DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02 (2016 Repl. & 2017 Supp.)), and the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the final adoption of an amendment to Chapter 45 (Medicaid Reimbursement for Federally Qualified Health Centers) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

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

The major components of the reimbursement model include: (1) an APM for primary care services, behavioral health services, preventive, diagnostic, and comprehensive dental services; (2) a limit on reimbursement for administrative costs; (3) an additional payment based upon performance of each FQHC beginning in January 2018; and (4) a new PPS reimbursement model for new providers that enroll in the Medicaid program after the effective date of the corresponding SPA. These rules set forth the standards for participation in the Medicaid program, the standards used to develop the PPS, APM, cost reporting and auditing processes, and establish the requirements for Medicaid reimbursement of FQHCs for Medicaid-reimbursable services that are outside the scope of core services that qualify for APM rates. DHCF projects an increase in aggregate expenditures of approximately $151,000 in Fiscal Year (FY) 2016, and $2,507,000 in FY 2017.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on August 5, 2016, at 63 DCR 010227. Two (2) sets of comments were received and a number of substantive changes were made. A Notice of Second Emergency and Proposed Rulemaking was adopted on November 19, 2016 and published in the *D.C. Register* on December 2, 2016, at 63 DCR 014902. Two (2) sets of comments were received from FQHC stakeholders and DHCF made a number of substantive changes to the rules in response to the comments. A Notice of Third Emergency and Proposed Rulemaking was adopted on March 16, 2017 and published in the *D.C. Register* on March 31, 2017 at 64 DCR 003175. One (1) set of comments was received and DHCF made a number of substantive changes in order to conform with the State Plan submission and requirements set forth by the U.S Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). A Notice of Fourth Emergency and Proposed Rulemaking was adopted on September 19, 2017 and published in the *D.C Register* on

October 6, 2017 at 64 DCR 009994. Comments were received from the D.C. Primary Care Association (DCPCA) on this most recent rulemaking. DHCF carefully considered all comments received, but no substantive changes were made, as is discussed in the summary below.

Primary Care Services Per Encounter Reimbursement Rate

As in the comments on the third emergency and proposed rules, DCPCA again raised concerns about the scope of primary care services and reimbursement, asserting that "other ambulatory services" must be covered on a per visit basis under § 1902(bb) of the Social Security Act. DCPCA adds that if DHCF is not going to reimburse "other ambulatory services" on a per encounter basis then those visits should not be included in denominator when calculating per encounter rates.

As proposed, DHCF will cover the full scope of services required under § 1902(bb)(1). Services that meet the definition of primary medical, behavioral health, preventive and diagnostic dental or comprehensive dental services will be reimbursed on a per encounter basis. All other services reimbursable under the Medicaid fee schedule that are appropriately provided in a clinic setting and not within these indicated categories, including ambulatory services, will be paid on a fee-for-service basis under the Medicaid fee schedule. DHCF believes this approach is consistent with federal requirements and other state reimbursement approaches.

When calculating the PPS or APM encounter rate, DHCF looks at the costs associated with all eligible FQHC encounters to derive a per encounter rate that reimburses FQHCs for their actual costs. This approach is consistent with federal FQHC reimbursement requirements and comports with the Medicaid reimbursement principles of efficiency and economy. In keeping with these requirements, DHCF is not proposing further changes at this time.

Administration of the MCO Wrap-Around Supplemental Payment

As in prior comments, DCPCA reiterated concerns that the managed care organization (MCO) wrap-around supplemental payment process set forth in these rules places an undue burden of proof for "unmatched" claims on FQHCs. DCPCA recommends a reversion to the prior wrap-around supplemental payment adjudication system or implementation of an alternative process. DCPCA stated that the process for administration of the wrap-around supplemental payment does not comply with their interpretation of the relevant federal statute nor is it consistent with current legal opinion and court decisions at District and Appellate level.

DHCF believes that the rule, as written, complies with the requirements set forth at 42 USC § 1396a(bb)(5)(B) and is consistent with legal guidance from CMS. Under the process set forth in these rules, an FQHC that furnishes services to Medicaid beneficiaries pursuant to a contract with an MCO will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. DHCF will reimburse a wrap-around supplemental payment to FQHCs for "matched" FQHC claims from MCOs. To ensure that FQHCs can appeal an MCO's claim denial, DHCF set forth an FQHC appeals process for MCO decisions on claims for reimbursement in § 4519.3. DHCF believes that the wrap-around supplemental payment process paired with the appeals process set forth in these rules will provide a fair, consistent, and timely

approach for administration of the wrap-around supplemental payment. For these reasons, DHCF is not proposing any revisions at this time.

Billing Guidance

Finally, DCPCA requested that DHCF issue further billing guidance on the process for billing of: services provided to dual eligible beneficiaries and qualified Medicare beneficiaries; group behavioral health visits with service dates prior to September 1, 2017; dental services; and substance use disorder treatment delivered to beneficiaries enrolled in managed care. DHCF has remained engaged with FQHCs throughout the policy development process and will continue to do so as the agency begins implementation of the new reimbursement methodology. DHCF will provide additional information on billing, claiming, and other issues to ensure FQHCs are prepared to operate under the new reimbursement methodology.

These rules correspond to a related State Plan amendment (SPA), which was approved by CMS on September 20, 2017 with an effective date of September 1, 2016. The Council of the District of Columbia authorized the SPA in the "Fiscal Year 2016 Budget Support Act of 2015," effective October 22, 2015 (D.C. Law 21-36; 62 DCR 10905 (August 14, 2015)).

This final rule was adopted on January 24, 2018, and shall become effective on the date of publication of this notice in the *D.C. Register*.

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

CHAPTER 45 MEDICAID REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

4500 GENERAL PROVISIONS

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

4500.2 Prior to seeking Medicaid reimbursement each FQHC must:

(a) Be approved by the federal Health Resources Services Administration (HRSA) and meet the requirements set forth in the applicable provisions of Title XVIII of the Social Security Act and implementing regulations, which shall include but not be limited to meeting the requirements governing federal approval of FQHC Look-Alikes;

(b) Be screened and enrolled in the Medicaid program pursuant to the requirements set forth in Chapter 94 of Title 29 of the District of Columbia Municipal Regulations; and

(c) Obtain a National Provider Identifier (NPI) for each site operated by an FQHC.

(d) Submit the FQHC's Scope of Project approved by the federal Health Resources Services Administration (HRSA).

4500.3 Medicaid reimbursable services provided by an FQHC shall be consistent with the Section 1905(a)(2) of the Social Security Act and furnished in accordance with Section 4231 of the State Medicaid Manual.

4500.4 Services may be provided at other sites including mobile vans, intermittent sites such as a homeless shelter, a seasonal site, or a beneficiary's place of residence, provided the claims for reimbursement are consistent with the services covered under Section 1905(a)(2) of the Social Security Act and described in Sections 4502 and 4505 - 4508.

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

4500.6 Services for which an FQHC seeks Medicaid reimbursement pursuant to this Chapter shall be delivered in accordance with the corresponding standards for service delivery, as described in relevant sections of the District of Columbia State

Plan for Medical Assistance and implementing regulations.

4501 REIMBURSEMENT

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

(a) A Prospective Payment System (PPS) as described in Section 4502; or

(b) An Alternative Payment Methodology (APM) as described in Sections 4503 - 4506.

4501.2 Each FQHC that is geographically located in the District of Columbia and enrolled in the District's Medicaid program as of the effective date of the corresponding State Plan Amendment (SPA) that elects to be reimbursed for services under an APM shall sign an agreement with the DHCF.

4501.3 The APM referenced in Subsection 4501.2 shall become effective on or after the date of an executed agreement between DHCF and the FQHC, or the effective date of the corresponding State Plan amendment, whichever is later.

4501.4 The APM shall comply with Section 1902(bb)(6) of the Social Security Act.

4501.5 Any FQHC that elects not to be reimbursed under an APM shall be reimbursed under the PPS methodology described in Section 4502.

4501.6 An FQHC may only be reimbursed at the PPS or APM rate for services that are within the scope of services described in Sections 4502, 4505, 4506, 4507, and 4508, in accordance with Section 1905(a)(2) of the Social Security Act.

4501.7 If an FQHC seeks Medicaid reimbursement for services covered under the DC Medicaid State Plan, in accordance with Section 1905(a)(2)(B) and (C) of the Social Security Act, that are outside the scope of services described in Sections 4502, 4505, 4506, 4507, and 4508, the FQHC shall be reimbursed at the fee-for-service rate if it meets the following conditions:

(a) Obtain a separate D.C. Medicaid identification number in accordance with Chapter 94 of Title 29 DCMR;

(b) Obtain a separate Healthcare Provider Taxonomy Code;

(c) Ensure that all individuals providing the service are authorized to render the service and meet the requirements governing the service; and

(d) Be subject to the limitations set forth in the State Plan for Medical Assistance (State Plan) and any governing rules and regulations.

4501.8 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.

4501.9 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.

4501.10 The payment received by an FQHC from Medicare, any other payor and Medicaid shall not exceed the Medicaid reimbursement rate.

4501.11 Each FQHC shall ensure that a service that requires multiple procedures, and which may be performed as part of a single course of treatment under general standards of care, shall be completed as a single encounter unless multiple visits are medically required to complete the treatment plan and the medical necessity is documented in the clinical record.

4501.12 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 APM rate methodology for the total number of encounters provided.

4501.13 Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4502 PROSPECTIVE PAYMENT SYSTEM

4502.1 Medicaid reimbursement for services furnished on or after January 1, 2001 by an FQHC shall be at a Prospective Payment System (PPS) rate consistent with the requirements set forth in Section 1902(bb) of the Social Security Act and subject to the following conditions:

(a) When an FQHC furnishes "other ambulatory services" as defined under Section 1902(bb) of the Social Security Act, DHCF shall reimburse the provider using the fee-for-service rate; and

(b) Other ambulatory services shall include services provided by an FQHC to a Medicaid-enrolled beneficiary that meet the following conditions:

(1) Not included in the scope of services defined under section 4501.6;

(2) Not provided in a hospital setting, either on an inpatient or outpatient basis; and

(3) Is a reimbursable service under the Medicaid State Plan.

4502.2 The PPS rate shall be paid for each encounter with a Medicaid beneficiary when a medical service or services are furnished. The PPS for services rendered beginning on or after January 1, 2001 through and including September 30, 2001, shall be calculated as follows:

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

(b) The amount established in Subsection 4502.2(a) shall be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during FY 2001. Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change. The amount of the adjustment shall be negotiated between the parties. The adjustment shall be implemented no later than ninety (90) days after establishment of the negotiated rate; and

(c) Allowable costs shall include reasonable costs that are incurred by the FQHC in furnishing Medicaid coverable services to Medicaid eligible beneficiaries, as determined by 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.

4502.3 For services furnished beginning FY 2002 and each fiscal year thereafter, an FQHC shall be reimbursed at a rate that is equal to the rate in effect the previous fiscal year, increased by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during the fiscal year.

4502.4 Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change, consistent with the requirements established in Section 4509.

4502.5 In any case in which an entity first qualifies as an FQHC after FY 2000, the prospective rate for services furnished in the first year shall be equal to the average of the prospective rates paid to other FQHCs located in the same area with a similar caseload, effective on the date of application. For each fiscal year following the first year in which the entity first qualified as an FQHC, the

prospective payment rate shall be computed in accordance with Subsection 4502.3. This section shall not apply to a new provider. Reimbursement for a new provider is set forth in Section 4512.

4502.6 An FQHC that furnishes services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a per member per month (PMPM) payment) from such entity is less than the amount the FQHC would be entitled to receive under Subsections 4502.2 through 4502.5, will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made at least every four (4) months and reconciled at least annually. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4502.7 The amount of the wrap-around supplemental payment identified in Subsection 4502.6 shall equal the difference between the payment received from the managed care organization (MCO) as determined on a per encounter basis and the FQHC PPS rate calculated pursuant to this section. 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 PPS rate the FQHC would be entitled to receive on a per encounter basis. 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 Subsection 4502.6.

4503 ALTERNATIVE PAYMENT METHODOLOGY FOR PRIMARY CARE SERVICES

4503.1 The APM rate for primary care services rendered beginning the effective date of the corresponding SPA by an FQHC shall be determined as described in this section. The APM rate shall be applicable to all sites within the District of Columbia for FQHCs operating in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for primary care services described in Section 4507 in accordance with Section 1905(a)(2) of the Social Security Act.

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

4503.3 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate shall be determined based upon each

FQHC's FY 2013 audited allowable costs.

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

4503.5 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate for primary care services shall not be lower than the 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.

4503.6 Except as described in Subsection 4503.4, for services rendered beginning January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for primary care services as follows:

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

4503.7 Except as described in Subsection 4503.4, the APM rate for primary care services rendered on or after January 1, 2019, shall be determined as described in Subsection 4503.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.

4503.8 The APM rate established pursuant to Subsection 4503.7 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4516.

4503.9 An FQHC that furnishes primary care services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a 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 at least every four (4) months and reconciled at least annually. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4503.10 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC APM rate calculated pursuant to this section. 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 Subsection 4503.9.

4503.11 Reimbursement shall be limited for each beneficiary to one primary care encounter per day. The FQHC shall document each encounter in the beneficiary's medical record.

4503.12 The APM rate established pursuant to this section may be subject to adjustment to take into account any change in the scope of services as described in Section 4509.

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

4503.14 If an FQHC seeks Medicaid reimbursement for services that are outside the scope of primary care services described in Section 4507 in accordance with Section 1905(a)(2) of the Social Security Act, such as prescription drugs, labor and delivery services, or laboratory and x-ray services that are not office based, the FQHC shall follow the requirements set forth in Subsection 4501.07.

4504 ALTERNATIVE PAYMENT METHODOLOGY FOR BEHAVIORAL HEALTH SERVICES

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

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

behavioral health encounters.

4504.3 Effective September 1, 2017, the reimbursement rate claimable for each beneficiary attending group therapy behavioral health services 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. FQHCs seeking reimbursement for group psychotherapy shall comply with the requirements set forth under Subsection 4501.7.

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

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

4504.6 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate for behavioral services shall not be lower than the 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.

4504.7 Except as described in Subsection 4504.5, for services rendered beginning January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for behavioral health services as follows: The APM rate for behavioral health services shall be the amount determined under Subsection 4504.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.

4504.8 Except as described in Subsection 4504.5, the APM rate for behavioral health services rendered on or after January 1, 2019, shall be determined as described in Subsection 4504.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.

4504.9 The APM rate established pursuant to Subsection 4504.8 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act except for the years the APM rate is rebased as described in Section 4516.

4504.10 An FQHC that furnishes behavioral health services that qualify as an encounter to

Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a 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 at least every four months and reconciled at least annually. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4504.11 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC APM rate calculated pursuant to this section. 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 Subsection 4504.10.

4504.12 For services furnished on or after the effective date of the corresponding SPA, reimbursement shall be limited for each beneficiary to one behavioral service encounter per day. 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.

4504.13 The APM rate established pursuant to this Section may be subject to adjustment to take into account any change in the scope of services as described in Section 4509 in accordance with Section 1905(a)(2) of the Social Security Act.

4504.14 Each FQHC shall include the Current Procedural Terminology (CPT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement.

4504.15 If an FQHC seeks Medicaid reimbursement for services that are outside the scope of behavioral health services described in Section 4508, such as rehabilitative services, including Mental Health Rehabilitative Services, prescription drugs, or laboratory and x-ray services that are not office-based, the FQHC shall comply with the requirements set forth under Subsection 4501.07.

4504.16 Each FQHC that delivers substance abuse services must be certified by the Department of Behavioral Health in accordance with Chapter 63 of Title 22-A of

the District of Columbia Municipal Regulations.

4505 ALTERNATIVE PAYMENT METHODOLOGY FOR PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

4505.1 The APM rate for preventive and diagnostic dental services rendered beginning the effective date of the corresponding SPA by an FQHC shall be determined as described in this section. The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available per encounter with a D.C. Medicaid beneficiary for preventive and diagnostic dental services described in Subsection 4505.5.

4505.2 The APM rate for preventive and diagnostic dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for preventative and diagnostic dental services and administrative and capital costs and dividing it by the total number of eligible preventive and diagnostic dental service encounters.

4505.3 For services rendered beginning the effective date of the corresponding SPA through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4505.4 Except as described in Subsection 4505.16, for services rendered beginning January 1, 2018 through December 31, 2018, the APM rate for preventive and diagnostic dental services shall be determined as described in Subsection 4505.2, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.

4505.5 Except as described in Subsection 4505.16, the APM for preventive and diagnostic dental services rendered on or after January 1, 2019 shall be determined as described in Subsection 4505.2 except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs, including those with less than ten thousand (10,000) annual encounters.

4505.6 The APM rate established pursuant to Subsection 4505.5 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4516.

4505.7 Subject to the limitations set forth in the section, covered preventive and diagnostic dental services provided by the FQHC may include the following procedures in accordance with Section 1905(a)(2) of the Social Security Act:

(a) Diagnostic-American Dental Association (ADA) dental procedure codes (D0100-D0999) representing clinical oral examinations, radiographs, diagnostic imaging, tests and examinations; and

(b) Preventive-ADA dental procedure codes (D1000-D1999) representing dental prophylaxis, topical fluoride treatment (office procedure), space maintenance (passive appliances and sealants).

4505.8 Only procedure codes listed in Subsection 4505.7 that are included on the D.C. Medicaid Fee for Service schedule as covered benefits shall be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at http://www.dc-medicaid.com.

4505.9 An FQHC that furnishes preventive and diagnostic dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a 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 at least every four months and reconciled at least annually. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4505.10 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the amount of the FQHC APM rate calculated pursuant to this section. 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 Subsection 4505.9.

4505.11 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.

4505.12 If an encounter comprises both a preventive and diagnostic service and a comprehensive dental service as described in Section 4506, the FQHC shall bill the encounter as a comprehensive dental service.

4505.13 All preventive and diagnostic dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Section 964 (Dental Services) of Title 29 DCMR.

4505.14 Each FQHC shall include the Current Dental Terminology (CDT) code(s) that correspond to the specific services provided on each claim submitted for reimbursement with associated tooth number, quadrant, and arch if applicable for the dental procedure.

4505.15 Each provider of preventive and diagnostic dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act (HORA) of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2016 Supp.)), or consistent with the applicable professional practices act within the jurisdiction where services are provided.

4505.16 An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4505.2 or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

4506 ALTERNATIVE PAYMENT METHODOLOGY FOR COMPREHENSIVE DENTAL SERVICES

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

4506.2 The APM rate shall be applicable to all sites for FQHCs operating in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for comprehensive dental services described in Subsection 4506.8.

4506.3 The APM rate for comprehensive dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for comprehensive dental services and related administrative and capital costs and dividing it by the total number of eligible comprehensive dental service encounters.

4506.4 For services rendered beginning on or after the effective date of the corresponding SPA, through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

4506.5 Except as described in Subsection 4506.17, for services rendered from January 1, 2018 through December 31, 2018, the APM rate for comprehensive dental services shall be determined as described in Subsection 4506.3, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year

as reported in the audited cost report.

4506.6 Except as described in Subsection 4506.17, the APM for comprehensive dental services rendered on or after January 1, 2019, the twenty percent (20%) administrative cap described in Subsection 4506.5 shall apply in determining the APM rate for all FQHCs, including those with less than ten thousand (10,000) annual encounters.

4506.7 The APM rate established pursuant to Subsection 4506.6 shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 4516.

4506.8 Subject to the limitations set forth in this section, covered comprehensive dental services provided by the FQHC may include the following procedures:

(a) Restorative - ADA dental procedure codes (D2000-D2999) representing amalgam restoration, resin-based composite restorations, crowns (single restorations only), and additional restorative services;

(b) Endodontic - ADA dental procedures codes (D3000-D3999) representing pulp capping, pulpotomies, endodontic therapy of primary and permanent teeth, endodontic retreatment, apexification/recalcification procedures, apicoectomy/periradicular services, and other endodontic services;

(c) Peridontic - ADA dental procedure codes (D4000-D4999) representing surgical services, including usual postoperative care), nonsurgical periodontal services, and other periodontal services;

(d) Prosthodontic - ADA dental procedure codes (D5000-D5899) representing complete and partial dentures treatment including repairs and rebasing, interim prosthesis, and other removable prosthetic services;

(e) Maxillofacial Prosthetics - ADA dental procedure code (D5982) representing the surgical stent procedure;

(f) Implants Services - ADA dental procedure codes (D6000-D6199) representing Pre-surgical and surgical services, implant-supported prosthetics, and other implant services;

(g) Oral and Maxillofacial Surgery - ADA dental procedure codes (D7000-D7999) representing treatment and care related to extractions, alveoloplasty, vestibuloplasty, surgical treatment of lesions, treatment of fractures, repair traumatic wounds including complicated suturing;

(h) Orthodontics - ADA dental procedure codes (D8000-D8999) representing

orthodontic treatments and services; and

(i) Adjunctive General Services - ADA dental procedure codes (D9000-D9999) representing unclassified treatment, anesthesia, professional consultation, professional visits, drugs and miscellaneous.

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

4506.10 An FQHC that furnishes comprehensive dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a 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 at least every four (4) months and reconciled at least annually. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

4506.11 The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the managed care entity as determined on a per encounter basis and the FQHC APM rate calculated receive pursuant to this section. 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 Subsection 4506.10.

4506.12 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.

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

4506.14 All comprehensive dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Section 964 (Dental Services) of Title 29 DCMR.

4506.15 Each FQHC shall include the CDT code(s) that correspond to the specific services provided on each claim submitted for reimbursement with associated tooth number, quadrant, surface, and arch if applicable for the dental procedure.

4506.16 Each provider of comprehensive dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2016 Supp.)), or consistent with the applicable professional practices act within the jurisdiction where services are provided.

4506.17 An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Subsection 4506.3 or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

4507 PRIMARY CARE SERVICES

4507.1 Covered primary care services provided by the FQHC shall be limited to the following services:

(a) Health services related to family medicine, internal medicine, pediatrics, obstetrics (excluding services related to birth and delivery), and gynecology which include but are not limited to:

(1) Health management services and treatment for illness, injuries or chronic conditions (examples of chronic conditions include diabetes, high blood pressure, etc.) including but not limited to health education and self-management training;

(2) Services provided pursuant to the Early and Periodic Screening, Diagnostic and Treatment benefit for Medicaid eligible children under the age of twenty-one (21);

(3) Preventive fluoride varnish for children, provided the service is furnished during a well-child visit by a physician or pediatrician who is acting within the scope of practice authorized pursuant to District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2016 Supp.)) ("HORA").

(4) Preventive and diagnostic services, including but not limited to the

following:

(i) Prenatal and postpartum care rendered at an FQHC, excluding labor and delivery;

(ii) Lactation consultation, education and support services if provided by a certified nurse mid-wife licensed in accordance with HORA and certified by the International Board of Lactation Consultant Examiners (IBLCE) or a registered lactation consultant certified by IBLCE;

(iii) Physical exams;

(iv) Family planning services;

(v) Screenings and assessments, including but not limited to, visual acuity and hearings screenings, and nutritional assessments and referrals;

(vi) Risk assessments and initial counseling regarding risks for clinical services;

(vii) PAP smears, breast exams and mammography referrals when provided as part of an office visit; and

(viii) Preventive health education.

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

(a) A physician;

(b) An Advanced Practiced Registered Nurse (APRN);

(c) A physician assistant working under the supervision of physician; or

(d) A nurse-mid-wife.

4508 BEHAVIORAL HEALTH SERVICES

4508.1 Covered behavioral health services provided by an FQHC shall be limited to ambulatory mental health and substance abuse evaluation, treatment and management services identified by specific Current Procedural Terminology (CPT) codes. Such codes include psychiatric diagnosis, health and behavioral health assessment and treatment, individual and family therapy, and

pharmacologic management. DHCF shall issue a transmittal to the FQHCs which shall include the specific CPT codes including any billing requirements for covered behavioral health services.

4508.2 Covered behavioral health services set forth in this section shall be delivered by the following health care professionals who shall be licensed in accordance with the HORA and certified by the Department of Behavioral Health when required by District Law:

(a) A physician, including a psychiatrist;

(b) An APRN;

(c) A psychologist;

(d) A licensed independent clinical social worker;

(e) A licensed independent social worker (LISW);

(f) A graduate social worker, working under the supervision of an LISW;

(g) A licensed professional counselor;

(h) A certified addiction counselor;

(i) A licensed marriage and family therapist; and

(j) A licensed psychologist associate, working under the supervision of a psychologist or psychiatrist.

4509 CHANGE IN THE SCOPE OF SERVICES

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

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

(a) Type: for FQHCs adopting either the PPS or APM payment rate, the addition of a new service not previously provided by the FQHC must be

consistent with the services described in Section 4505 – 4508 in accordance with Section 1905(a)(2) of the Social Security Act;

(b) Intensity: for FQHCs adopting the either the PPS or APM payment rate, a change in quantity or quality of a service demonstrated by an increase or decrease in the total quantity of labor and materials consumed by an individual patient during an average encounter or a change in the types of patients served;

(c) Duration: for FQHCs adopting the either the PPS or APM payment rate, a change in the average length of time it takes FQHC providers to complete an average patient visit due to changing circumstances such as demographic shifts or the introduction of disease management programs;

(d) Amount: for FQHCs adopting either the PPS or APM payment rate, an increase or decrease in the amount of services that an average patient receives in a Medicaid-covered visit such as additional outreach or case management services or improvements to technology or facilities that result in better services to the FQHC's patients.

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

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

4509.5 DHCF shall review the costs related to the change in the scope of services. Rate changes based on a change in the scope of services provided by an FQHC shall be evaluated in accordance with the Medicare reasonable cost principles set forth in 42 CFR Chapter IV, Sub Chapter B, Part 413 and 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.

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

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

(b) Divided by the total allowable cost stated in the FQHC's prior year's cost

report; and

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

4509.7 Subject to the limitation set forth in Subsection 4509.8, the adjustment to the APM rate shall be determined by dividing the total allowable cost plus the incremental allowable cost attributable to a change in the scope, by the total number of encounters including the encounters affected by the scope change during the corresponding time period.

4509.8 The adjustment to the APM rate shall only be granted if the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC's allowable costs in the core service category for the fiscal year in which the change in scope of service became effective. This percentage shall be calculated by comparing the FQHC's APM rate at the beginning of the fiscal year in question with the cost per encounter as calculated by a completed Medicaid cost report using data from the same fiscal year.

4509.9 For services furnished on or after the effective date of the corresponding SPA, an FQHC shall submit a written notification to DHCF within ninety (90) days after a change of the scope of service, and the FQHC shall file a cost report demonstrating the increase in cost per encounter no later than 90 days after the close of one year of operation in which the scope change occurred. The FQHC shall submit documentation in support of the request, including the HRSA approved Scope of Project documenting the need for the change.

4509.10 DHCF shall provide a written notice of its determination to the FQHC within one hundred eighty (180) days of receiving all information related to the request described in Subsections 4509.9.

4509.11 If approved, the PPS or APM rate calculated pursuant to Sections 4502 or 4503 - 4506 shall be adjusted to reflect the adjustment for the change in the scope of service. The adjustment shall be effective on the first day of the first full month after DHCF has approved the request. There shall be no retroactive adjustment.

4509.12 DHCF shall review or audit the subsequently filed annual cost report to verify the costs that have a changed scope. Based upon that review DHCF may adjust the rate in accordance with the requirements set forth in this section.

4510 ALLOWABLE COSTS

4510.1 The standards established in this section are to provide guidance in determining whether certain cost items will be recognized as allowable costs incurred by a FQHC in furnishing primary care, behavioral health, diagnostic and preventive dental services, and comprehensive dental services regardless of the applicable payment methodology. In the absence or specific instructions or guidelines, each

FQHC shall follow the Medicare reasonable cost principles set forth in 45 CFR § 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR § 413 Principles of Reasonable Cost Reimbursement and instructions set forth in the Medicare Provider Reimbursement Manual.

4510.2 Allowable costs, to the extent they are reasonable, necessary and related to patient care shall include but are not limited to the following:

(a) Compensation for the services rendered by each health care professional listed in Subsections 4507.2, 4508.2, 4505.15 and 4506.16 and other supporting health care professionals including but not limited to registered nurses, licensed practical nurses, nurse aides, medical assistants, physician's assistants, technicians, etc.;

(b) Compensation for services for supervising health care professionals described in Subsections 4507.2, 4508.2, 4505.15 and 4506.16;

(c) Costs of services and supplies incident to the provision of services as described in (f) of this subsection;

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

(e) Enabling services that support an individual's management of his or her health and social service needs or improve the FQHC's ability to treat the individual, including:

(1) Health education and promotion services including assisting the individual in developing a self-management plan, executing the plan through self-monitoring and management skills, educating the individual on accessing care in appropriate settings and making healthy lifestyle and wellness choices; connecting the individual to peer and/or recovery supports including self-help and advocacy groups; and providing support for improving an individual's social network. These services shall be provided by health educators, with or without specific degrees in this area, family planning specialists, HIV specialists, or other professionals who provide information about health conditions and guidance about appropriate use of health services;

(2) Translation and interpretation services during an encounter at the FQHC. These services are provided by staff whose full time or dedicated time is devoted to translation and/or interpretation

services or by an outside licensed translation and interpretation service provider. Any portion of the time of a physician, nurse, medical assistant, or other support and administrative staff who provides interpretation or translation during the course of his or her other billable activities shall not be included;

(3) Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services). Such services shall not be reimbursed separately as enabling services where such referrals are provided during the course of other billable treatment activities;

(4) Eligibility assistance services designed to assist individuals in establishing eligibility for and gaining access to Federal, State and District programs that provide or financially support the provision of medical related services;

(5) Health literacy;

(6) Outreach services to identify potential patients and clients and/or facilitate access or referral of potential health center patients to available health center services, including reminders for upcoming events, brochures and social services;

(7) Care coordination, which consists of services designed to organize person-centered care activities and information sharing among those involved in the clinical and social aspects of an individual's care to achieve safer and more effective healthcare and improved health outcomes. These services shall be provided by individuals trained as, and with specific titles of care coordinators, case managers, referral coordinators, or other titles such as nurses, social workers, and other professional staff who are specifically allocated to care coordination during assigned hours but not when these services are an integral part of their other duties such as providing direct patient care;

(8) Staff cost related to quality improvement, data analytics, and compliance; and

(9) Training for health care professionals for the provision of health care services.;

(f) Incidental services and supplies that are integral, although incidental, to the diagnostic or treatment components of the services described in Subsections 4505.7, 4506.8, 4507.1(a), and 4508.1 which shall include but

are not limited to the following:

(1) Lactation consultation, education and support services that are provided by health care professionals described in Subsection 4507.1(4)(ii);

(2) Medical services ordinarily rendered by an FQHC staff person such as taking patient history, blood pressure measurement or temperatures, and changing dressings;

(3) Medical supplies, equipment or other disposable products such as gauze, bandages, and wrist braces;

(4) Administration of drugs or medication treatments, including administration of contraceptive treatments, that are delivered during a primary care visit, not including the cost of the drugs and medications;

(5) Immunizations;

(6) Electrocardiograms;

(7) Office-based laboratory screenings or tests performed by FQHC employees in conjunction with an encounter, which shall not include lab work performed by an external laboratory or x-ray provider. These services include but are not limited to stool testing for occult blood, dipstick urinalysis, cholesterol screening, and tuberculosis testing for high-risk beneficiaries; and

(8) Hardware and software systems, including implementation services, used to facilitate patient record-keeping and related services to support implementation.

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

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

4510.5 The cost claimed on the cost report for services, facilities and supplies furnished by a related party shall not exceed the lower of:

(a) The cost incurred by the related party; or

(b) The price of comparable services, facilities, or supplies generally available.

4510.6 Administrative and capital costs shall be allocated and included in determining the total allowable costs for primary care services and behavioral health services.

4510.7 Administrative and general overhead costs shall consist of overhead facility costs as described in Subsection 4510.8 and administrative costs as described in Subsection 4510.9.

4510.8 Capital and facility costs shall include but not be limited to:

(a) Rent;

(b) Insurance;

(c) Interest on mortgages or loans;

(d) Utilities;

(e) Depreciation on buildings;

(f) Depreciation on equipment;

(g) Maintenance, including janitorial services;

(h) Building security services; and

(i) Real estate and property taxes.

4510.9 Administrative costs shall include but not be limited to:

(a) Administrative Salaries (*i.e.*, salary expenditures related to the administrative work of a FQHC);

(b) Fringe benefits and payroll taxes of personnel described in paragraph (a) of this subsection;

(c) Depreciation on office equipment;

(d) Office supplies;

(e) Legal expenses;

(f) Accounting expenses;

(g) Training costs of administrative personnel for the provision of health care services;

(h) Telephone expense; and

(i) Hardware and software, including implementation costs, not related to patient record keeping.

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

4511 EXCLUSIONS FROM ALLOWABLE COSTS

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

(a) Cost of services that are outside the scope of services covered under Section 1905(a)(2) of the Social Security Act and described in Sections 4505 - 4508;

(b) Graduate Medical Education costs; and

(c) Expenses incurred by the FQHC that are unrelated to the delivery of primary care, behavioral health and dental services as defined in Sections 4505 - 4508, which shall include but are not limited to the following:

(1) Staff educational costs, including student loan reimbursements, except for training and staff development, required to enhance job performance;

(2) Marketing and public relations expenses;

(3) Community services that are provided as part of a large scale effort, such as a mass scale community wide immunization program or any other community wide service

(4) Environmental activities;

(5) Research;

(6) Transportation costs except as provided for in Section 4510;

(7) Indirect costs allocated to unallowable direct health service costs;

(8) Entertainment including costs for office parties and other social functions, retirement gifts, meals, and lodging;

(9) Board of Director fees;

(10) Federal, state and local income taxes;

(11) Excise taxes;

(12) All costs related to physicians and other professional's private practices;

(13) Donations, services and goods and space, except for those that are allowable pursuant to the Office of Management and Budget Circular No. A-122 and the Medicare Provider Reimbursement Manual;

(14) Fines and penalties;

(15) Bad debts, including losses arising from uncollectible accounts receivable and other claims, related collection and legal costs;

(16) Advertising, except for recruitment of personnel, procurement of goods and services, and disposal of medical equipment and supplies;

(17) Contributions to a contingency reserve or any similar provision made for an event, the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of the event taking place;

(18) Over-funding of contributions to self-insurance funds that do not represent payments based on current liabilities;

(19) Fundraising expenses;

(20) Goodwill;

(21) Political contributions, lobbying expenses or other related expenses;

(22) Costs attributable to the use of a vehicle or other company equipment for personal use;

(23) Other personal expenses not related to patient care for the core

services; and

(24) Charitable contributions.

4511.2 Costs reimbursed or otherwise paid for by locally funded grants or other locally funded sources, shall be offset against expenses in determining allowable cost. Such offset does not apply to local grants funded with federal dollars.

4511.3 An FQHC shall identify each grant by name and funding source in the supplemental data submitted with the cost report.

4511.4 Revenues related to the following categories shall be offset against expense.

(a) Investment Income: Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs;

(b) Refunds and rebates for expenses;

(c) Rental income for building and office space;

(d) Related organization transactions pursuant to 42 CFR § 413.17;

(e) Sale of drugs to other than patient; and

(f) Vending Machines.

4511.5 Enabling services described in Subsection 4510.2 shall not include any services that may be or are included as a part of a patient encounter, administrative, facility or other reimbursable cost described in these rules. The costs of enabling services shall be reasonable as determined in accordance with the Medicare reasonable cost principles set forth in 42 CFR § 413.

4512 REIMBURSEMENT FOR NEW PROVIDERS

4512.1 Each new provider seeking Medicaid reimbursement as an FQHC shall meet all of the requirements set forth in Section 4500.

4512.2 Reimbursement for services furnished by a new provider shall be determined in accordance the PPS methodology set forth in this section.

4512.3 The PPS rate for services furnished during the first year of operation shall be calculated as of the first day of the District's fiscal year in which the FQHC commences operations, and shall be equal to the average of the PPS rates paid to other FQHCs located in the same geographical area with a similar caseload.

4512.4 After the first year of operation, the FQHC shall submit a cost report to DHCF. DHCF shall audit the cost report in accordance with the standards set forth in Sections 4510 and 4511 and establish a PPS for each of the following four categories:

(a) Primary care services covered under Section 1905(a)(2) of the Social Security Act as set forth in Section 4507;

(b) Behavioral health services covered under Section 1905(a)(2) of the Social Security Act as set forth in Section 4508;

(c) Preventive and diagnostic dental services covered under Section 1905(a)(2) of the Social Security Act as set forth in Subsection 4505.7; and

(d) Comprehensive dental services covered under Section 1905(a)(2) of the Social Security Act as set forth in Subsection 4506.7.

4512.5 The PPS shall be calculated for each category described in Subsections 4512.4(a) through 4512.4(d) by taking the sum of the FQHC's audited allowable cost for the applicable category, including related administrative and capital costs, and dividing it by the total number of eligible encounters for that category.

4512.6 The PPS rate described in Subsection 4512.5 shall remain in effect until all provider rates are rebased in accordance with Section 4516. After rebasing the FQHC shall be have the option of electing an APM rate in accordance with the procedures set forth in Section 4501.

4512.7 In addition to the PPS rate described in this section, the FQHC shall be entitled to receive a supplemental wrap-around payment as described in Subsections 4502.6 through 4502.7.

4512.8 Each new FQHC provider seeking Medicaid reimbursement shall:

(a) Obtain a separate National Provider Identification number; and

(b) Be screened and enrolled in the Medicaid program pursuant to the requirements set forth in Chapter 94 of Title 29 DCMR.

4512.9 Each new FQHC shall only seek Medicaid reimbursement for services provided consistent with the services described in Sections 4505 – 4508 in accordance with Section 1905(a)(2) of the Social Security Act.

4512.10 If an FQHC discontinues operations, either as a facility or at one of its sites, the FQHC shall notify DHCF in writing at least ninety days (90) prior to

discontinuing services.

4512.11 The new provider will be allowed one encounter on the same day for each of the categories described in Subsection 4512.4(a), (b), and either (c) or (d), consistent with the requirements set forth under Subsections 4505.12 and 4506.13.

4513 REIMBURSEMENT FOR OUT OF STATE PROVIDERS

4513.1 A 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 Subsection 4500.2 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..

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

4514 MANDATORY REPORTING REQUIREMENTS

4514.1 Each FQHC shall report to DHCF, annually, on the following two (2) measure sets:

(a) 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

(b) The performance measures set forth in the table below:

FQHC Performance Measures				
Measure Number/ Name	**Measurement Domain**	**NQF #**	**Steward**	**Description**
1.Extended After Hours	Patient-Centered Access	N/A	DHCF	FQHC offers extended hours beyond the traditional 8am-5pm business hours.

2. 24/7 Access Policy	Patient-Centered Access	N/A	DHCF	Make access to care available 24/7. At a minimum, 24/7 access includes the availability of clinical services and advice at times that assure accessibility and meet the needs of the population to be served, and access to clinical telephonic advice when the FQHC is closed. When the FQHC is closed, 24/7 access includes the provision of telephone access to an individual with qualification and training (consistent with licensing requirements in the District) to exercise professional judgment in assessing a FQHC patient's need for emergency medical care, and the ability to direct a patient on how to seek emergency care. A patient's need for emergency care might arise from an emergent physical, oral, behavioral and/or other health need. If the patient's needs are not immediate, the individual responding to the patient via the FQHC's telephone access line shall also have the capacity to refer patients to a physician or to a licensed or certified independent practitioner that delivers health care services within the FQHC or outside the FQHC, if needed, for further assessment and future care.
3. Adults' Access to Preventive/ Ambulatory Health Services	Patient-Centered Access	N/A	NCQA	The percentage of members twenty (20) years and older who had an ambulatory or preventive care visit. **Numerator:** Number of ambulatory or preventive care visits during the measurement year **Denominator:** Members age twenty (20) years and older as of December 31 of the measurement year
4. Follow-up After Hospital Discharge	Transitions of Care	N/A	Minnesota Community Measurement	Percentage of patients with selected clinical conditions (heart failure, pneumonia, ischemic vascular disease and Chronic obstructive pulmonary disease) that have follow-up telephonic/ electronic contact from the FQHC within three (3) calendar days of discharge or a follow-up face-to-face visit with a health care provider (physician, physician assistant, nurse practitioner, nurse, care-coordinator) within seven (7) calendar days of hospital discharge.
5. Follow-up After Hospitalization for Mental Illness	Transitions of Care	0576	NCQA	For discharges of patients age six (6) and older who were hospitalized for treatment of selected mental health disorders, the percentage that had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within thirty (30) calendar days of discharge. • The percentage of discharges for which the patient received follow-up within seven (7) calendar days of discharge.

6. Timely Transmission of Transition Record	Transitions of Care	0648	American Medical Association-Physician Consortium for Performance Improvement	The percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to their home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within twenty-four (24) hours of discharge.
7. Plan All-Cause Readmission	Utilization	1768	NCQA	For FQHC patients eighteen (18) years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within thirty (30) calendar days and the predicted probability of an acute readmission. Data is reported in the following categories: 1. Count of Index Hospital Stays (denominator) 2. Count of thirty (30)-Day Readmissions (numerator) 3. Average adjusted Probability of Readmission
8. Potentially Preventable Hospitalization	Utilization	N/A	AHRQ	Percentage of inpatient admissions among FQHC participants for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.
9. Low-Acuity Non-Emergent Emergency Department Visits	Utilization	N/A	DHCF	Percentage of avoidable low-acuity non-emergent ED visits.

4514.2 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 1st each year.

4514.3 The measurement year for measures outlined in Subsection 4514.1(b) shall begin October 1, 2017 of and end on September 30, 2018, repeating annually, unless otherwise specified by DHCF.

4514.4 For measures described in Subsection 4514.1(a), 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 1st of each year, beginning September 1, 2017.

4515 PERFORMANCE PAYMENT

4515.1 Beginning October 1, 2017, each FQHC that elects the APM rate and meets the standards outlined in Subsection 4515.2 may be eligible to participate in the FQHC performance payment program.

4515.2 To participate in the performance payment program, a FQHC must have elected

the APM rate and must submit the following to DHCF by September 1, 2018 and annually thereafter:

(a) Letter of Intent to participate in the performance payment program;

(b) Most current HRSA-approved quality improvement plan and any annual updates. 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

(c) Annual performance data reporting measures described in Subsection 4514.1(a).

4515.3 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.

4515.4 The performance payment program's baseline year will be the first year in which FQHC 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 1st of the first year that an FQHC elects to participate in the performance program and end on September 30th.

4515.5 The measurement year (MY) is any year following an FQHC meeting the participation requirements described in Subsection 4515.2 and the completion of the baseline year; the first MY under the FQHC performance payment program will begin on October 1, 2018.

4515.6 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 performance during the prior measurement year.

4515.7 FQHCs shall be assessed based on either the attainment or the improvement of a defined threshold. If a FQHC did not attain its goal, then DHCF shall assess whether the FQHC improved from the previous measurement year. The following guidelines are set forth below:

(a) For measures #3 through 9, as described in Subsection 4514.1(b), a FQHC must achieve above the seventy-fifth (75th) percentile from the previous measurement year;

(b) For measures #1 and 2, as described in Subsection 4514.1(b), the

improvement benchmark will only be assessed on attainment of the goal. Specifically, whether the FQHC has provided DHCF with documentation demonstrating they have met the specifications outlined in the measures;

(c) For measures # 3 through 9 as described in Subsection 4514.1(b), where improvement can be measured, the improvement benchmark will be a statistically significant improvement in the performance of a measure as compared to the prior year's performance. A statistically significant improvement has a probability of 0.05 that the improvement was not due to random error. DHCF shall perform the appropriate statistical analysis (*e.g.*, t-test) to determine that the performance between measurement years is a result that cannot be attributed to chance.

4515.8 DHCF shall provide written notification of the attainment and individualized improvement thresholds to each participating FQHC no later than one hundred and eighty (180) calendar days after the conclusion of the previous MY after all performance measures are received and validated.

4515.9 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 described in Subsection 4514.1(b) subject to the following terms and conditions:

(a) Each FQHC must notify DHCF of their selection of the aggregation option no later than September 1st prior to the baseline or new measurement year;

(b) FQHCs opting to aggregate their populations together must do so for calculation of all measures during a given baseline or measurement year;

(c) Each FQHC shall report data that is identifiable for the FQHC's individual performance, along with the aggregated data;

(d) A FQHC shall elect the option to aggregate annually and may change their selection, including opting against pooling or opting to pool with a different FQHC, on an annual basis; and

(e) When a FQHC has opted to aggregate beneficiaries, performance is measured for the aggregated FQHCs throughout the duration of the performance period unless one of the aggregated entities withdraws from the FQHC program during the performance period. If one of the FQHCs that has opted to aggregate beneficiaries withdraws before the performance period is complete, the remaining FQHC's performance will be measured based on the remaining FQHC's beneficiaries.

4515.10 For MY2019, beginning on October 1, 2018, the amount of the performance bonus funding pool available for payment shall be the difference between all of the District's FQHCs' uncapped administrative cost and the District's FQHCs'

capped administrative cost reflected in 2013 audited cost reports.

4515.11 For MY2020 and future years, the amount of the performance bonus funding pool shall be the amount available in the previous year 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.

4515.12 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 ninety (90) calendar days before October 1st.

4515.13 The available funds in the annual performance bonus funding pool will be allocated to each participating FQHC that qualifies for a performance award as described in Subsection 4515.14.

4515.14 A participating FQHC's performance payment shall be the FQHC's maximum annual bonus payment as described in Subsection 4515.15, multiplied by the FQHC's annual performance percentage using the methodology described in Subsection 4515.17.

4515.15 Each participating FQHC's maximum annual bonus payment shall be the FQHC's market share determined in accordance with Subsection 4515.16, multiplied by the annual performance bonus funding pool, plus any additional allocation calculated pursuant to Subsection 4515.16(c).

4515.16 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 determined in the following manner:

(i) Calculate the quartiles of the number of unique Medicaid beneficiaries that received primary care services from the FQHC. The quartiles are the three (3) points that divide the

data set into four (4) equal groups, each group comprising a quarter (1/4) 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;

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

(iii) Multiply the IQR by one point five (1.5) to obtain the IQR factor;

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

(v) 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; and

(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 (a); and

(c) If there is an upper bound outlier, and there are remaining performance payment pool 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.

4515.17 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:

(a) A maximum of one hundred (100) points will be awarded to each FQHC across the three (3) measurement domains (*i.e.*, patient-centered care access (measures 1-3), transitions of care (measures 4-6), and utilization (measures 7-9) as described in Subsection 4514.1(b).

(b) Each measure in the domain is assigned points by dividing the total points by the number of measures in each domain. Points for each domain for the first three (3) MYs are described in the table set forth in Subsection 4515.17(c). Future point distribution for measurement attainment or improvement will be provided by DHCF to FQHCs by a transmittal on an annual basis ninety (90) calendar days before October 1.

(c)

FQHC Performance Measure Point Distribution Methodology			
	MY 2019	**MY 2020**	**MY 2021**
Total Patient-Centered Access Domain Points *(allowed points per measure)*	20 *(10)*	15 *(7.5)*	10 *(5)*
Total Clinical Process Domain Points	30 *(7.5)*	25 *(6.25)*	20 *(5)*
Total Utilization Domain Points	50 *(16.67)*	60 *(20)*	70 *(23.3)*
Total	**100**	**100**	**100**

(d) Points for each measure shall be awarded in cases where an FQHC meets either the attainment or improvement benchmark based on the prior measurement year's performance as described below:

(1) An FQHC shall receive the allowed points per measure as described in Subsection 4515.17(c) if they submit documentation for the Extended Hours and 24/7 Access measures (*e.g.*, ten (10) points in MY2019 for each of these measures);

(2) An FQHC shall receive points if they have met or exceeded the seventy-fifth (75th) percentile attainment benchmark.

(3) An FQHC performing below the attainment benchmark may be able to receive the allowed points per measure as described in Subsection 4515.17(c) for each measure if it has met its improvement threshold described in Subsection 4515.7(c).

(4) If an FQHC neither attains nor improves performance on a given measure, zero points will be awarded for that measure.

(e) The annual performance percentage for each qualifying FQHC shall be calculated using the following methodology:

(1) Sum points awarded for each measure in the domain to determine the domain totals;

(2) Sum domain totals to determine total performance points;

(3) Divide total performance points by the maximum allowed points to determine the annual performance percentage.

4515.18 If participating FQHCs have aggregated beneficiaries together for determination of performance, the award percentage for the aggregated entities shall be applied to each FQHC's maximum bonus amount to determine the FQHC's performance award individually.

4515.19 Beginning with MY2019, and annually thereafter, performance payments shall be calculated and distributed no later than 180 calendar days after the conclusion of each measurement year once all performance measures are received and have been validated.

4516 REBASING FOR APM

4516.1 No later than January 1, 2018 and every three (3) years thereafter, the cost and financial data used to determine the APM rate shall be updated based upon audited cost reports that reflect costs that are two (2) years prior to the base year and in accordance with the methodology set forth in Sections 4503, 4504, 4505, and 4506.

4517 COST REPORTING AND RECORD MAINTENANCE

4517.1 Each FQHC shall submit to DHCF a Medicaid cost report, prepared based on the accrual basis of accounting, in accordance with Generally Accepted Accounting Principles. In addition, FQHCs are required to submit their audited financial statements and any supplemental statements as required by DHCF no later than one hundred and fifty days (150) days after the end of each FQHC's fiscal year, unless DHCF grants an extension or the FQHC discontinues participation in the Medicaid program as a FQHC. In the absence of audited financial statements, the

FQHC may submit unaudited financial statements prepared by the FQHC.

4517.2 Each FQHC shall also submit to DHCF its FQHC Medicare cost report that is filed with its respective Medicare fiscal intermediary, if submission of the Medicare cost report is required by the federal Centers for Medicare and Medicaid Services.

4517.3 Each FQHC shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the FQHC's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and any other original documents which pertain to the determination of costs.

4517.4 Each FQHC shall maintain the records pertaining to each cost report for a period of not less than ten (10) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.

4517.5 DHCF reserves the right to audit each FQHC's Medicaid cost reports and financial reports at any time. DHCF may review or audit the cost reports to determine allowable costs in the base rate calculation or any rate adjustment as set forth in these rules.

4517.6 If a provider's cost report has not been submitted to DHCF within hundred and fifty (150) days after the end of the FQHC's fiscal year as set forth in Subsection 4517.1, or within the deadline granted pursuant to an extension, DHCF reserves the right not to adjust the FQHC's APM rate or PPS rate for services as described in Subsections 4502.3, 4503.7, 4504.8, 4505.4 and 4506.4.

4517.7 Each FQHC shall submit to DHCF a copy of the annual HRSA Uniform Data System (UDS) report within thirty (30) calendar days of the filing.

4518 ACCESS TO RECORDS

4518.1 Each FQHC shall grant full access to all records during announced and unannounced audits and reviews by DHCF personnel, representatives of the U.S. Department of Health and Human Services, and any authorized agent(s) or official(s) of the federal or District of Columbia government.

4519 APPEALS

4519.1 For appeals of DHCF Payment Rate Calculations, Scope of Service Adjustments or Audit Adjustments for FQHCs the following applies:

(a) At the conclusion of any required audit, payment rate or scope of service

adjustment, the FQHC shall receive a notice that includes a description of each audit finding, payment rate or scope of service adjustment and the reason for any adjustment to allowable costs or to the payment rate;

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

(c) The written request for administrative review shall identify the specific audit adjustment, payment rate calculation, or scope of service adjustment to be reviewed, and include an explanation of why the FQHC believes the adjustment or calculation to be in error, the requested relief, and supporting documentation;

(d) DHCF shall mail a formal response to the FQHC no later than sixty (60) calendar days from the date of receipt of the written request for administrative review;

(e) Within thirty (30) calendar days of receipt of DHCF's written determination relative to the administrative review, the FQHC may appeal the determination by filing a written request for appeal with the Office of Administrative Hearings (OAH);

(f) The filing of an appeal with OAH shall not stay DHCF's action to adjust the FQHCs payment rate;

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

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

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

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

4519.2 For FQHC appeals of DHCF decisions on fee-for-service claims the following applies:

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

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

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

(d) Nothing in this rule waives or modifies the requirements for the timely filing of Medicaid provider claims set forth in 29 DCMR §§ 900, *et seq.*

4519.3 For FQHC appeals of MCO decisions on claims for reimbursement the following applies:

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

(1) Exhaust the MCO appeal process for the MCO that issued the denial, nonpayment or underpayment; and

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

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

(1) MCO name;

(2) MCO ID;

(3) A copy of the final WND indicating that the FQHC has exhausted all available appeal opportunities with the MCO, or documentation indicating the deadline for the MCO to render a final WND has expired;

(4) An original fee-for-service equivalent claim for reimbursement which shall include:

(i) Date of Service;

(ii) Healthcare Common Procedure Coding System/Current Procedural Terminology code;

(iii) Payment amount at issue;

(iv) Medicaid ID of the enrollee; and

(v) Name and Date of Birth of enrollee; and

(5) A written statement by the FQHC describing why the MCO's decision should not be upheld, including any supporting documentation; and

(c) DHCF will notify the MCO when a FQHC request for administrative reconsideration has been filed to allow the MCO the opportunity to share supporting documentation;

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

(e) DHCF shall render a written decision within forty-five (45) calendar days of receiving a complete request for administrative reconsideration. If new information is provided to DHCF that warrants an extension in the amount of time it will take the agency to render a decision, the agency reserves the right to extend its review period by no more than ten (10) calendar days. The FQHC shall be notified if such an extension is required;

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

(1) Basis for decision; and

(2) Supporting documentation or findings, if appropriate; and

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

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

(i) If DHCF determines that the decision of the MCO was proper and the FQHC is not due reimbursement or payment, DHCF shall deny reimbursement; and

(j) Nothing in this rule waives or modifies the requirements for the timely filing of Medicaid provider claims set forth in 29 DCMR §§ 900, *et seq.*

4599 DEFINITIONS

4599.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

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

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

Encounter - A face-to-face visit between a Medicaid beneficiary and a qualified FQHC health care professional as described in Subsections 4507.2, 4508.2, 4505.15 and 4506.16, who exercises independent judgment when

providing services for a primary care, behavioral health service or dental service as described under the State Plan in accordance Section 1905(a)(2) of the Social Security Act. An encounter may also include a visit between a Medicaid beneficiary receiving healthcare services and a provider via telemedicine in accordance with District requirements.

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

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

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

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

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