Attachment 3.1-A, beginning page 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2, 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 under Section 12.b.i.J.

iv. **Alternative Payment Methodology for Behavioral Health Services**

A. The APM rate for Behavioral Health services rendered beginning September 1, 2016 shall be determined as described in this section. The same APM rate shall be applicable to all sites within the District of Columbia for FQHC operating in multiple locations. The APM rate shall be available per encounter with a District Medicaid beneficiary for Behavioral Health services described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3.

B. Except for group therapy as described in Section 12.b.iv.C and reimbursement to certain FQHCs as described in Section 12.b.iv.E, 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 administrative and capital costs and dividing it by the total number of eligible Behavioral Health encounters.

C. Effective September 1, 2017, the reimbursement rate for each beneficiary attending group therapy shall be equal to the D.C. Medicaid Fee for Service schedule rate for group psychotherapy. The D.C. Medicaid Fee for Service schedule is available online at http://www.dc-medicaid.com. FQHC seeking reimbursement for group psychotherapy shall comply with the requirements set forth under Section 12.b.i.J.

D. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

E. 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 Section 12.b.iv.B or the APM rate based on costs reported by the FQHC or FQHC look-alike.

F. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate for behavioral services shall not be lower than the Medicaid PPS in FY 2016. If an FQHC's APM rate for Behavioral Health services is less than the Medicaid PPS rate, the APM rate shall be adjusted up to the Medicaid PPS rate for the applicable time period.

G. Except as described in Sections 12.b.iv.C and 12.b.iv.E, 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: The APM rate for Behavioral Health services shall be the amount determined under Section 12.b.iv.B, except that administrative costs shall not exceed twenty percent (20%) of the FQHC's 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.

H. Except as described in Sections 12.b.iv.C and 12.b.iv.E, the APM rate for Behavioral Health services rendered on or after January 1, 2019, shall be determined as described in Section 12.b.iv.B except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.

I. The APM rate established pursuant to Section 12.b.iv.H 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 12.b.xiv.

J. 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 PMPM 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. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

K. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on per encounter basis and the FQHC APM rate calculated pursuant to Sections b.iv.A.-I. If an FQHC receives a PMPM 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, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. 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 as part of the annual reconciliation described in Section 12.b.iv.J.

L. Reimbursement shall be limited for each beneficiary to one behavioral service encounter per day. Reimbursement for a Behavioral Health encounter shall not affect an FQHCs ability to claim for group psychotherapy on a fee-for-service basis for the same service day. The FQHC shall document each encounter in the beneficiary's medical record.

M. 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 12.b.vii.

N. If an FQHC seeks Medicaid reimbursement for services that are outside the scope of Behavioral Health services covered under Section 1905(a)(2) of the Social Security Act and described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3, such as rehabilitative services, including Mental Health Rehabilitative Services (MHRS), prescription drugs, or laboratory and x-ray services that are not office-based, the FQHC shall comply with the requirements set forth under Section 12.b.i.J

v. **Alternative Payment Methodology for Preventive and Diagnostic Dental Services**

A. The APM rate for Preventive and Diagnostic Dental services rendered beginning September 1, 2016 shall be determined as described in this section. The APM rate shall be applicable to all sites an FQHC operating in multiple locations. The APM rate shall be available per encounter with a District Medicaid beneficiary for preventive and diagnostic dental services described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4.

B. The APM rate for Preventive and Diagnostic Dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for Preventive and Diagnostic Dental services and administrative and capital costs and dividing it by the total number of eligible Preventive and Diagnostic Dental service encounters.

C. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

D. Except as described in section 12.b.v.N, 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 section 12.b.v.B, 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.

E. Except as described in section 12.b.v.N, the APM for Preventive and Diagnostic Dental services rendered on or after January 1, 2019 shall be determined as described in Subsection 12.b.v.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs, including those with less than ten thousand (10,000) annual encounters.

F. The APM rate established pursuant to Section 12.b.v.E 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 12.b.xiv.

G. Subject to the limitations set forth in this section, covered Preventive and Diagnostic Dental services provided by the FQHC shall include the procedures described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4 and in accordance with Section 1905(a)(2) of the Social Security Act.

H. Only procedure codes that are listed in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4, and included on the Medicaid Fee for Service schedule as covered benefits, will be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at http://www.dc-medicaid.com.

I. 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 PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.v.A-F will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

J. 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 Section 12.b.v. A - F. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM payment for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. 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 as part of the annual reconciliation described in Section 12.b.v.I.

K. Reimbursement of preventive and diagnostic dental service encounters shall be limited to one encounter per day for each beneficiary. The FQHC shall document each encounter in the beneficiary's dental record.

L. If an encounter comprises both a Preventive and Diagnostic service and a Comprehensive Dental care service as described in Section 12.b.vi, the FQHC shall bill the encounter as a Comprehensive Dental care service.

M. All Preventive and Diagnostic Dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, Section 10; and District laws and rules.

N. 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 Section 12.b.v.B or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

vi. **Alternative Payment Methodology for Comprehensive Dental Services**

A. The APM rate for Comprehensive Dental services rendered beginning September 1, 2016 by an FQHC shall be determined as described in this section.

B. The same APM rate shall be applicable to all sites an FQHC operates in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for comprehensive dental services described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4.

C. 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.

D. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

E. Except as described in section 12.b.vi.N, the APM for services rendered beginning January 1, 2018 through December 31, 2018, the APM rate for comprehensive dental services shall be determined under Section 12.b.vi.C, 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.

F. Except as described in section 12.b.vi.N, the APM for comprehensive dental services rendered on or after January 1, 2019 the twenty percent (20%) administrative cap described in Section 12.b.vi.D shall apply in determining the APM rate for all FQHCs, including those with less than 10,000 annual encounters.

G. The APM rate established pursuant to Section 12.b.vi.F 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 are rebased as described in Section 12.b.xiv.

H. Subject to the limitations set forth in this section, covered comprehensive dental services provided by the FQHC shall include the procedures described in Supplement 1 to Attachment 3.1-A, pages 38 – 39, Section 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 37 - 38, Section 26.B.5.

I. Only procedure codes listed in Supplement 1 to Attachment 3.1-A, pages 38 - 39 , Section 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 37 - 38, Section 26.B.5, that are included on the Medicaid Fee for Service schedule as covered benefits will be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at http://www.dc-medicaid.com.

J. 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 PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive pursuant to Sections 12.b.vi. A-G will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to

yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

K. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the entity as determined on a per encounter basis and the FQHC APM calculated receive pursuant to Sections 12.b.vi. A - G. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM payment for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. 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 as a part of the annual reconciliation described in Section 12.b.vi.J.

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

M. If an encounter comprises both a Preventive and Diagnostic service as described in Section 12.b.v and a Comprehensive Dental care service, the FQHC shall bill the encounter as a Comprehensive Dental care service.

N. All comprehensive dental services shall be provided in accordance with the requirements, including any limitations, as set forth in in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, Section 10; and District laws and rules.

O. 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 Section 12.b.vi.B or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

vii. **Change in Scope of Services**

A. An FQHC may apply for an adjustment to its PPS or APM rate (in any of the 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 September 1, 2016, based upon a change in the scope of the services provided by the FQHC subject to the requirements set forth in the section.

B. A change in the scope of services shall only relate to services furnished on or after

September 1, 2016 and shall consist of a change in the type, intensity, duration or amount of service as described below:

I. Type: for FQHCs adopting either the PPS or APM payment rate, the addition of a new service not previously provided by the FQHC must be consistent with Section 1905(a)(2) of the Social Security Act and the services described in Supplement 1 to Attachment 3.1-A, pages 36 – 40, Section 26.B.2 through 5 and Supplement 1 to Attachment 3.1-B, pages 35 - 39, Section 26.B.2 through 5; or

II. 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;

III. 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; or

IV. Amount: for FQHCs adopting the 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.

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

D. A change in the scope of services shall not include a change in the number of encounters, or a change in the number of staff that furnish the existing service.

E. 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 reasonable cost principles set forth in 42 CFR Chapter IV, Sub Chapter B, Part 413 and 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.

F. 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 any of the four service categories described in Section 12.b.vii.A. 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:

I. 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;

II. Divided by the total allowable cost stated in the FQHC's prior year's cost report; and

III. Multiplied by one hundred percent (100%).

G. Subject to the limitation set forth in Section 12.b.vii.H, 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.

H. 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 any of the four service categories described in Section 12.b.vii.A. 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.

I. An FQHC shall submit a written notification to DHCF within ninety (90) days after a change in the scope of service, and the FQHC shall file a cost report demonstrating the increase in cost per encounter no later than ninety (90) days after the close of one (1) year of operation in which the scope change occurred. The FQHC shall submit documentation in support of the request including the HRSA approved Scope of Project documenting the need for the change.

J. 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 Section 12.b.vii.I.

K. If approved, the PPS or APM rate calculated pursuant to Sections 12.b.iii through 12.b.vi 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.

L. 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.

viii. **Allowable Costs**

Allowable costs are identified in accordance with 45 CFR 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR 413 Principles of Reasonable Cost Reimbursement. Further guidance found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45 will apply consistent with federal requirements.

ix. **Exclusions from Allowable Costs**

Certain cost items costs incurred by an FQHC in furnishing Primary Care, Behavioral Health, Diagnostic and Preventive Dental Services, or Comprehensive Dental Services regardless of applicable payment methodology, will be excluded from allowable costs. Further guidance found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45 will apply consistent with federal requirements.

x. **Reimbursement for New Providers**

A. Each new provider seeking Medicaid reimbursement as an FQHC shall meet all of the requirements set forth in Supplement 1 to Attachment 3.1-A, pages 35 – 36, Section 26.B.1 and Supplement 1 to Attachment 3.1-B, pages 34 - 35, Section 26.B.1.

B. Reimbursement for services furnished by a new provider shall be determined in accordance with the PPS methodology set forth in this section.

C. The PPS rate for services furnished during the first year of operation shall be calculated as of the first day of the District 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.

D. 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 12.b.viii and 12.b.ix and establish a PPS for each of the following four categories:

1. Primary Care services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, page beginning 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2;

II. Behavioral Health services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3;

III. Preventive and Diagnostic Dental services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, page 37, Section 26.B.4; and

IV. Comprehensive Dental services covered under Section 1905(a)(2) of the Social Security Act as described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.5, and Supplement 1 to Attachment 3.1-B, page 39, Section 26.B.5.

E. The PPS shall be calculated for each category described in subsections Section 12.b.x.D.I through IV 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.

F. The PPS rate described in subsection Section 12.b.x.E shall remain in effect until all provider rates are rebased in accordance with Section 12.b.xiv. After rebasing the FQHC shall be have the option of electing an APM rate in accordance with the procedures set forth in Section 12.b.i.

G. In addition to the PPS rate described in this section, the FQHC shall be entitled to receive a supplemental wrap-around supplemental payment as described in Sections 12.b.ii.F through 12.b.ii.G.

H. Each new FQHC shall only seek Medicaid reimbursement for services provided consistent with the services described in Supplement 1 to Attachment 3.1-A, pages 36 - 40, Sections 26.B.2 through 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 35 - 39, Sections 26.B.2 through 26.B.5 in accordance with Section 1905(a)(2) of the Social Security Act.

I. 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.

J. The new provider will be allowed one encounter on the same day for each of the categories described in Section 12.b.x.D.I, II, and either III or IV, consistent with the requirements set forth under Sections 12.b.v.L and 12.b.vi.M.

xi. **Reimbursement for Out-of-State Providers**

A. 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 Supplement 1 to Attachment 3.1-A, page 35, Section 26.B.1.a and Supplement 1 to Attachment 3.1-B, page 34, Section 26.B.1.a and shall be reimbursed at the PPS rate as determined by the state Medicaid program in the state in which the FQHC is geographically located..

B. 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.

xii. **Mandatory Reporting Requirements**

A. Each FQHC shall report to DHCF, annually, on the following two measure sets:

I. HRSA UDS "Quality of Care" and "Health Outcomes and Disparities" measures which may be located at the HRSA Bureau of Primary Care website at https://www.bphc.hrsa.gov/datareporting/reporting/index.html; and

II. Other performance measures set forth by DHCF at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45.

B. DHCF will notify FQHCs of the performance measures, measure specifications, and any changes through transmittals issued to the FQHCs no later than ninety (90) calendar days prior to October 1 each year.

C. The measurement year for measures outlined in 12.b.xii.A.II shall begin October 1, 2017 of and end on September 30, 2018, repeating annually, unless otherwise specified by DHCF.

D. For measures described in 12.b.xii.A.I, each FQHC shall submit measures to DHCF once HRSA has approved the FQHC's final report. The final report must be sent to DHCF no later than September 1 of each year, beginning September 1, 2017.

xiii. **Performance Payment**

A. Beginning October 1, 2017, each FQHC that elects the APM rate and meets the standards outlined in Section 12.b.xiii.B. may be eligible to participate in the FQHC performance payment program.

B. To participate in the performance payment program, a FQHC must have elected the APM rate and must submit to DHCF the following by September 1, 2018 and

annually thereafter in accordance with further guidance found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45 :

I. Letter of Intent to participate in the performance payment program;

II. Most current HRSA-approved quality improvement plan and any updates which HRSA may or may not have requested. In subsequent years, if the FQHC has not updated the HRSA-approved plan, then the FQHC shall provide DHCF with written notification that there have been no changes to the quality improvement plan; and

III. Annual performance data reporting measures set forth under 12.b.xii.A.II.

C. DHCF shall notify the FQHC if all requirements have been met no later than fifteen (15) business days after the receipt of the required materials.

D. The performance payment program's baseline year will be the first year in which FQHCs performance is measured to benchmark improvement in future years. The baseline year for FQHCs that elect to participate in the performance payment program shall begin October 1, 2017 and end on September 30, 2018. For FQHCs that elect to participate in the performance payment program after the initial baseline year, their first baseline year will begin on October 1 of the first year that an FQHC elects to participate in the performance program and end on September 30.

E. The measurement year (MY) is any year following an FQHC's satisfaction of participation requirements described in Section 12.b.xiii.B and completion of the baseline year. During the MY, each FQHC will be assessed on its attainment of or improvement in performance measures and guidelines found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45, which will apply consistent with federal requirements. The first MY under the FQHC performance payment program will begin on October 1, 2018.

F. Assessments and benchmarks will be based on comparing data collected in the baseline year to data collected during the first measurement year. During subsequent years, benchmarks will be based on the prior measurement year's performance.

G. DHCF shall provide written notification of the attainment and individualized improvement thresholds to each participating FQHC no later than 180 calendar days after the conclusion of the previous MY after all performance measures are received and validated.

H. A FQHC may opt to aggregate its beneficiary population with another FQHC's population for the purposes of calculating attainment of a performance measure or improvement on any of the required measures set forth under 12.b.xii.A.. Further guidance found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45 will apply consistent with federal requirements.

I. For MY 2019, beginning on October 1, 2018, and annually thereafter, performance payments will be calculated and distributed from the performance bonus funding pool established during the MY after the conclusion of each measurement year. For MY2019, the amount of the performance bonus funding pool available for distribution to all FQHCs shall be the difference between the FQHCs' uncapped administrative cost and the capped administrative cost reflected in 2013 audited cost reports.

J. For MY2020 and future years, the amount of the performance bonus funding pool shall be the amount available in the previous year's pool, adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act.

K. DHCF shall notify the FQHCs of the performance bonus funding pool amount no later than ninety (90) calendar days prior to October 1, 2018, and annually thereafter 90 calendar days before October 1.

L. The available funds in the annual performance bonus pool will be allocated to each participating FQHC that qualifies for a performance award as described in Section 12.b.xiii.N.

M. A participating FQHC's performance payment shall be the FQHC's maximum annual bonus payment as described in Section 12.b.xiii.N, multiplied by the FQHC's annual performance percentage using the methodology described in in Section 12.b.xiii.O.

N. A participating FQHC's performance award from the annual performance bonus pool will be the FQHC's maximum annual bonus payment multiplied by the FQHC's annual performance percentage for that year, as calculated using the methodology described in Section 12.b.xiii.O.V. Each participating FQHC's maximum annual bonus payment shall be the FQHC's market share multiplied by the annual performance bonus pool described in section 12.b.xiii.L added to any additional allocation referenced in Section 12.b.xiii.N.II.

I. The market share shall be calculated as follows:

a. In cases where there are no statistical outliers, the market share for a participating FQHC shall be the number of the FQHC's unique Medicaid beneficiaries that received primary care services from the FQHC during the baseline or previous measurement year, divided by the total number of Medicaid beneficiaries who received primary care services from the participating FQHCs during the baseline or previous measurement year.

b. In cases where there is a statistical outlier, the market share calculation shall be determined as follows:

1. DHCF shall apply a cap for FQHCs whose market share is considered a statistical outlier. A statistical outlier is any FQHC that has a market share less than the lower bound or exceeding the upper bound. The upper-bound and lower-bound outlier shall be calculated using the following steps:

   a) Calculate the quartiles of the number of unique Medicaid beneficiaries that received primary care services from the FQHC. The quartiles are the three points that divide the data set into four equal groups, each group comprising a quarter of the data. The first quartile is defined as the middle number, otherwise known as the median, between the smallest number and the median of the data set. The second quartile is the median of the data. The third quartile is the middle value between the median and the highest value of the data set.

   b) Calculate the interquartile range (IQR) by subtracting the first quartile from the third quartile;

   c) Multiply the IQR by 1.5 to obtain the IQR factor;

   d) Add the third quartile to the IQR factor to calculate the upper bound; and

   e) Subtract the IQR factor from first quartile to calculate the lower bound.

2. If an FQHC is a statistical outlier because its total number of beneficiaries exceeds the upper bound, the FQHC's market share will be the median of the upper bound number and the FQHC's actual number of unique Medicaid beneficiaries that received primary care services in the baseline or previous measurement year divided by the total number of Medicaid

beneficiaries who received primary care services from the participating FQHCs during the baseline or previous measurement year.

3. If an FQHC is a statistical outlier because its number of beneficiaries is less than the lower bound, the outlier FQHC's market share will be the lower bound number, divided by the total number of Medicaid beneficiaries who received primary care services from the participating FQHCs during the baseline or previous measurement year.

4. For FQHCs that are not statistical outliers participating during a measurement year when there are statistical outliers, the non-outlier FQHC's market share shall be calculated in same manner as described in subparagraph 12.xiii.N.I.b..

II. If there is an upper bound outlier, and there are remaining performance payment pool funds after all funds have been disseminated according to market share, the remaining additional funds shall be proportionally allocated to the non-outlier FQHCs based on the number of that FQHCs primary care beneficiaries divided by the total number of non-outlier FQHC beneficiaries..

O. To determine the FQHC's annual performance percentage for each year, DHCF shall score each participating FQHC's performance in three measurement domains. This scoring will be determined as follows:

I. Assessments and benchmarks will be based on comparing data collected in the baseline year to data collected during the first measurement year. During subsequent years, benchmarks will be based on the FQHC's improvement over a prior measurement year's performance.

II. A maximum of one hundred (100) points will be awarded to each FQHC across the three (3) measurement domains.

III. Each measure in the domain is assigned points by dividing the total points by number of measures in each domain. Further guidance found at http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45 will apply consistent with federal requirements.

IV. Points for each measure will be awarded in cases where an FQHC either meets the attainment or improvement benchmark based on the prior year's performance as described below:

a. For domain measures where improvement can be measured, the improvement benchmark will be a statistically significant improvement in performance of the measure compared to the prior year's performance, where the percentage improvement over the prior year is greater than a value that can be attributed to chance. DHCF shall perform the appropriate statistical analysis to determine that performance between years is a result that cannot be attributed to chance.

b. For domain measures where attainment is measured, an FQHC must achieve the attainment benchmark of the seventy-fifth (75th) percentile for the previous measurement year to receive points for the clinical process and utilization measures. Setting the threshold at the seventy-fifth (75th) percentile means that only FQHCs performing at the level of the top quartile for the previous year would earn points for attainment. FQHCs performing below the attainment benchmark may be able to receive points if they have improved measure performance.

c. If a FQHC neither attains nor improves performance on a given measure, no points will be awarded for that measure. The total number of points for a FQHC will be the sum of the total points earned, through either attainment or improvement on a measure.

V. The annual performance percentage for each qualifying FQHC shall be calculated using the following methodology:

a. Sum points awarded for each measure in the domain to determine the domain totals;

b. Sum domain totals to determine total performance points;

c. Divide total performance points by the maximum allowed points to determine the award percentage.

VI. If participating FQHCs have aggregated beneficiaries together for determination of performance, the award percentage for the aggregated entities shall be applied to each FQHC's maximum bonus amount to determine the FQHC's performance award individually.

VII. Beginning with MY2019, and annually thereafter, performance payments shall be calculated and distributed no later than 180 calendar days after the conclusion of each measurement year once all performance measures are received and have been validated.

xiv. **Rebasing for APM**

A. 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 years prior to the base year and in accordance with the methodology set forth in 12.b.iii, 12.b.iv, 12.b.v, and 12.b.vi of this Section.

xv. **Cost Reporting and Record Maintenance**

A. Each FQHC shall submit 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 an FQHC. In the absence of audited financial statements, the FQHC may submit unaudited financial statements prepared by the FQHC.

B. 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 (CMS).

C. 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.

D. 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.

E. 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 12.b of this Section.

F. If a provider's cost report has not been submitted within hundred and fifty (150) days after the end of the FQHC's fiscal year as set forth in Subsection 12.b.xv.A, 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 Sections 12.b.ii.C, 12.b.iii.G, 12.b.iv.H, 12.b.v.D and 12.b.vi.D.

G. 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.

xvi. **Access to Records**

A. 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.

xvii. **Appeals**

A. For appeals of DHCF Payment Rate Calculations, Scope of Service Adjustments or Audit Adjustments for FQHCs:

I. 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.

II. 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.

III. The written request for administrative review shall identify the specific audit adjustment and/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.

IV. 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.

V. 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).

VI. The filing of an appeal with OAH shall not stay DHCF's action to adjust the FQHC's payment rate.

VII. Resolution of payment rate, scope of service adjustment, or audit adjustment in favor of an FQHC shall be applied consistent with the process as described below:

a. The resolution of audit findings in favor of an FQHC will be applied retroactively to the date the initial adjustment was to have taken effect;

b. The resolution of scope of service adjustments in favor of an FQHC shall be prospective only, beginning the first day of the month following resolution of the scope of services adjustment; and

c. The resolution of payment rate adjustments shall be retroactive to the date when DHCF received a completed request for administrative review.

B. For FQHC appeals of DHCF decisions on fee-for-service claims:

I. An FQHC may request a formal review of a decision made on a fee-for-service claim. To be eligible for a formal review, the FQHC must make the request within three-hundred and sixty-five (365) calendar days of receiving notice of the decision.

II. The written request for formal review shall include an explanation of the problem, the requested relief, supporting documentation and meet any additional standards DHCF or its designee may require. Written requests for formal review must be sent to the addresses provided in the DC MMIS Provider Billing Manual.

III. DHCF or its designee shall render a written decision on a request for a formal review within forty-five (45) calendar days of a completed request for review.

C. For FQHC appeals of MCO decisions on claims for reimbursement:

I. Effective July 1, 2017, for dates of services after April 1, 2017, an FQHC may request administrative reconsideration from DHCF in order to challenge an MCO's denial, nonpayment or underpayment of a claim. To be eligible for administrative reconsideration, the FQHC shall:

a. Exhaust the MCO appeal process for the MCO that issued the denial, nonpayment or underpayment; and

b. Receive a final written notice of determination (WND) from the MCO, or provide documentation that the timeframe for the MCO to render a final WND has expired without decision.

II. Requests for administrative reconsideration shall be made to DHCF in writing by mail, email, fax, or in person to DHCF's Appeals Coordinator within thirty (30) calendar days of the date of the final WND from the MCO. If no final WND was provided, the request shall be made within thirty (30) calendar days of the date that the MCO was due to render its final WND.

III. DHCF will notify the MCO when a FQHC request for administrative reconsideration has been filed to allow the MCO the opportunity to share supporting documentation.

IV. DHCF reserves the right to request additional information and/or supporting documentation from the FQHC and/or the MCO, as appropriate, to assist in its determination. Failure to respond to agency requests for additional information and/or supporting documentation within the timeframe provided will not prevent DHCF from rendering a written decision.

V. DHCF shall render a written decision within forty-five (45) calendar days of receiving a complete request for administrative reconsideration.

   a. If new information is provided to DHCF that warrants an extension in the amount of time it will take the agency to render a decision, the agency reserves the right to extend its review period by no more than ten (10) calendar days. The FQHC shall be notified if such an extension is required.

VI. The written decision shall constitute the final determination on the subject claim. The written decision by DHCF shall include the following minimum information:

   a. Basis for decision; and

   b. Supporting documentation or findings, if appropriate.

VII. If DHCF determines that the decision of the MCO was improper, then DHCF will direct the MCO to make proper payment to the provider no later than thirty (30) calendar days of its written decision. Once payment is made, the FQHC can follow protocol in making a request to DHCF for wrap payment.

VIII. If DHCF determines that the decision of the MCO was proper, but that the FQHC is still due reimbursement or payment, DHCF shall make the appropriate payment no later than thirty (30) calendar days of its written decision.

IX. If DHCF determines that the decision of the MCO was proper and the FQHC is not due reimbursement or payment, DHCF shall deny reimbursement.

DEFINITIONS

For the purposes of Section 12.b in this State Plan Amendment, the following terms and phrases 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 Supplement 1 to Attachment 3.1-A, pages 37 – 40, Sections 28.B.2.b, 28.B.3.b, 28.B.4.c, and 28.B.5.c, and Supplement 1 to Attachment 3.1-B, pages 36 -39, Sections 26.B.2.b, 26.B.3.b, 26.B.4.c, 26.B.5.c, who exercises independent judgment when providing services for a Primary care, Behavioral Health service or Dental service as described under the State Plan in accordance with Section 1905(a)(2) of the Social Security Act. An encounter may also include a visit between a Medicaid beneficiary receiving healthcare services and a provider via telemedicine in accordance with District laws and rules.

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 – A FQHC that enrolls in the District's Medicaid Program after September 1, 2016 or during the time period after the rates are rebased.

Per Member Per Month (PMPM) payments – A single payment by an MCO to an FQHC to cover multiple visits.

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.

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

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

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

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

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

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

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

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

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

   a. General supervisory services of the medical director; and

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

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

   a. Physician Services

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

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

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

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

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

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

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

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

   a. General supervisory services of the medical director;

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

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

   a. Physician Services

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

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

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

The services furnished voluntarily by physicians are not reimbursable.

b. Pharmacy Services - Quality of Life Prescriptions

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

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

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

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

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

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

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

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

15. Reimbursement Methodology for Case Management Services

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

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

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

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

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

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

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

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

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

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

Reimbursement Methodology

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

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

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

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

STATE District of Columbia

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

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

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

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

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

STATE District of Columbia

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

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

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

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

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

20. Emergency Hospital Services

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

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

"Department" shall mean the Department of Health.

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

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

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

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

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

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

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

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

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

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

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

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

21. Fee-for-Service Providers

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

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

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

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

21. (Continued) Fee for Service Providers

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

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

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

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

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

23. Tuberculosis-Related Services

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

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

24. Personal Care Services

a. Payment for Personal Care Aide Services shall be provided at an hourly rate established by the State Medicaid Agency to be billed in fifteen (15) minute increments.

b. Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with PCA service authorization and the person's plan of care for each unit of service submitted on every claim.

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

d. Claims for PCA services submitted by a Provider in any period during which the person has been admitted to another health care facility shall be denied except on the day when the person is admitted or discharged.

e. The agency's fee schedule rate was set as of November 14th, 2015 and is effective for services provided on or after that date. The agency's fee schedule rate will be updated annually to reflect changes in the Medicare Home Health Agency Market Basket and changes in the District of Columbia Living Wage. All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload

25. Rehabilitative Services

Mobile Community Outreach Service Teams (MCOTT)

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

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

Hypothetical number of clients = 100

Rate Calculation: ($2,332,421.00/100)/365days =$ 63.90

(this is a per person, per day rate)

2. Services must be medically necessary and prior authorized.

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

26. Case Management Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   (b) Nursing facilities,

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

   (d) Institutes for the treatment of mental diseases.

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

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

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

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

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

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

REIMBURSEMENT METHODOLOGY FOR SCHOOL BASED HEALTH SERVICES (SBHS)

EPSDT School based health services (SBHS) are delivered by District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), referred to as "providers" for Section 28.I of this Attachment, in DCPS and DCPCS school settings within the District of Columbia.

Providers who arrange for the delivery of SBHS services by a privately owned or operated entity meeting the definition of "Nonpublic special education school or program" as defined in D.C. Official Code § 38-2561.01, are referred to as "nonpublic programs". Nonpublic programs must be certified as "Full Approval Status" schools by the Office of the State Superintendent of Education (OSSE) in accordance with D.C. Official Code § 38-2561.07 and 5-A DCMR §§ 2800 *et seq.*, and shall be used when a provider is unable to provide free and appropriate public education to the beneficiary. A nonpublic program shall submit claims for SBHS to OSSE, and OSSE shall maintain enrollment with DHCF as the SBHS nonpublic program provider of record. Reimbursement to OSSE for SBHS delivered in nonpublic programs shall be subject to cost based reimbursement.

SBHS are defined in Supplement 1, Attachment 3.1-A pages 6, 6a and 6b and include the following Medicaid services:

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

I. Cost-Based Reimbursement for District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS)

A. Direct Medical Payment Methodology

Providers are being paid on a cost basis for SBHS provided on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS direct medical services per unit of service at the lesser of the provider's billed charges or the statewide enterprise interim

rate. On an annual basis, a District-specific cost reconciliation and cost settlement for all over and under payments will be processed based on a yearly filed CMS-approved cost report.

B. Interim Payments

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

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

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

- Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data sources:
  a. School Based Health Services CMS-approved Cost Report received from schools
  b. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
     i. Direct medical RMTS percentage
  c. School District specific IEP Medicaid Eligibility Rates (MER)

D. Data Sources and Cost Finding Steps

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

1) Allowable Costs:

Direct costs for direct medical services include unallocated payroll and other costs that can be charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by DCPS and DCPCS, excluding transportation personnel. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These

direct costs will be calculated on a Medicaid provider-specific level and reduced for any federal payments for these costs, resulting in adjusted direct costs. Allowable provider costs related to Direct Medical Services include: 1) Salaries; 2) Benefits; 3) Medically-related purchased or contracted services; and, 4) Medically-related supplies and materials.

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

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

Indirect Cost Rate:

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

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

a. Direct Medical RMTS Percentage

i. Direct Medical Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 1200). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation

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

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

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

E. Specialized Transportation Services Payment Methodology

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

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

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

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

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

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

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

F. Certification of Funds Process

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

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

G. Annual Cost Report Process

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

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

2) Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

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

H. Cost Reconciliation Process

The cost reconciliation process must be completed within fifteen (15) months of the end of the cost report submission date. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school based health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

For the purposes of cost reconciliation, the District may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. Cost Settlement Process

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

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

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

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

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

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

II. Cost-Based Reimbursement for SBHS Delivered in Nonpublic programs on Behalf of OSSE

A. General Provisions

1) In accordance with the requirements of Supplement 3 of Attachment 3.1-B, pp. 5-5b and 5-A DCMR §§ 2803.6, 2803.10, and 2854.2, DHCF will reimburse OSSE for expenditures incurred when paying for the delivery of SBHS to D.C. Medicaid enrollees covered under the Individuals with Disabilities Education Act (IDEA) who attend nonpublic special education schools that maintain "Full Approval Status" certification. Reimbursement for SBHS delivered in nonpublic programs shall be retrospective and subject to an annual cost reporting and reconciliation process.

2) Reimbursement under this Section shall be limited to payments resulting from placement in nonpublic programs, pursuant to D.C. Official Code § 38-2561.03 (Supp. 2010).

3) Reimbursement for services delivered during the course of an Extended School Year (ESY) shall not be covered.

4) Effective October 1, 2014, DC pays nonpublic providers for school based services based costs which is determined based on a reconciliation of a CMS-approved cost report. OSSE shall submit the CMS-approved cost report in accordance with (II)(B). DHCF will audit cost reports, and use nonpublic schools' invoices, described in (II)(B)(1), to tie the costs of services claimed on the cost reports. Services included on invoices must be based on services documented on each student's IEP.

B. Documentation Standards, Cost Reporting, and Record Maintenance

1) OSSE shall ensure that each nonpublic program submits all Medicaid related documentation along with each invoice which shall include costs for services delivered to a Medicaid beneficiary. Invoices submitted to OSSE must provide specific itemization of services and costs, including but not limited to the type of service, the frequency of each service, the unit of service, the total units of services, the costs of services per hour or per day, and total costs of services. Services included on invoices must be based on services

documented on each student's IEP, and must clearly identify the medical services and educational services.

2) OSSE will complete an annual cost report for all SBHS delivered during the previous District fiscal year covering October 1 through September 30. The cost report template shall be approved by CMS.

3) OSSE shall use the accrual method of accounting and prepare the cost report in accordance with the requirements of this section, generally accepted accounting principles, and program instructions.

4) The cost report is due to DHCF, or its designee, on or before June 30 of the year following the reporting period, and includes a "certification of funds statement" to be completed, certifying the OSSE's actual, incurred costs/expenditures.

5) OSSE must maintain financial records and data sufficient to support an appropriate determination of allowable costs based upon the amounts reflected in the cost report. For purposes of this section, financial records include the general ledger, books of original entry, transaction documents, statistical data, and any other original document pertaining to the determination of costs covered under this Section.

6) OSSE must maintain adequate administrative records supporting its certification of nonpublic programs and the nonpublic programs' assurances that SBHS will be delivered by qualified health care professionals determined to be licensed practitioners of the healing arts, as set forth in 42 C.F.R. §§ 440.60, 440.110, 440.130, and 440.167, the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) and implementing rules.

7) OSSE must maintain the records that are pertinent to each cost report for a period of not less than seven (7) years after the date on which the cost report is filed with DHCF. If the records relate to a cost reporting period that is under currently audit or appeal, the records also must be retained until the conclusion of the audit or appeal.

8) All records and other pertinent information are subject to periodic verification and review by DHCF, or its designee.

9) All filed SBHS Cost Reports are subject to an audit or desk review by DHCF, or its designee.

C. Appeals and Reconciliation

1) At the conclusion of any required audit, OSSE shall receive an audited cost report that will include a description and the reason for each audit adjustment.

2) Within thirty (30) days of receiving the audited cost report, if OSSE disagrees with the audited cost report, then OSSE may request an administrative review of the audited cost report by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, Office of the Director, Department of Health Care Finance, 441 4th Street, NW, Suite 900 S, Washington, D.C. 20001.

3) The written request for administrative review shall include an identification of the specific audit adjustment to be reviewed, an explanation of why OSSE views the calculation to be in error, the requested relief, and supporting documentation.

4) DHCF shall mail a formal response to OSSE no later than forty-five (45) days from the date of receipt of the written request for administrative review.

D. Program Integrity

1) Reimbursement available under Section 28.II excludes room and board, tuition and other educational costs.

2) OSSE shall be prohibited from reporting expenditures that coincide with services delivered in nonpublic programs that hold probationary or provisional certification. DHCF, or its designee, shall reserve the right to request documentation to support compliance with this requirement.

3) OSSE shall not submit costs associated with initial Psychological Evaluations pursuant to Supplement 1 of Attachment 3.1-A, pp. 6-6b and Supplement 6 of Attachment 3.16 pp. 5-5b for SBHS eligibility under this section. The sending LEA incurs the cost of an initial Psychological Evaluation based on its obligation to place a beneficiary in an appropriate nonpublic program setting. LEAs incurring expenditures for initial Psychological Evaluations should incorporate those amounts into the RMTS methodology outlined in Section 28.I.

4) OSSE shall ensure it maintains accurate records of the National Provider Identification numbers for all SBHS rendering providers who deliver services in nonpublic programs.

5) OSSE shall ensure access to all related SBHS.

29. Other Non-Institutional Services

A. Licensed or Otherwise State-Approved Freestanding Birth Centers

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

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

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

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

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

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

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

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

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

30. Other Laboratory and X-ray Services

A. Other lab and x-ray services are defined per Supplement 1 to Attachment 3.1-A, page 4 and Supplement 1 to Attachment 3.1-B page 4, and are reimbursed based on the agency's fee schedule.

B. The agency's fee schedule rate was set as of August 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.dc-medicaid.com.

C. To receive Medicaid reimbursement, a provider of x-ray services shall be:

(1) Licensed or registered in accordance with D.C. Official Code § 44-202 and other applicable District of Columbia laws;

(2) In compliance with manufacturer's guidelines for use and routine inspection of equipment; and

(3) Screened and enrolled as a District Medicaid provider pursuant to 29 DCMR § 9400.

D. Medical reimbursement rates for other laboratory or x-ray services are eighty percent (80%) of the rates established by Medicare, and will not exceed Medicare on a per test basis.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
■	HCBS Adult Day Health-
	Reimbursement for adult day health services associated with the 1915(i) HCBS State Plan Option and defined per Attachment 3.1-A page 35 shall be paid based upon uniform per-diem rates at two acuity levels. Acuity level 1 will be reimbursed at ninety eight dollars and seventy cents ($98.70). Acuity level 2 will be reimbursed at one hundred and twenty five dollars and seventy eight cents ($125.78). The agency's fee schedule rate was set as of 4/1/2015 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DHCF Provider Web Portal available at www.dc.medicaid.com/dcwebportal/nonsecure/feeScheduleDownload.

ADHP will be reimbursed at two different acuity levels. To be eligible for reimbursement at acuity level 1 ADHP services, an individual shall obtain a total score of four (4) or five (5). To be eligible for reimbursement at acuity level 2 ADHP services, an individual shall obtain a total score of six (6) or higher. The specific acuity level does not affect the benefit package received by an individual. ADHP consists of one set of services that are available to all participants, regardless of acuity level. Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered plan. Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs and the other, for those whose assessed needs are higher. The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.

Adult Day Health providers are defined per the 1915(i) HCBS per Supplement 1, Attachment 3.1-A, pages 55 and 56. Reimbursement for adult day health services is paid using two bundled per-diem rates that are reasonable and adequate to meet the costs incurred by an efficient and economically prudent provider. The bundled per-diem rate consists of staffing costs in addition to program materials, indirect costs, and administrative costs. Room and board are excluded in the per-diem rates.

The per diem rates are binding rates; the District will pay each provider a fixed per-diem rate. The District will pay the lesser of the per-diem rate or the amount billed by a provider in accordance with standard Medicaid payment methodology. The staffing structure used to develop the rates were tied to the program requirements and is sufficient to allow providers to meet all program requirements, but they are not bound to adhere to the wages or benefit rates included in the rate model beyond compliance with existing federal and District laws (such as our living wage laws) and the program requirements outlined in the SPA. The agency's per diem rates will be effective on the date of approval, for any services provided on or after that date. Except as otherwise noted in the Plan, State developed per-diem rates are the same for both governmental and private individual practitioners and will be published via transmittal available at https://www.dc-medicaid.com.

For FY 2016 and annually thereafter, the per-diem rates will be inflated by the corresponding CMS Market Basket Index for Nursing Facilities for that period.

DHCF intends to rebase the per-diem reimbursement rates using submitted cost-reports from FY 2016, and based on a revised reimbursement methodology to be developed by DHCF. DHCF shall submit and seek CMS approval of a new State Plan Amendment prior to effectuating these new rates and revised payment methodology. DHCF anticipates that the new approved rates and payment methodology will become effective in FY 2018.

Staffing, wages, and benefits

The model incorporates five principle types of employees to ensure adequate staffing to meet beneficiary needs and program requirements. These include direct support personnel (DSP) providing hands-on support and care; social services professionals delivering services and programming; a program director; a registered nurse (RN); and a medical director. The cost of each of these staff types was estimated as a function of five data points: (1) the base wage or salary required to recruit and retain qualified staff and to meet District living wage law; (2) the hour paid staff would be on-duty at the program, as well as hours for paid leave; (3) the ratio of each staff member to beneficiaries attending the program; (4) the number of days in a fiscal year a program would reasonably be operating; and (5) the additional cost of providing employee benefits such as health insurance or other fringe benefits as appropriate.

Information about these five data points and how they were determined for each of the five staffing types are shown in the table below.

	Base wage or salary	Hours on duty per fiscal year	Ratio of staff member to beneficiaries	Number of operating days	Marginal addition for fringe benefits
Direct support	Based on DC	2080 (FTE) plus 80 hours	1:10 in Acuity 1; 1:4	260 (fiscal year,	20%

personnel	Living Wage	paid leave	in Acuity 2	excluding weekends)	
Social services personnel	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:20	260 (fiscal year, excluding weekends)	20%
Program director	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Registered nurse	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Medical director	Based on competitive wages in DC	520 (0.25 FTE)	1:40	260 (fiscal year, excluding weekends)	No benefits

These data were used to calculate annual total and per-beneficiary costs for each staffing type, which was further refined into a per-diem, per-beneficiary staffing cost.

These costs are used to develop a fee for service rate and are not a part of a CMS approved methodology to identify costs eligible for certification.

Program materials, indirect costs, and administrative costs

In addition to the staffing component, the rate includes additional funding for program materials, supplies, and indirect costs, including: (1) programming supplies; (2) food and snack costs; (3) indirect costs such as rental and building maintenance costs, utilities, telecommunications, and transportation; and (4) staff training and quality management. The estimate of these costs were based in part on qualitative data collection conducted in meetings, site visits, and phone calls with existing District health care providers, and in part on similar cost categories as reported by existing District provides via cost reporting. Annualized costs were translated into per-diem, per-beneficiary rates using an expected operating year of 260 days and expected program size of 40 beneficiaries.

After summing the staffing component and the program and indirect costs, an additional 13% was added to the rate to reflect administrative costs. The District uses this rate for other provider types and it was used here for consistency.

Lastly, the rate was adjusted to reflect attendance rates; effectively, the rate was increased slightly to accommodate continued operating costs each day a provider is open for business, despite its complete census not attending every day.

Service Limitations

ADHP services shall not be provided to persons who reside in institutions. Providers cannot bill for services that are provided for more than five (5) days per week and for more than eight (8) hours per day. Additionally, providers will not be reimbursed for ADHP services if the participant is concurrently receiving the following services:

(a) Day Habilitation and Individualized Day Supports under the 1915 (c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);

(b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS);

(c) Personal Care Aide services; (State Plan and 1915 (c) waivers), or

(d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501.

A provider will also not be reimbursed for ADHP services if the participant is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately precedes or follows the receipt of ADHP services, to ensure that the participant is receiving services in the setting most appropriate to his/her clinical needs.

☐ HCBS Habilitation

☐ HCBS Respite Care

☐ Other services –please add boxes as needed

For Individuals with Chronic Mental Illness, the following services:

HCBS Day Treatment or Other Partial Hospitalization Services

☐ HCBS Psychosocial Rehabilitation

☐ HCBS Clinic Services (whether or not furnished in a facility for CMI)