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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 DHCP, 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.

l. Drug Administration Fee

A pharmacy that employs or contracts a pharmacist who administers immunizations, vaccines, and emergency anaphylaxis agents in accordance with Supplement 1 to Attachment 3.1-A, page 8.1 and Supplement 1 to Attachment 3.1-B, page 8 shall be eligible to receive payment for administering these drugs. Except for flu vaccines, Medicaid reimbursement shall not be available if an immunization or vaccine that is covered under the VFC Program is administered to a child. The pharmacist must ensure all written protocols in support of the administration of immunizations, vaccines, and emergency anaphylaxis agents are current and reviewed with the delegating physicians annually in accordance with District laws and rules or the applicable professional practices act within the jurisdiction where services are provided. There shall be one administration fee for injectable products, and there shall be separate administration fee for nasal products. The administration fees are payable for immunizations, vaccines, and emergency anaphylaxis agents administered to Medicaid beneficiaries of all ages. The agency's fees are set as of September 1, 2019 and are effective for services provided on or after that date. Fees may be updated annually and shall be published on the Medicaid website at www.dc-medicaid.com. Except as otherwise noted in the plan, state-developed fees are the same for both governmental and private providers. Reimbursement for the administration of immunizations, vaccines, and anaphylaxis agents shall not include a professional dispensing fee.

DEFINITIONS

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

Administration fee – a fee reimbursed to a pharmacy that employs or contracts a pharmacist that directly applies an immunization, vaccine, or emergency anaphylaxis agent by injection or inhalation to the body of a Medicaid beneficiary.

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 – 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.

6. Physician and Specialty Services (Continued)

c. The District uses both the facility and non-facility rates that are derived from the Medicare physician fee schedule, which is effective on January 1 of each calendar year. For FY 2018, the District uses the Medicare physician fee schedule effective January 1, 2018 through December 31, 2018. The Medicaid Management Information System (MMIS) is calibrated to reimburse either the facility or non-facility rates, depending on the place of service (facility or non-facility) noted on the provider submitted claims.

d. For services rendered on or after November 23, 2019 through June 30, 2020, supplemental payments in the amount of four million and five hundred thousand dollars ($4,500,000.00) shall be equally distributed among physician groups. Supplemental payments shall not exceed four and a half ($4.5) million dollars. Supplemental payments shall be made no later than June 30, 2020.

To receive a supplemental payment, a physician group shall meet all of the following conditions:

i. Be a group practice, consistent with the conditions set forth under 42 C.F.R. § 411.352, and additionally have at least five hundred (500) physicians that are members of the group (whether employees or direct or indirect owners) as defined at 42 C.F.R. § 411.351;

ii. Be screened and enrolled with the Department of Health Care Finance (DHCF); and

iii. Contract with a public, general hospital located in an economically underserved area of the District of Columbia to provide at least two (2) of the following services to Medicaid beneficiaries:

A. Inpatient services, as described in Supplement 1 to Attachment 3.1A, section 1.B, page 2, and Supplement 1 to Attachment 3.1B, section 1.B, page 2;

B. Emergency hospital services, as described in Supplement 1 to Attachment 3.1A, section 24.E, page 28; Supplement 1 to Attachment 3.1B, section 24.E, page 27; and Attachment 4.19B, Part 1 section 20.a, page 11; or

C. Intensive care physician services, as authorized under Supplement 1 to Attachment 3.1A, section 5, pages 6b-7, and Supplement 1 to Attachment 3.1B, section 5, pages 5b-6.

A. Reimbursement Methodology

The reimbursement methodology is designed to ensure that the rates adequately support the unique program requirements for Private Duty Nursing services and ensure access to these services. There are three (3) distinct Private Duty Nursing rates: (1) assessments and supervisory nurse visits; (2) Private Duty Nursing services provided by a Registered Nurse (R.N.); and (3) Private Duty Nursing services provided by a Licensed Practical Nurse (L.P.N.).

1) Assessments and Supervisory Nurse Visits

The reimbursement rate for initial assessments, reassessments, and supervisory nurse visits is a flat per visit rate and it is derived by dividing the total annual R.N. cost by the average annual work hours multiplied by a factor of two. The annual cost of an R.N. includes: the average annual wages/salary paid to a R.N. plus administrative add-ons stated above.

Based on available salary data obtained from the Bureau of Labor and Statistics, Occupational Employment and Wages, for May 2016, the average annual salary for an R.N. in the District of Columbia is $80,500.

The average annual work hours equals the typical 2080 full time work hours less the 88 federal holiday hours, sick leave, vacation time and the District's mandatory continuing professional education hours. Further based on information provided by DHCF program staff and inquiries with providers, the duration of the initial assessment and supervisory visit is reasonably estimated to be two hours per visit.

7b. Home Health Services

Home Health services and provider qualifications are outlined per Attachment 3.1A, Supplement 1, page 9a-9r and Attachment 3.1B, Supplement 1, page 8a-8r. Reimbursement for Home Health Services shall be based on a prospective payment basis established by the State Medicaid Agency in accordance with the reimbursement methodologies outlined in this section and Section 21. For all services provided, the reimbursement will be the lesser of the amount described in Section 21 or derived from the methodology outlined in this section, or the amount charged by the provider.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Home Health Services. The agency's fee schedule rates for Home Health Services were set as of October 1, 2019 and are effective for services provided on or after that date. All rates are published on the agency's website at: http:\\www.dc-medicaid.com.

Living Wage Adjustment

Effective October 1, 2017 and annually thereafter, the reimbursement rates for Home Health Aides shall be adjusted annually with the Living Wage rate published by the District of Columbia, Department of Employment Services. This adjustment entails updating the reimbursement rates to reflect the published living wage amount, to ensure the rates are consistently aligned with current District of Columbia Living wage rates in effect during that fiscal year.

Inflation Adjustment

Effective October 1, 2017 and annually thereafter, the reimbursement rates for Skilled Nursing services shall be adjusted annually by the Medicare Economic Index factor for skilled nursing published by the Centers for Medicare and Medicaid Services.

Administrative Add-ons

All rate methodologies under this section shall include the following administrative expense add-ons in computing the rate amounts:

- 11% Employee Taxes – This is comprised of the Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%)
- 8% Employee Benefits – Medical Insurance and Sick Leave Provision
- 18% - Provider Administrative overhead, based on the reviewed Fiscal Year (FY) 2013 cost reports filed by Home Health Agencies for Home Health services

Reimbursement Methodology

Home Health services delivered are defined in Supplement 1 to Attachment 3.1-A beginning at page 9, and include the following Medicaid services:

- Physical Therapy/Speech Therapy/Occupational Therapy;
- Home Health Aide;
- Medical Supplies, Equipment and Appliances; and
- Skilled Nursing Services.

A. Reimbursement for physical therapy, speech therapy, occupational therapy, and home health aide services, and medical supplies, equipment and appliances, is described in Section 21 of Attachment 4.19B, Part 1.

B. Skilled Nursing Services

The reimbursement methodology is designed to ensure that the rates adequately support the unique program requirements for services under the skilled nursing rubric and ensure access to skilled nursing services. There are three (3) distinct skilled nursing rates: (1) assessments and supervisory nurse visits; (2) skilled nursing services provided by a Registered Nurse (R.N.); and (3) skilled nursing services provided by a Licensed Practical Nurse (L.P.N.).

1) Assessments and Supervisory Nurse Visits

The reimbursement rate for initial assessments, reassessments, and supervisory nurse visits is a flat per visit rate and it is derived by dividing the total annual R.N. cost by the average annual work hours multiplied by a factor of two. The annual cost of an R.N. includes: the average annual wages/salary paid to a R.N. plus administrative add-ons stated above.

Based on available salary data obtained from the Bureau of Labor and Statistics, Occupational Employment and Wages, for May 2016, the average annual salary for an R.N. in the District of Columbia is $80,500.

The average annual work hours equals the typical 2080 full time work hours less the 88 federal holiday hours, sick leave, vacation time and the District's mandatory continuing professional education hours. Further based on information provided by DHCF program staff and inquiries with providers, the duration of the initial assessment and supervisory visit is reasonably estimated to be two hours per visit.

Formula

$$\frac{\text{Annual R.N. Salary + Administrative Add-ons}}{\text{(Average Annual Work Hours)}} \times 2 \text{ hours}$$

2) Skilled Nursing Visits by an R.N. or L.P.N.

The reimbursement rate is an hourly rate computed by dividing the total annual cost of either an R.N. or L.P.N. by the average annual work hours. The annual cost of an R.N. or L.P.N. includes: the average annual wages/salary paid to an R.N. or L.P.N. plus administrative add-ons stated above.

Based on available salary data obtained from the Bureau of Labor and Statistics, Occupational Employment and Wages, for May 2016, the average annual salary for a R.N. and L.P.N. in the District of Columbia are $80,500 and $55,200 respectively.

Formula

$$\frac{\text{Annual R.N. or L.P.N. Salary + Administrative Add-ons}}{\text{(Average Annual Work Hours)}}$$

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 D, 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 accompanied with this UPL are that out-of- state charges, emergency claims and physicians 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 government 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.

e. 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 in Fiscal Year 2020, each eligible hospital shall receive a supplemental hospital access payment calculated as set forth below:

1) For visits and services beginning November 30, 2019 and ending on September 30, 2029, 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, three (3) years prior to the current fiscal year outpatient Medicaid payments, divided by the total in District private hospital for the same District Fiscal Year 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 the corresponding District year, as determined by the State Medicaid agency;

2) Applicable private hospital 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 November 30, 2019, ending September 30, 2029, 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 the corresponding District Fiscal Year.

4) These supplemental payments are annual lump-sum amounts made in four quarterly installments. The District makes each quarterly payment not later than fifteen (15) days after the end of the quarter.

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 (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.

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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: