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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 16-009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499



Region III/Division of Medicaid and Children's Health Operations

SWIFT # 082420164035

September 20, 2017

Claudia Schlosberg, J.D.
Senior Deputy Director/State Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., Suite 900 South
Washington, D.C. 20001

Dear Ms. Schlosberg:

I am writing to inform you that we have reviewed the District of Columbia's State Plan Amendment (SPA) #16-009 entitled, Reimbursement of Federally Qualified Health Centers. This SPA proposes to authorize the District of Columbia to reimburse FQHCs an alternative payment methodology (APM) rate for FQHCs that elect an APM rate effective September 1, 2016, and to reimburse FQHCs a performance payment effective January 1, 2018.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is September 1, 2016. A copy of the approved SPA pages and signed CMS-179 form are included under this cover.

If you have any further questions regarding this SPA, please contact LCDR Frankeena Wright at 215-861-4754 or by email at Frankeena.Wright@cms.hhs.gov.

Sincerely,

A redacted signature consisting of several black rectangular boxes of varying sizes, obscuring the name and any handwritten notes or dates.

Francis McCullough
Associate Regional Administrator

cc: Alice Weiss, DHCF
Sabrina Tillman Boyd, CMS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 16-009	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE September 1, 2016
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services		

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)


6. FEDERAL STATUTE/REGULATION CITATION Section 1902(bb) of the Social Security Act (42 U.S.C. § 1396a(bb))	7. FEDERAL BUDGET IMPACT a. FFY 16 \$ 105,750.00 b. FFY 17 \$ 1,754,537.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement 1 to Attachment 3.1-A , pp. 35 (new) – 42 (new) Supplement 1 to Attachment 3.1-B, pp. 34 (new) – 41 (new) Attachment 4.19B, pp. 6f, 6g (new) – 6ff (new)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment 4.19B, pp. 6f

10. SUBJECT OF AMENDMENT:


Reimbursement of Federally Qualified Health Centers

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Resolution Number: 21-0158
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Claudia Schlosberg, J.D. Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 th Street, NW, 9 th Floor, South Washington, DC 20001
13. TYPED NAME Claudia Schlosberg J.D.	
14. TITLE Senior Deputy Director/Medicaid Director	
15. DATE SUBMITTED August 23, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED August 23, 2016	18. DATE APPROVED September 20, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL September 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Francis McCullough	22. TITLE Associate Regional Administrator

26. Rural Health Clinics and Federally Qualified Health CentersA. Rural Health Clinic Services

The District of Columbia does not have any rural areas.

B. Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) services, as described in 26.B.2 through 5 of this section, are included in the reimbursement methodology described in Attachment 4.19-B, Part 1, beginning page 6f, Section 12.b.

1. General Provisions:

a. Prior to seeking Medicaid reimbursement, each FQHC must:

- i. 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 attendant regulations;
- ii. Be screened and enrolled in the District of Columbia Medicaid program;
- iii. Obtain a National Provider Identifier (NPI). The NPI shall be obtained for each site operated by an FQHC; and
- iv. Submit the FQHC's Scope of Project approved by the Health Resources Services Administration (HRSA).

b. 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.

c. Services may be provided at other sites including mobile vans, intermittent sites such as a homeless shelter, seasonal sites and a beneficiary's place of residence, provided the claims for reimbursement are consistent with the services described covered under Section 1905(a)(2) of the Social Security Act and in Section 26.B.2 through 5.

d. 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).

e. Services for which an FQHC seeks Medicaid reimbursement pursuant to this Section and Attachment 4.19-B, Part 1, beginning page 6f, Section 12.b 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.

2. Primary Care Services

a. Covered Primary Care services provided by the FQHC shall be limited to the following services:

i. 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 (EPSDT) 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 District of Columbia's authorized scope of practice, or in accordance with the applicable professional practices act within the jurisdiction where services are provided ;

(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, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided, 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 hearing 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.
- ii. Incidental services and supplies that are integral, although incidental, to the diagnostic or treatment components of the services described in 26.B.1.a of this Section and included in allowable costs as described in Attachment 4.19-B, Part 1, page 6q, Section 12.b.viii. Incidental services and supplies include, but are not limited to, the following:
- (1) Lactation consultation, education and support services that are provided by health care professionals described in 26.B.2 of this Section;
 - (2) Medical services ordinarily rendered by an FQHC staff person such as taking patient history, blood pressure measurement or temperatures, and changing dressings;
 - (3) Medical supplies, equipment or other disposable products such as gauze, bandages, and wrist braces;
 - (4) Administration of drugs or medication treatments, including administration of contraceptive treatments, that are delivered during a Primary Care visit, not including the cost of the drugs and medications;
 - (5) Immunizations;
 - (6) Electrocardiograms;

- (7) Office-based laboratory screenings or tests performed by FQHC employees in conjunction with an encounter, which shall not include lab work performed by an external laboratory or x-ray provider. These services include, but are not limited to, stool testing for occult blood, dipstick urinalysis, cholesterol screening, and tuberculosis testing for high-risk beneficiaries; and
 - (8) Hardware and software systems used to facilitate patient record-keeping.
- iii. Enabling services are those services that support an individual's management of their health and social service needs or improve the FQHC's ability to treat the individual and shall include the following:
- (1) Health education and promotion services including assisting the individual in developing a self-management plan, executing the plan through self-monitoring and management skills, educating the individual on accessing care in appropriate settings and making healthy lifestyle and wellness choices; connecting the individual to peer and/or recovery supports including self-help and advocacy groups; and providing support for improving an individual's social network. These services shall be provided by health educators, with or without specific degrees in this area, family planning specialists, HIV specialists, or other professionals who provide information about health conditions and guidance about appropriate use of health services;
 - (2) Translation and interpretation services during an encounter. These services are provided by staff whose full time or dedicated time is devoted to translation and/or interpretation services or by an outside licensed translation and interpretation service provider. Any portion of the time of a physician, nurse, medical assistant, or other support and administrative staff who provides interpretation or translation during the course of his or her other billable activities shall not be included;
 - (3) Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services). Such services shall not be reimbursed separately as enabling services where such

referrals are provided during the course of other billable treatment activities;;

- (4) Eligibility assistance services designed to assist individuals in establishing eligibility for and gaining access to Federal, State and District programs that provide or financially support the provision of medical related services;
- (5) Health literacy;
- (6) Outreach services to identify potential patients and clients and/or facilitate access or referral of potential health center patients to available health center services, including reminders for upcoming events, brochures and social services; and
- (7) Care coordination, which consists of services designed to organize person-centered care activities and information sharing among those involved in the clinical and social aspects of an individual's care to achieve safer and more effective healthcare and improved health outcomes. These services shall be provided by individuals trained as, and with specific titles of care coordinators, case managers, referral coordinators, or other titles such as nurses, social workers, and other professional staff who are specifically allocated to care coordination during assigned hours but not when these services are an integral part of their other duties such as providing direct patient care.

b. Primary Care services as set forth in this 26.B.1 of this Section shall be delivered by the following health care professionals, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided:

- i. A physician;
- ii. An Advanced Practiced Registered Nurse (APRN);
- iii. A physician assistant working under the supervision of physician;
or
- iv. A nurse-mid-wife.

3. Behavioral Health Services

a. 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 psychotherapy, family therapy and pharmacologic management. DHCF shall issue a transmittal to the FQHCs which shall include the specific CPT codes including any billing requirements for covered Behavioral Health services. FQHCs that deliver substance abuse services must be certified by the Department of Behavioral Health.

- b. Covered Behavioral Health services as set forth in this section shall be delivered by the following health care professionals, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided:
 - i. A physician, including a psychiatrist;
 - ii. An APRN;
 - iii. A psychologist;
 - iv. A licensed independent clinical social worker;
 - v. A licensed independent social worker (LISW);
 - vi. A graduate social worker, working under the supervision of a LISW;
 - vii. A licensed professional counselor;
 - viii. A certified addiction counselor;
 - ix. A licensed marriage and family therapist; and
 - x. A licensed psychologist associate, working under the supervision of a psychologist or psychiatrist.

4. Preventive and Diagnostic Dental Services

- a. Covered Preventive and Diagnostic Dental services may include the following procedures:
 - i. Diagnostic procedures- clinical oral examinations, radiographs, diagnostic imaging, tests and examinations; and
 - ii. Preventive procedures- dental prophylaxis, topical fluoride treatment (office procedure), space maintenance (passive appliances and sealants).
- b. All Preventive and Diagnostic Dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, Section 10. .
- c. 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 District of Columbia's statutory requirements on authorized scope of practice, or consistent with the applicable professional practices act within the jurisdiction where services are provided.

5. Comprehensive Dental Services

- a. Covered Comprehensive Dental services provided by the FQHC shall include the following procedures:
 - i. Restorative procedures - amalgam restoration, resin-based composite restorations, crowns (single restorations only), and additional restorative services;
 - ii. Endodontic procedures- pulp capping, pulpotomies, endodontic therapy of primary and permanent teeth, endodontic retreatment, apexification/recalcification procedures, apicoectomy/periradicular services, and other endodontic services;
 - iii. Peridontic procedures - surgical services, including usual postoperative care), nonsurgical periodontal services, and other periodontal services;
 - iv. Prosthodontic procedures- complete and partial dentures treatment including repairs and rebasing, interim prosthesis, and other removable prosthetic services;
 - v. Maxillofacial Prosthetics procedures- the surgical stent procedure;
 - vi. Implants Services - Pre-surgical and surgical services, implant-supported prosthetics, and other implant services;
 - vii. Oral and Maxillofacial Surgery - treatment and care related to extractions, alveoloplasty, vestibuloplasty, surgical treatment of lesions, treatment of fractures, repair traumatic wounds including complicated suturing;
 - viii. Orthodontics - orthodontic treatments and services; and
 - ix. Adjunctive General Services - unclassified treatment, anesthesia, professional consultation, professional visits, drugs and miscellaneous.
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professional practices act within the jurisdiction where services are provided.

12. b. Federally Qualified Health Centers**i. General Provisions**

- A. Medicaid reimbursement for services provided by a Federally Qualified Health Center (FQHC) shall be either:
 - I. A Prospective Payment System (PPS) as described in Section 12.b.ii; or
 - II. For FQHCs that elect this method, an Alternative Payment Methodology (APM) as described in Sections 12.b.iii through 12.b.vi.
- B. Each FQHC that is geographically located in the District of Columbia and is enrolled in the District's Medicaid program as of September 1, 2016 that elects to be reimbursed for services under an APM shall sign an agreement with the Department of Health Care Finance (DHCF).
- C. The APM referenced in Subsection 12.b.i.A.II shall become effective on or after the date of an executed agreement between DHCF and the FQHC, or September 1, 2016, whichever is later.
- D. The APM shall comply with 1902(bb)(6) of the Social Security Act .
- E. Any FQHC that elects not to be reimbursed under the APM described in Sections 12.b.iii – vi will receive payment under the PPS methodology described in Section 12.b.ii.
- F. An FQHC may only be reimbursed at the PPS or APM rate for services that are within the scope of services described in Section 12.b.2, and Supplement 1 to Attachment 3.1-A, pages 36-40, Sections B.2 – 5, and Supplement 1 to Attachment 3.1-B, pages 35-39, Sections B.2 – 5 and in accordance with Section 1905(a)(2) of Social Security the Act.
- G. Each encounter for a Medicaid enrollee who is enrolled in Medicare or another form of insurance (or both) shall be paid an amount that is equal to the difference between the payment received from Medicare and any other payers and the FQHC's payment rate calculated pursuant to these rules.
- H. Each encounter for a qualified Medicare beneficiary for whom Medicaid is responsible for only cost-sharing payments shall be paid the amount that is equal to the difference between the payment the FQHC received from Medicare and the FQHCs' Medicare prospective payment rate.
- I. The payment received by an FQHC from Medicare, any other payer and Medicaid shall not exceed the Medicaid reimbursement rate.

- J. If an FQHC seeks Medicaid reimbursement for services outside the scope of services described in Section 12.b.i.F and in accordance with Section 1905(a)(2) of the Social Security Act , reimbursement shall be subject to the D.C. Medicaid Fee for Service Fee Schedule if the FQHC meets the conditions outlined in District rulemaking. The D.C. Medicaid Fee for Service Fee Schedule is available online at <http://www.dc-medicaid.com>
- K. Each FQHC shall ensure that a service that requires multiple procedures but under general standards of care are performed as part of a single course of treatment shall be completed as a single encounter unless multiple visits are medically required to complete the treatment plan and the medical necessity is documented in the clinical record.
- L. At the end of each fiscal year, DHCF will review and reconcile the total payments made to each FQHC that elects the APM rate to ensure that the overall per encounter rate is at least equal to the PPS rate for that FQHC for the fiscal year. If the payments are less than the total amount that would be paid under the PPS rate methodology for that FQHC, DHCF will pay the FQHC the difference between the amount paid and the amount the FQHC would have been due under the PPS rate methodology for the total number of encounters provided. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.
- ii. **Prospective Payment System (PPS) Rate Methodology**
- A. Medicaid reimbursement for services furnished on or after January 1, 2001 by an FQHC will be on a prospective payment system consistent with the requirements set forth in Section 1902(bb) of the Social Security Act and subject to District rulemaking.
- B. The PPS rate shall be paid for each encounter with a Medicaid beneficiary when a medical service or services are furnished. The PPS for services rendered beginning on or after January 1, 2001 through and including September 30, 2001, shall be calculated as follows:
- I. The sum of the FQHC's audited allowable costs for FYs 1999 and 2000 shall be divided by the total number of patient encounters in FYs 1999 and 2000;
- II. The amount established in 12.b.ii.B.I shall be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during FY 2001. Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change.

The amount of the adjustment shall be negotiated between the parties. The adjustment shall be implemented not later than ninety (90) days after establishment of the negotiated rate; and

- III. Allowable costs shall include reasonable costs that are incurred by an FQHC in furnishing Medicaid coverable services to Medicaid eligible beneficiaries, as determined by Reasonable Cost Principles set forth in 42 CFR Chapter IV, Sub Chapter B, Part 413 and 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
- C. For services furnished beginning FY 2002 and each fiscal year thereafter, an FQHC shall be reimbursed at a rate that is equal to the rate in effect the previous fiscal year, increased by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during the fiscal year.
- D. Each FQHC shall report to DHCF any increase or decrease in the scope of services, including the starting date of the change, consistent with the requirements established in Section 12.b.vii.
- E. In any case in which an entity first qualifies as an FQHC after FY 2000, the prospective rate for services furnished in the first year shall be equal to the average of the prospective rates paid to other FQHCs located in the same area with a similar caseload, effective on the date of application. For each fiscal year following the first year in which the entity first qualified as an FQHC, the prospective payment rate shall be computed in accordance with Section 12.b.ii.C. This section shall not apply to a new provider seeking reimbursement as an FQHC. Reimbursement for a new provider is set forth in Section 12.b.x.
- F. An FQHC that furnishes services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including per member per month (PMPM) payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.ii.B through 12.b.ii.E will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR Section 447.45 and 45 CFR Section 95, Subpart A.

- G. The amount of the wrap-around supplemental payment identified in Section 12.b.ii.F shall equal the difference between the payment received from the MCO as determined on a per encounter basis and the FQHC PPS rate calculated pursuant to this section. If an FQHC receives a PMPM payment from an MCO and has a capitation payment arrangement with the MCO, the amount payable to the FQHC shall be offset by the capitation payment. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider as part of the annual reconciliation described in Section 12.b.ii.F.

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

- A. The APM rate for Primary Care services rendered beginning on September 1, 2016 shall be determined as described in this section. The same APM rate shall be applicable to all sites an FQHC operates within the District of Columbia in multiple locations. The APM rate will be paid to FQHCs on a per encounter basis for Primary Care services described in Supplement 1 to Attachment 3.1-A, beginning page 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2 and in accordance with 1905(a)(2) delivered to an enrolled District Medicaid beneficiary.
- B. The APM rate for Primary Care services shall be calculated by taking the sum of the FQHC's audited allowable costs for Primary Care services and related administrative and capital costs and dividing it by the total number of eligible Primary Care encounters.
- C. For services rendered beginning on September 1, 2016 through December 31, 2017, the APM shall be determined based upon each FQHC's FY 2013 audited allowable costs.
- D. An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years, at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Section 12.b.iii.B or the APM rate based on costs reported by the FQHC or FQHC look-alike.
- E. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate for Primary Care services shall not be lower than the Medicaid PPS rate in FY 2016. If an FQHC's APM rate for Primary Care services is less than the Medicaid PPS rate, the APM rate shall be adjusted up to the Medicaid PPS rate for the applicable time period.
- F. Except as described in Section 12.b.iii.D, for services rendered beginning January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM

rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for Primary Care services as follows:

- I. The APM rate for Primary Care services shall be the amount determined under Section 12.b.iii.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- G. Except as described in Section 12.b.iii.D, the APM rate for Primary Care services rendered on or after January 1, 2019, shall be determined as described in Section 12.b.iii.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.
- H. The APM rate established pursuant to Section 12.b.iii.G shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 12.b.xiv.
- I. An FQHC that furnishes Primary Care services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including a PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.iii.A-H will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.
- J. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the managed care entity as determined on a per encounter basis and the FQHC APM rate calculated pursuant to Sections 12.b.iii.A - H. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider as part of the annual reconciliation described in 12.b.iii.I. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.

- K. Reimbursement shall be limited for each beneficiary to one Primary Care encounter per day. The FQHC shall document each encounter in the beneficiary's medical record.
- L. The APM rate established pursuant to this section may be subject to adjustment to take into account any change in the scope of services as described in Section 12.b.vii.
- M. If an FQHC seeks Medicaid reimbursement for services that are outside the scope of Primary Care services described in Section 1905(a)(2) of the Social Security Act, Supplement 1 to Attachment 3.1-A, beginning page 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2, such as prescription drugs, labor and delivery services, or laboratory and x-ray services that are not office-based, the FQHC shall follow the requirements set forth under Section 12.b.i.J.

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

- A. The APM rate for Behavioral Health services rendered beginning September 1, 2016 shall be determined as described in this section. The same APM rate shall be applicable to all sites within the District of Columbia for FQHC operating in multiple locations. The APM rate shall be available per encounter with a District Medicaid beneficiary for Behavioral Health services described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3.
- B. Except for group therapy as described in Section 12.b.iv.C and reimbursement to certain FQHCs as described in Section 12.b.iv.E, the APM rate for Behavioral Health services shall be calculated by taking the sum of the FQHC's audited allowable costs for Behavioral Health services and administrative and capital costs and dividing it by the total number of eligible Behavioral Health encounters.
- C. Effective September 1, 2017, the reimbursement rate for each beneficiary attending group therapy shall be equal to the D.C. Medicaid Fee for Service schedule rate for group psychotherapy. The D.C. Medicaid Fee for Service schedule is available online at <http://www.dc-medicaid.com>. FQHC seeking reimbursement for group psychotherapy shall comply with the requirements set forth under Section 12.b.i.J.
- D. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.
- E. An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit, will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for

similar facilities pursuant to Section 12.b.iv.B or the APM rate based on costs reported by the FQHC or FQHC look-alike.

- F. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate for behavioral services shall not be lower than the Medicaid PPS in FY 2016. If an FQHC's APM rate for Behavioral Health services is less than the Medicaid PPS rate, the APM rate shall be adjusted up to the Medicaid PPS rate for the applicable time period.
- G. Except as described in Sections 12.b.iv.C and 12.b.iv.E, for services rendered beginning January 1, 2018 through December 31, 2018, each FQHC shall be reimbursed an APM rate (which shall apply to all of the FQHC's sites if the FQHC has more than one (1) site), for each encounter with a D.C. Medicaid beneficiary for Behavioral Health services as follows: The APM rate for Behavioral Health services shall be the amount determined under Section 12.b.iv.B, except that administrative costs shall not exceed twenty percent (20%) of the FQHC's total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- H. Except as described in Sections 12.b.iv.C and 12.b.iv.E, the APM rate for Behavioral Health services rendered on or after January 1, 2019, shall be determined as described in Section 12.b.iv.B except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs.
- I. The APM rate established pursuant to Section 12.b.iv.H shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 12.b.xiv.
- J. An FQHC that furnishes Behavioral Health services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive under this section will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.
- K. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on per encounter basis and the FQHC APM rate calculated pursuant to Sections b.iv.A.-I. If an FQHC receives a PMPM payment from an MCO and has a capitation payment arrangement with the MCO, the FQHC shall receive an offset equal to the amount

of the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider as part of the annual reconciliation described in Section 12.b.iv.J.

- L. Reimbursement shall be limited for each beneficiary to one behavioral service encounter per day. Reimbursement for a Behavioral Health encounter shall not affect an FQHC's ability to claim for group psychotherapy on a fee-for-service basis for the same service day. The FQHC shall document each encounter in the beneficiary's medical record.
- M. The APM rate established pursuant to this Section may be subject to adjustment to take into account any change in the scope of services as described in Section 12.b.vii.
- N. If an FQHC seeks Medicaid reimbursement for services that are outside the scope of Behavioral Health services covered under Section 1905(a)(2) of the Social Security Act and described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3, such as rehabilitative services, including Mental Health Rehabilitative Services (MHRS), prescription drugs, or laboratory and x-ray services that are not office-based, the FQHC shall comply with the requirements set forth under Section 12.b.i.J

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

- A. The APM rate for Preventive and Diagnostic Dental services rendered beginning September 1, 2016 shall be determined as described in this section. The APM rate shall be applicable to all sites an FQHC operating in multiple locations. The APM rate shall be available per encounter with a District Medicaid beneficiary for preventive and diagnostic dental services described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4.
- B. The APM rate for Preventive and Diagnostic Dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for Preventive and Diagnostic Dental services and administrative and capital costs and dividing it by the total number of eligible Preventive and Diagnostic Dental service encounters.
- C. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.

- D. Except as described in section 12.b.v.N, for services rendered beginning January 1, 2018 through December 31, 2018, the APM rate for Preventive and Diagnostic Dental services shall be determined as described in section 12.b.v.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- E. Except as described in section 12.b.v.N, the APM for Preventive and Diagnostic Dental services rendered on or after January 1, 2019 shall be determined as described in Subsection 12.b.v.B, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for all FQHCs, including those with less than ten thousand (10,000) annual encounters.
- F. The APM rate established pursuant to Section 12.b.v.E shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is rebased as described in Section 12.b.xiv.
- G. Subject to the limitations set forth in this section, covered Preventive and Diagnostic Dental services provided by the FQHC shall include the procedures described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4 and in accordance with Section 1905(a)(2) of the Social Security Act.
- H. Only procedure codes that are listed in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4, and included on the Medicaid Fee for Service schedule as covered benefits, will be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at <http://www.dc-medicaid.com>.
- I. An FQHC that furnishes Preventive and Diagnostic dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive under Sections 12.b.v.A-F will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two-year payment requirement at 42 CFR 447.45 and 45 CFR 95, Subpart A.
- J. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the MCO as determined on a per encounter

basis and the amount of the FQHC APM rate calculated pursuant to Section 12.b.v. A - F. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM payment for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap-around supplemental payment submission. This amount shall be offset against total amounts otherwise payable to the provider as part of the annual reconciliation described in Section 12.b.v.I.

- K. Reimbursement of preventive and diagnostic dental service encounters shall be limited to one encounter per day for each beneficiary. The FQHC shall document each encounter in the beneficiary's dental record.
- L. If an encounter comprises both a Preventive and Diagnostic service and a Comprehensive Dental care service as described in Section 12.b.vi, the FQHC shall bill the encounter as a Comprehensive Dental care service.
- M. All Preventive and Diagnostic Dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, Section 10; and District laws and rules.
- N. An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Section 12.b.v.B or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

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

- A. The APM rate for Comprehensive Dental services rendered beginning September 1, 2016 by an FQHC shall be determined as described in this section.
- B. The same APM rate shall be applicable to all sites an FQHC operates in multiple locations. The APM rate shall be available for each encounter with a D.C. Medicaid beneficiary for comprehensive dental services described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, beginning page 37, Section 26.B.4.
- C. The APM rate for Comprehensive Dental services shall be calculated by taking the sum of the FQHC's audited allowable costs for Comprehensive Dental

services and related administrative and capital costs and dividing it by the total number of eligible Comprehensive Dental service encounters.

- D. For services rendered beginning September 1, 2016 through December 31, 2017, the APM rate shall be determined based upon each FQHC's FY 2013 audited allowable costs.
- E. Except as described in section 12.b.vi.N, the APM for services rendered beginning January 1, 2018 through December 31, 2018, the APM rate for comprehensive dental services shall be determined under Section 12.b.vi.C, except that administrative costs shall not exceed twenty percent (20%) of the total allowable costs for any FQHC that has ten thousand (10,000) or more encounters in a year as reported in the audited cost report.
- F. Except as described in section 12.b.vi.N, the APM for comprehensive dental services rendered on or after January 1, 2019 the twenty percent (20%) administrative cap described in Section 12.b.vi.D shall apply in determining the APM rate for all FQHCs, including those with less than 10,000 annual encounters.
- G. The APM rate established pursuant to Section 12.b.vi.F shall be adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act, except for the years the APM rate is are rebased as described in Section 12.b.xiv.
- H. Subject to the limitations set forth in this section, covered comprehensive dental services provided by the FQHC shall include the procedures described in Supplement 1 to Attachment 3.1-A, pages 38 – 39, Section 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 37 - 38, Section 26.B.5.
- I. Only procedure codes listed in Supplement 1 to Attachment 3.1-A, pages 38 - 39 , Section 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 37 - 38, Section 26.B.5, that are included on the Medicaid Fee for Service schedule as covered benefits will be reimbursed by the Medicaid program. The D.C. Medicaid Fee for Service schedule is available online at <http://www.dc-medicaid.com>.
- J. An FQHC that furnishes comprehensive dental services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment (including PMPM payment) from such entity is less than the amount the FQHC would be entitled to receive pursuant to Sections 12.b.vi. A-G will be eligible to receive a wrap-around supplemental payment processed and paid by DHCF. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to

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

- K. The amount of the wrap-around supplemental payment shall equal the difference between the payment received from the entity as determined on a per encounter basis and the FQHC APM calculated receive pursuant to Sections 12.b.vi. A - G. In cases where an FQHC has a capitation payment arrangement with an MCO under which it receives a PMPM payment for certain services, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the APM rate the FQHC would be entitled to receive on a per encounter basis. The FQHC shall report their monthly capitation payment amount to DHCF. The FQHC shall report the aggregate of all capitation payments received in the period covered by each wrap submission. This amount shall be offset against total amounts otherwise payable to the provider as a part of the annual reconciliation described in Section 12.b.vi.J.
- L. Reimbursement of comprehensive dental service encounters shall be limited to one encounter per day for each beneficiary. The FQHC shall document each encounter in the beneficiary's dental record.
- M. If an encounter comprises both a Preventive and Diagnostic service as described in Section 12.b.v and a Comprehensive Dental care service, the FQHC shall bill the encounter as a Comprehensive Dental care service.
- N. All comprehensive dental services shall be provided in accordance with the requirements, including any limitations, as set forth in in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, Section 10; and District laws and rules.
- O. An FQHC, or an FQHC look-alike as determined by HRSA, which has been in operation for fewer than five (5) years at the time of audit will receive the lesser of the average APM rate calculated as of the first day of the District fiscal year for similar facilities pursuant to Section 12.b.vi.B or the APM rate based on costs reported by the FQHC, or FQHC look-alike.

vii. **Change in Scope of Services**

- A. An FQHC may apply for an adjustment to its PPS or APM rate (in any of the four (4) service categories: (1) Primary Care, (2) Behavioral Health, (3) Preventive and Diagnostic Dental services; and (4) Comprehensive Dental services) during any fiscal year after September 1, 2016, based upon a change in the scope of the services provided by the FQHC subject to the requirements set forth in the section.
- B. A change in the scope of services shall only relate to services furnished on or after

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

- I. Type: for FQHCs adopting either the PPS or APM payment rate, the addition of a new service not previously provided by the FQHC must be consistent with Section 1905(a)(2) of the Social Security Act and the services described in Supplement 1 to Attachment 3.1-A, pages 36 – 40, Section 26.B.2 through 5 and Supplement 1 to Attachment 3.1-B, pages 35 - 39, Section 26.B.2 through 5; or
 - II. Intensity: for FQHCs adopting the either the PPS or APM payment rate, a change in quantity or quality of a service demonstrated by an increase or decrease in the total quantity of labor and materials consumed by an individual patient during an average encounter or a change in the types of patients served;
 - III. Duration: for FQHCs adopting the either the PPS or APM payment rate, a change in the average length of time it takes FQHC providers to complete an average patient visit due to changing circumstances such as demographic shifts or the introduction of disease management programs; or
 - IV. Amount: for FQHCs adopting the either the PPS or APM payment rate, an increase or decrease in the amount of services that an average patient receives in a Medicaid-covered visit such as additional outreach or case management services or improvements to technology or facilities that result in better services to the FQHC's patients.
- C. A change in the cost of a service, in and of itself, is not considered a change in the scope of services.
- D. A change in the scope of services shall not include a change in the number of encounters, or a change in the number of staff that furnish the existing service.
- E. DHCF shall review the costs related to the change in the scope of services. Rate changes based on a change in the scope of services provided by an FQHC shall be evaluated in accordance with the reasonable cost principles set forth in 42 CFR Chapter IV, Sub Chapter B, Part 413 and 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
- F. The adjustment to the PPS rate shall only be granted if the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC's allowable costs in any of the four service categories described in Section 12.b.vii.A. for the fiscal year in which the change in scope of service became effective. The PPS rate adjustment for a change in scope shall be determined as the current PPS rate multiplied by the percentage change in the allowable cost

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attributable to the change in scope. The percentage change shall be calculated as follows:

- I. The total allowable cost including the change in scope for a twelve (12) month period, minus the total allowable cost stated in the FQHC's prior year's cost report;
 - II. Divided by the total allowable cost stated in the FQHC's prior year's cost report; and
 - III. Multiplied by one hundred percent (100%).
- G. Subject to the limitation set forth in Section 12.b.vii.H, the adjustment to the APM rate shall be determined by dividing the total allowable cost plus the incremental allowable cost attributable to a change in the scope, by the total number of encounters including the encounters affected by the scope change during the corresponding time period.
- H. The adjustment to the APM rate shall only be granted if the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC's allowable costs in any of the four service categories described in Section 12.b.vii.A. for the fiscal year in which the change in scope of service became effective. This percentage shall be calculated by comparing the FQHC's APM at the beginning of the fiscal year in question with the cost per encounter as calculated by a completed Medicaid cost report using data from the same fiscal year.
- I. An FQHC shall submit a written notification to DHCF within ninety (90) days after a change in the scope of service, and the FQHC shall file a cost report demonstrating the increase in cost per encounter no later than ninety (90) days after the close of one (1) year of operation in which the scope change occurred. The FQHC shall submit documentation in support of the request including the HRSA approved Scope of Project documenting the need for the change.
- J. DHCF shall provide a written notice of its determination to the FQHC within one hundred eighty (180) days of receiving all information related to the request described in Section 12.b.vii.I.
- K. If approved, the PPS or APM rate calculated pursuant to Sections 12.b.iii through 12.b.vi shall be adjusted to reflect the adjustment for the change in the scope of service. The adjustment shall be effective on the first day of the first full month after DHCF has approved the request. There shall be no retroactive adjustment.
- L. DHCF shall review or audit the subsequently filed annual cost report to verify the costs that have a changed scope. Based upon that review DHCF may adjust the

rate in accordance with the requirements set forth in this section.

viii. **Allowable Costs**

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

ix. **Exclusions from Allowable Costs**

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

x. **Reimbursement for New Providers**

- A. Each new provider seeking Medicaid reimbursement as an FQHC shall meet all of the requirements set forth in Supplement 1 to Attachment 3.1-A, pages 35 – 36, Section 26.B.1 and Supplement 1 to Attachment 3.1-B, pages 34 - 35, Section 26.B.1.
- B. Reimbursement for services furnished by a new provider shall be determined in accordance with the PPS methodology set forth in this section.
- C. The PPS rate for services furnished during the first year of operation shall be calculated as of the first day of the District fiscal year in which the FQHC commences operations, and shall be equal to the average of the PPS rates paid to other FQHCs located in the same geographical area with a similar caseload.
- D. After the first year of operation, the FQHC shall submit a cost report to DHCF. DHCF shall audit the cost report in accordance with the standards set forth in Sections 12.b.viii and 12.b.ix and establish a PPS for each of the following four categories:
 - I. Primary Care services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, page beginning 36, Section 26.B.2, and Supplement 1 to Attachment 3.1-B, beginning page 35, Section 26.B.2;

- II. Behavioral Health services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, beginning page 37, Section 26.B.3, and Supplement 1 to Attachment 3.1-B, beginning page 36, Section 26.B.3;
 - III. Preventive and Diagnostic Dental services covered under Section 1905(a)(2) of the Social Security Act and as described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.4, and Supplement 1 to Attachment 3.1-B, page 37, Section 26.B.4; and
 - IV. Comprehensive Dental services covered under Section 1905(a)(2) of the Social Security Act as described in Supplement 1 to Attachment 3.1-A, beginning page 38, Section 26.B.5, and Supplement 1 to Attachment 3.1-B, page 39, Section 26.B.5.
- E. The PPS shall be calculated for each category described in subsections Section 12.b.x.D.I through IV by taking the sum of the FQHC's audited allowable cost for the applicable category, including related administrative and capital costs and dividing it by the total number of eligible encounters for that category.
 - F. The PPS rate described in subsection Section 12.b.x.E shall remain in effect until all provider rates are rebased in accordance with Section 12.b.xiv. After rebasing the FQHC shall have the option of electing an APM rate in accordance with the procedures set forth in Section 12.b.i.
 - G. In addition to the PPS rate described in this section, the FQHC shall be entitled to receive a supplemental wrap-around supplemental payment as described in Sections 12.b.ii.F through 12.b.ii.G.
 - H. Each new FQHC shall only seek Medicaid reimbursement for services provided consistent with the services described in Supplement 1 to Attachment 3.1-A, pages 36 – 40, Sections 26.B.2 through 26.B.5, and Supplement 1 to Attachment 3.1-B, pages 35 - 39, Sections 26.B.2 through 26.B.5 in accordance with Section 1905(a)(2) of the Social Security Act.
 - I. If an FQHC discontinues operations, either as a facility or at one of its sites, the FQHC shall notify DHCF in writing at least ninety days (90) prior to discontinuing services.
 - J. The new provider will be allowed one encounter on the same day for each of the categories described in Section 12.b.x.D.I, II, and either III or IV, consistent with the requirements set forth under Sections 12.b.v.L and 12.b.vi.M.

xi. Reimbursement for Out-of-State Providers

TN No. 16-009 Approval Date 09/20/2017 Effective Date September 1, 2016

Supersedes

TN No. 94-08

- A. An FQHC located outside of the District of Columbia that seeks reimbursement for services furnished to District of Columbia Medicaid beneficiaries shall comply with the requirements set forth under Supplement 1 to Attachment 3.1-A, page 35, Section 26.B.1.a and Supplement 1 to Attachment 3.1-B, page 34, Section 26.B.1.a and shall be reimbursed at the PPS rate as determined by the state Medicaid program in the state in which the FQHC is geographically located..
- B. For Medicaid beneficiaries that are enrolled out-of-state, the FQHC shall seek reimbursement from the state in which the beneficiary is enrolled. The FQHC shall not seek reimbursement from DHCF.

xii. **Mandatory Reporting Requirements**

- A. Each FQHC shall report to DHCF, annually, on the following two measure sets:
 - I. HRSA UDS “Quality of Care” and “Health Outcomes and Disparities” measures which may be located at the HRSA Bureau of Primary Care website at <https://www.bphc.hrsa.gov/datareporting/reporting/index.html>; and
 - II. Other performance measures set forth by DHCF at <http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45>.
- B. DHCF will notify FQHCs of the performance measures, measure specifications, and any changes through transmittals issued to the FQHCs no later than ninety (90) calendar days prior to October 1 each year.
- C. The measurement year for measures outlined in 12.b.xii.A.II shall begin October 1, 2017 of and end on September 30, 2018, repeating annually, unless otherwise specified by DHCF.
- D. For measures described in 12.b.xii.A.I, each FQHC shall submit measures to DHCF once HRSA has approved the FQHC’s final report. The final report must be sent to DHCF no later than September 1 of each year, beginning September 1, 2017.

xiii. **Performance Payment**

- A. Beginning October 1, 2017, each FQHC that elects the APM rate and meets the standards outlined in Section 12.b.xiii.B. may be eligible to participate in the FQHC performance payment program.
- B. To participate in the performance payment program, a FQHC must have elected the APM rate and must submit to DHCF the following by September 1, 2018 and

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

- I. Letter of Intent to participate in the performance payment program;
 - II. Most current HRSA-approved quality improvement plan and any updates which HRSA may or may not have requested. In subsequent years, if the FQHC has not updated the HRSA-approved plan, then the FQHC shall provide DHCF with written notification that there have been no changes to the quality improvement plan; and
 - III. Annual performance data reporting measures set forth under 12.b.xii.A.II.
- C. DHCF shall notify the FQHC if all requirements have been met no later than fifteen (15) business days after the receipt of the required materials.
- D. The performance payment program's baseline year will be the first year in which FQHCs performance is measured to benchmark improvement in future years. The baseline year for FQHCs that elect to participate in the performance payment program shall begin October 1, 2017 and end on September 30, 2018. For FQHCs that elect to participate in the performance payment program after the initial baseline year, their first baseline year will begin on October 1 of the first year that an FQHC elects to participate in the performance program and end on September 30.
- E. The measurement year (MY) is any year following an FQHC's satisfaction of participation requirements described in Section 12.b.xiii.B and completion of the baseline year. During the MY, each FQHC will be assessed on its attainment of or improvement in performance measures and guidelines found at <http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45>, which will apply consistent with federal requirements. The first MY under the FQHC performance payment program will begin on October 1, 2018.
- F. Assessments and benchmarks will be based on comparing data collected in the baseline year to data collected during the first measurement year. During subsequent years, benchmarks will be based on the prior measurement year's performance.
- G. DHCF shall provide written notification of the attainment and individualized improvement thresholds to each participating FQHC no later than 180 calendar days after the conclusion of the previous MY after all performance measures are received and validated.

- H. A FQHC may opt to aggregate its beneficiary population with another FQHC's population for the purposes of calculating attainment of a performance measure or improvement on any of the required measures set forth under 12.b.xii.A.. Further guidance found at <http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45> will apply consistent with federal requirements.
- I. For MY 2019, beginning on October 1, 2018, and annually thereafter, performance payments will be calculated and distributed from the performance bonus funding pool established during the MY after the conclusion of each measurement year. For MY2019, the amount of the performance bonus funding pool available for distribution to all FQHCs shall be the difference between the FQHCs' uncapped administrative cost and the capped administrative cost reflected in 2013 audited cost reports.
- J. For MY2020 and future years, the amount of the performance bonus funding pool shall be the amount available in the previous year's pool, adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act.
- K. DHCF shall notify the FQHCs of the performance bonus funding pool amount no later than ninety (90) calendar days prior to October 1, 2018, and annually thereafter 90 calendar days before October 1.
- L. The available funds in the annual performance bonus pool will be allocated to each participating FQHC that qualifies for a performance award as described in Section 12.b.xiii.N.
- M. A participating FQHC's performance payment shall be the FQHC's maximum annual bonus payment as described in Section 12.b.xiii.N, multiplied by the FQHC's annual performance percentage using the methodology described in Section 12.b.xiii.O.
- N. A participating FQHC's performance award from the annual performance bonus pool will be the FQHC's maximum annual bonus payment multiplied by the FQHC's annual performance percentage for that year, as calculated using the methodology described in Section 12.b.xiii.O.V. Each participating FQHC's maximum annual bonus payment shall be the FQHC's market share multiplied by the annual performance bonus pool described in section 12.b.xiii.L added to any additional allocation referenced in Section 12.b.xiii.N.II.
- I. The market share shall be calculated as follows:

- a. In cases where there are no statistical outliers, the market share for a participating FQHC shall be the number of the FQHC's unique Medicaid beneficiaries that received primary care services from the FQHC during the baseline or previous measurement year, divided by the total number of Medicaid beneficiaries who received primary care services from the participating FQHCs during the baseline or previous measurement year.
- b. In cases where there is a statistical outlier, the market share calculation shall be determined as follows:
 1. DHCF shall apply a cap for FQHCs whose market share is considered a statistical outlier. A statistical outlier is any FQHC that has a market share less than the lower bound or exceeding the upper bound. The upper-bound and lower-bound outlier shall be calculated using the following steps:
 - a) Calculate the quartiles of the number of unique Medicaid beneficiaries that received primary care services from the FQHC. The quartiles are the three points that divide the data set into four equal groups, each group comprising a quarter of the data. The first quartile is defined as the middle number, otherwise known as the median, between the smallest number and the median of the data set. The second quartile is the median of the data. The third quartile is the middle value between the median and the highest value of the data set.
 - b) Calculate the interquartile range (IQR) by subtracting the first quartile from the third quartile;
 - c) Multiply the IQR by 1.5 to obtain the IQR factor;
 - d) Add the third quartile to the IQR factor to calculate the upper bound; and
 - e) Subtract the IQR factor from first quartile to calculate the lower bound.
 2. If an FQHC is a statistical outlier because its total number of beneficiaries exceeds the upper bound, the FQHC's market share will be the median of the upper bound number and the FQHC's actual number of unique Medicaid beneficiaries that received primary care services in the baseline or previous measurement year divided by the total number of Medicaid

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

3. If an FQHC is a statistical outlier because its number of beneficiaries is less than the lower bound, the outlier FQHC's market share will be the lower bound number, divided by the total number of Medicaid beneficiaries who received primary care services from the participating FQHCs during the baseline or previous measurement year.
 4. For FQHCs that are not statistical outliers participating during a measurement year when there are statistical outliers, the non-outlier FQHC's market share shall be calculated in same manner as described in subparagraph 12.xiii.N.I.b..
- II. If there is an upper bound outlier, and there are remaining performance payment pool funds after all funds have been disseminated according to market share, the remaining additional funds shall be proportionally allocated to the non-outlier FQHCs based on the number of that FQHCs primary care beneficiaries divided by the total number of non-outlier FQHC beneficiaries..
- O. To determine the FQHC's annual performance percentage for each year, DHCF shall score each participating FQHC's performance in three measurement domains. This scoring will be determined as follows:
- I. Assessments and benchmarks will be based on comparing data collected in the baseline year to data collected during the first measurement year. During subsequent years, benchmarks will be based on the FQHC's improvement over a prior measurement year's performance.
 - II. A maximum of one hundred (100) points will be awarded to each FQHC across the three (3) measurement domains.
 - III. Each measure in the domain is assigned points by dividing the total points by number of measures in each domain. Further guidance found at <http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=29-45> will apply consistent with federal requirements.
 - IV. Points for each measure will be awarded in cases where an FQHC either meets the attainment or improvement benchmark based on the prior year's performance as described below:

- a. For domain measures where improvement can be measured, the improvement benchmark will be a statistically significant improvement in performance of the measure compared to the prior year's performance, where the percentage improvement over the prior year is greater than a value that can be attributed to chance. DHCF shall perform the appropriate statistical analysis to determine that performance between years is a result that cannot be attributed to chance.
 - b. For domain measures where attainment is measured, an FQHC must achieve the attainment benchmark of the seventy-fifth (75th) percentile for the previous measurement year to receive points for the clinical process and utilization measures. Setting the threshold at the seventy-fifth (75th) percentile means that only FQHCs performing at the level of the top quartile for the previous year would earn points for attainment. FQHCs performing below the attainment benchmark may be able to receive points if they have improved measure performance.
 - c. If a FQHC neither attains nor improves performance on a given measure, no points will be awarded for that measure. The total number of points for a FQHC will be the sum of the total points earned, through either attainment or improvement on a measure.
- V. The annual performance percentage for each qualifying FQHC shall be calculated using the following methodology:
- a. Sum points awarded for each measure in the domain to determine the domain totals;
 - b. Sum domain totals to determine total performance points;
 - c. Divide total performance points by the maximum allowed points to determine the award percentage.
- VI. If participating FQHCs have aggregated beneficiaries together for determination of performance, the award percentage for the aggregated entities shall be applied to each FQHC's maximum bonus amount to determine the FQHC's performance award individually.
- VII. Beginning with MY2019, and annually thereafter, performance payments shall be calculated and distributed no later than 180 calendar days after the conclusion of each measurement year once all performance measures are received and have been validated.

xiv. **Rebasing for APM**

- A. Not later than January 1, 2018 and every three (3) years thereafter, the cost and financial data used to determine the APM rate shall be updated based upon audited cost reports that reflect costs that are two years prior to the base year and in accordance with the methodology set forth in 12.b.iii, 12.b.iv, 12.b.v, and 12.b.vi of this Section.

xv. **Cost Reporting and Record Maintenance**

- A. Each FQHC shall submit a Medicaid cost report, prepared based on the accrual basis of accounting, in accordance with Generally Accepted Accounting Principles. In addition, FQHCs are required to submit their audited financial statements and any supplemental statements as required by DHCF no later than one hundred and fifty days (150) days after the end of each FQHC's fiscal year, unless DHCF grants an extension or the FQHC discontinues participation in the Medicaid program as an FQHC. In the absence of audited financial statements, the FQHC may submit unaudited financial statements prepared by the FQHC.
- B. Each FQHC shall also submit to DHCF its FQHC Medicare cost report that is filed with its respective Medicare fiscal intermediary, if submission of the Medicare cost report is required by the federal Centers for Medicare and Medicaid Services (CMS).
- C. Each FQHC shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the FQHC's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and any other original documents which pertain to the determination of costs.
- D. Each FQHC shall maintain the records pertaining to each cost report for a period of not less than ten (10) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.
- E. DHCF reserves the right to audit the FQHC's Medicaid cost reports and financial reports at any time. DHCF may review or audit the cost reports to determine allowable costs in the base rate calculation or any rate adjustment as set forth in 12.b of this Section.
- F. If a provider's cost report has not been submitted within hundred and fifty (150) days after the end of the FQHC's fiscal year as set forth in Subsection 12.b.xv.A, or within the deadline granted pursuant to an extension, DHCF reserves the right not to adjust the FQHC's APM rate or PPS rate for services as described in Sections 12.b.ii.C, 12.b.iii.G, 12.b.iv.H, 12.b.v.D and 12.b.vi.D.

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

xvi. **Access to Records**

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

xvii. **Appeals**

- A. For appeals of DHCF Payment Rate Calculations, Scope of Service Adjustments or Audit Adjustments for FQHCs:
 - I. At the conclusion of any required audit, the FQHC shall receive a Notice of Audit Findings that includes a description of each audit finding and the reason for any adjustment to allowable costs or to the payment rate.
 - II. An FQHC may request an administrative review of payment rate calculations, scope of service adjustments or audit adjustments. The FQHC may request administrative review within thirty (30) calendar days of receiving the Notice of Audit Findings by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, DHCF.
 - III. The written request for administrative review shall identify the specific audit adjustment and/or payment rate calculation to be reviewed, and include an explanation of why the FQHC views the adjustment or calculation to be in error, the requested relief, and supporting documentation.
 - IV. DHCF shall mail a formal response to the FQHC not later than sixty (60) calendar days from the date of receipt of the written request for administrative review.
 - V. Within thirty (30) calendar days of receipt of DHCF's written determination relative to the administrative review, the FQHC may appeal the determination by filing a written request for appeal with the Office of Administrative Hearings (OAH).
 - VI. The filing of an appeal with OAH shall not stay DHCF's action to adjust the FQHC's payment rate.

- VII. Resolution of payment rate, scope of service adjustment, or audit adjustment in favor of an FQHC shall be applied consistent with the process as described below:
- a. The resolution of audit findings in favor of an FQHC will be applied retroactively to the date the initial adjustment was to have taken effect;
 - b. The resolution of scope of service adjustments in favor of an FQHC shall be prospective only, beginning the first day of the month following resolution of the scope of services adjustment; and
 - c. The resolution of payment rate adjustments shall be retroactive to the date when DHCF received a completed request for administrative review.
- B. For FQHC appeals of DHCF decisions on fee-for-service claims:
- I. An FQHC may request a formal review of a decision made on a fee-for-service claim. To be eligible for a formal review, the FQHC must make the request within three-hundred and sixty-five (365) calendar days of receiving notice of the decision.
 - II. The written request for formal review shall include an explanation of the problem, the requested relief, supporting documentation and meet any additional standards DHCF or its designee may require. Written requests for formal review must be sent to the addresses provided in the DC MMIS Provider Billing Manual.
 - III. DHCF or its designee shall render a written decision on a request for a formal review within forty-five (45) calendar days of a completed request for review.
- C. For FQHC appeals of MCO decisions on claims for reimbursement:
- I. Effective July 1, 2017, for dates of services after April 1, 2017, an FQHC may request administrative reconsideration from DHCF in order to challenge an MCO's denial, nonpayment or underpayment of a claim. To be eligible for administrative reconsideration, the FQHC shall:
 - a. Exhaust the MCO appeal process for the MCO that issued the denial, nonpayment or underpayment; and
 - b. Receive a final written notice of determination (WND) from the MCO, or provide documentation that the timeframe for the MCO to render a final WND has expired without decision.

- II. Requests for administrative reconsideration shall be made to DHCF in writing by mail, email, fax, or in person to DHCF's Appeals Coordinator within thirty (30) calendar days of the date of the final WND from the MCO. If no final WND was provided, the request shall be made within thirty (30) calendar days of the date that the MCO was due to render its final WND.
- III. DHCF will notify the MCO when a FQHC request for administrative reconsideration has been filed to allow the MCO the opportunity to share supporting documentation.
- IV. DHCF reserves the right to request additional information and/or supporting documentation from the FQHC and/or the MCO, as appropriate, to assist in its determination. Failure to respond to agency requests for additional information and/or supporting documentation within the timeframe provided will not prevent DHCF from rendering a written decision.
- V. DHCF shall render a written decision within forty-five (45) calendar days of receiving a complete request for administrative reconsideration.
 - a. If new information is provided to DHCF that warrants an extension in the amount of time it will take the agency to render a decision, the agency reserves the right to extend its review period by no more than ten (10) calendar days. The FQHC shall be notified if such an extension is required.
- VI. The written decision shall constitute the final determination on the subject claim. The written decision by DHCF shall include the following minimum information:
 - a. Basis for decision; and
 - b. Supporting documentation or findings, if appropriate.
- VII. If DHCF determines that the decision of the MCO was improper, then DHCF will direct the MCO to make proper payment to the provider no later than thirty (30) calendar days of its written decision. Once payment is made, the FQHC can follow protocol in making a request to DHCF for wrap payment.
- VIII. If DHCF determines that the decision of the MCO was proper, but that the FQHC is still due reimbursement or payment, DHCF shall make the appropriate payment no later than thirty (30) calendar days of its written decision.

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

DEFINITIONS

For the purposes of Section 12.b in this State Plan Amendment, the following terms and phrases shall have the meanings ascribed:

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

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

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

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

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

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

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

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