Table of Contents

State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 19-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street Suite 9400
Philadelphia, Pennsylvania 19107-3134

Centers for Medicaid & CHIP Services

SWIFT #091020194006

December 16, 2019

Melisa Byrd
Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

Dear Director Byrd:

I am writing to inform you that we have reviewed the District of Columbia's State Plan Amendment (SPA) 19-002, entitled Medicaid Cost-Based Reimbursement for Emergency Medical Ground Transportation Services. This amendment will allow the District to reimburse eligible governmental emergency ground transportation providers in accordance with the proposed cost-based methodology, effective April 1, 2019.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is April 1, 2019. 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 McGuire at 215-861-4754 or by email at Frankeena.McGuire@cms.hhs.gov.

Sincerely,

[redacted]

Francis T. McCullough
Deputy Group Director
Financial Management Group

cc: Alice Weiss, DHCF
Eugene Simms, DHCF
Sabrina Tillman Boyd, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **19-002**

2. STATE: **District of Columbia**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act**

TO: Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

4. PROPOSED EFFECTIVE DATE: **April 1, 2019**

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:

42 CFR 440.170(a)

7. FEDERAL BUDGET IMPACT:

FFY19: $ 975,000.00
FFY20: $ 1,950,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1A: p 3; Attachment 3.1B: p 3;
Supp 1 to Attachment 3.1A: Page 8-9;
Supp 1 to Attachment 3.1B: Page 7-8;
Supp 4 to Attachment 4.19B: Pages 1-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1A: p 3; Attachment 3.1B: p 3;
Supp 1 to Attachment 3.1A: Page 8-9;
Supp 1 to Attachment 3.1B: Page 7-8

10. SUBJECT OF AMENDMENT:

Medicaid Cost-Based Reimbursement for Emergency Medical Ground Transportation Services

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
D.C. Act: 22-434

12. SIGNATURE OF STATE AGENCY OFFICIAL

[redacted]

13. TYPED NAME

Melissa Byrd

14. TITLE

Senior Deputy Director/Medicaid Director

15. DATE SUBMITTED

June 28, 2019

16. RETURN TO

Melissa Byrd
Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

11/6/2019

18. DATE APPROVED

12/16/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

April 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted]

21. TYPED NAME

Francis McCullough

22. TITLE

Deputy Group Director

State/Territory: District of Columbia

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

c. Chiropractors' services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

d. Other practitioners' services.

_X_ Provided: **Emergency Medical Service Providers is detailed in Supp. 1 to Attachment 3.1-A**

__ Not provided:

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X_ Provided: ___ No limitations _X_ With limitations*

b. Home health aide services provided by a home health agency.

__X_ Provided: ___ No limitations _X_ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__X__ Provided: ___ No limitations _X_ With limitations*

State/Territory: District of Columbia

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALL NEEDY GROUP(S):

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services
_X_ Provided: ___ No limitations _X_ With limitations*

b. Optometrists' services.

_X_ Provided: ___ No limitations _X_ With limitations*

c. Chiropractors' services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

d. Other practitioners' services.

_X_ Provided: **Emergency Medical Service Providers is detailed in Supp. 1 to Attachment 3.1-B**

__ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

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b. Home health aide services provided by a home health agency.

__X_ Provided: ___ No limitations _X_ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__X__ Provided: ___ No limitations _X_ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
__X__ Provided: ___ No limitations _X_ With limitations*

_____ Not provided

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

6. Medical Care and any other type of Remedial Care Recognized Under State Law, Furnished by Licensed Practitioners Within The Scope of Their Practice as Defined by State Law

A. Podiatrists' Services

The limitations on routine foot care are the same as the limitations under Medicare and delineated in the Medicare Carriers Manual (HIM-14) and the Medicare Intermediary Manual (HIM-13). Special treatment should be prior authorized by the State Agency.

B. Optometrists' Services

Limited to specific services except where prior authorization is made by the State Agency. Services are further limited as follows:

1. Contact lenses must be prior authorized by the State Agency.

2. Eyeglasses are limited to one complete pair in a twenty- four (24) month period. Exceptions to this policy are:

   a. Recipients under twenty-one (21) years of age;

   b. Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter; and

   c. Broken or lost eyeglasses.

3. Special glasses such as sunglasses and tints must be prior authorized by the State Agency and justified in writing by the optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

   In addition, the optometrist must adhere to the dispensing procedures in the providers Medical Assistance Manual.

C. Chiropractors' Services

Chiropractors' services are not covered by the District of Columbia Medicaid Program.

D. Other Practitioners' Services

Emergency Medical Service Providers

a. Paramedics are licensed providers in the District of Columbia. Licensed paramedics are covered within their scope of practice defined by state law.
b. Emergency medical responders are licensed providers in the District of Columbia. Licensed emergency medical responders are covered within their scope of practice defined by state law.
c. Emergency medical technicians (EMTs), as well as advanced EMTs and EMT-Intermediate, are licensed providers in the District of Columbia. Licensed EMTs, advanced EMTs, and EMT-Intermediate are covered within their scope of practice defined by state law.

7. Home Health Services

General Provisions

In accordance with 42 CFR § 440.70, Home Health Services are physician-ordered services provided to a beneficiary in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board, as part of a written plan of care that the physician reviews every sixty (60) days.

An order for Home Health Services must be signed and dated by the beneficiary's physician and shall state the amount, frequency, scope, and duration of each Home Health service ordered. The physician's signature on the order constitutes a certification by the physician that the services ordered reflect the health status and needs of the beneficiary.

The Home Care Agency is responsible for developing and updated the plan of care and ensuring that services provided are in accordance with the physician's order and health status and needs of the beneficiary.

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

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The Home Care Agency is responsible for developing and updated the plan of care and ensuring that services provided are in accordance with the physician's order and health status and needs of the beneficiary.

Medicaid Cost-Based Reimbursement for the Provision of Emergency Medical Ground Transportation Services

This Section applies to reimbursement for Emergency Medical Transportation Services described in Section 24, Transportation Services, in Attachment 3.1 A, Page 9 and Section 24, Transportation Services, in Attachment 3.1 B, Page 8, and Transportation Services in Attachment 3.1D, Page 1.

This Section also governs reimbursement for Emergency Medical Service providers described in Attachment 3.1-A, Page 3, Supplement 1 to Attachment 3.1A, Page 9, Attachment 3.1-B, Page 3, and Supplement 1 to Attachment 3.1B, Page 8.

Effective April 1, 2019, eligible governmental emergency medical ground transportation providers will be eligible to receive Medicaid payments in accordance with the cost-based reimbursement methodology set forth in this Section for the provision of emergency medical ground transportation services to Medicaid recipients.

I. GENERAL PROVISIONS

A. The purpose of this Section is to establish principles of reimbursement for eligible providers of emergency medical ground transportation services participating in the District of Columbia Medicaid program.

B. Medicaid reimbursement to eligible providers of emergency medical ground transportation services provided beginning April 1, 2019 shall be consistent with the requirements of the cost-based reimbursement methodology set forth in this Section.

C. In order to receive Medicaid reimbursement, a eligible provider shall enter into a provider agreement with the Department of Health Care Finance (DHCF) for the provision of emergency medical ground transportation services and comply with the screening and enrollment requirements set forth in Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 of the District of Columbia Municipal Regulations (DCMR).

D. Emergency medical ground transportation services shall be provided in accordance with the licensure, certification, and service delivery requirements set forth in Chapter 5 (Emergency Medical Services) of Title 29 of the DCMR.

II. COST-BASED REIMBURSEMENT OF DISTRICT EMRGENCY MEDICAL GROUND TRANSPORTATION SERVICES

A. DHCF will reimburse eligible providers enrolled to provide Medicaid emergency medical ground transportation services in the District of Columbia in accordance with the cost-based reimbursement methodology set forth in this Chapter.

B. Total Medicaid reimbursement to eligible providers shall equal the sum of:

i. Medicaid fee-for-service reimbursement as described in § III.A; and

ii. Reimbursement for total allowable costs in excess of Medicaid fee-for-service reimbursement and reimbursement from other sources for emergency medical ground transportation services to Medicaid-eligible beneficiaries, or reconciled costs as defined in § VI.

C. DHCF will only provide cost-based reimbursement for allowable costs that are in excess of Medicaid fee-for-service reimbursement described in § III.A.

D. Total Medicaid reimbursement shall not exceed one hundred percent (100%) of actual allowable costs. DHCF shall determine allowable costs in accordance with the reconciliation standards outlined in § VI and the cost reporting and auditing processes outlined in § VII.

E. An eligible provider shall certify costs attributable to services provided to Medicaid beneficiaries through submission of the annual cost report in accordance with the requirements set forth in § VII.

F For each cost reporting period that an eligible provider's reconciled costs are greater than the sum of fee-for-service payments received from DHCF and reimbursement from other sources for emergency medical ground transportation services, DHCF shall make a payment to the eligible provider, following auditing of submitted cost reports and final determination of reconciled costs, equal to the amount of the difference, less the local Medicaid funding amount.

G. For each cost reporting period that an eligible provider's reconciled costs are less than fee-for-service payments received from DHCF and reimbursement from other sources for emergency medical ground transportation services to Medicaid-eligible beneficiaries for the cost reporting period, the eligible provider shall make a payment to DHCF, following auditing of submitted cost reports and final determination of reconciled, equal to the amount of the difference.

III. INTERIM RATE METHODOLOGY

A. DHCF will provide fee-for-service reimbursement of emergency medical ground transportation services provided to District Medicaid-enrolled beneficiaries to eligible providers in accordance with the reimbursement rates set forth in the District of Columbia Medicaid Fee Schedule. The effective date of the fee schedule is identified on page 13a of Attachment 4.19B, Part 1 of the District of Columbia Medicaid State Plan. The Medicaid Fee Schedule is located on the DHCF website at https://www.dc-medicaid.com/dcwebportal/home. Medicaid fee-for-service reimbursement for emergency medical ground transportation services includes reimbursement for the services outlined below:

i. Advanced Life Support 1;

ii. Advanced Life Support 2;

iii. Basic Life Support; and

iv. Ground Mileage.

B. All claims paid using interim rates for services provided during the reporting period, shall be subject to the reconciliation process set forth in § VI.

C. Reconciliation of payments, pursuant to the process set forth in § VI, may result in the identification and remittance of an additional payment owed to the eligible provider or identification and recoupment of any overpayment due to DHCF.

D. Following the close of each reporting year, DHCF may utilize audited financial data in the cost report to update interim rates for covered emergency medical ground transportation services, as identified in § III.A, for eligible governmental providers.

E. All future updates to the reimbursement rates for emergency medical ground transportation services for eligible governmental providers shall comply with the public notice requirements set forth in District Rulemaking.

IV. ELIGIBLE EMERGENCY MEDICAL GROUND TRANSPORTATION SERVICE PROVIDERS

A. To be eligible for cost-based reimbursement, emergency medical ground transportation service providers shall be a part of, owned by, or operated by the District of Columbia government.

B. Emergency medical ground transportation service providers that are not part of, owned by, or operated by the District of Columbia government are not eligible to receive cost-based reimbursement described in this Chapter.

C. Eligible emergency medical ground transportation services providers shall be enrolled with the District of Columbia Medicaid Program for the period claimed on the annual cost report.

V. ALLOWABLE COSTS

A. Allowable costs shall include expenses incurred by the eligible provider in provision of emergency medical ground transportation services as identified in the cost reporting template and audited by DHCF in accordance with the requirements set forth in § VII.

B. Allowable costs shall include items of expense incurred by the eligible provider within the following categories:

i. Capital related (i.e. expenditures associated with depreciation of buildings and equipment, leases and rentals, property insurance, and other capital related costs);

ii. Employee salary and fringe benefits;

iii. Administrative (i.e. expenditures associated with general supplies, housekeeping, postage, and other administrative costs); and

iv. Operational (i.e. expenditures associated with medical supplies, minor medical equipment, communications, and other operational costs).

C. An eligible provider may request reimbursement of allowable costs, up to the reconciled costs, as determined in accordance with § VI. Total Medicaid reimbursement to eligible providers shall not exceed one hundred percent (100%) of actual allowable costs

D. DHCF and eligible providers shall calculate and allocate allowable costs in accordance with the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 CFR Part 225 (Cost Principles for State, Local, and Indian Tribal Governments), which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the District of Columbia Medicaid program.

VI. CALCULATION OF RECONCILED COSTS

A. Reconciled costs shall be equal to an eligible provider's audited allowable costs less the sum of Medicaid fee-for-service payments and other sources of reimbursement.

B. DHCF shall apportion an eligible provider's allowable costs per medical transport to calculate a cost per medical transport rate, as defined in VI.C, below. The cost per medical transport rate will be based on the allowable costs included in the submitted cost report.

C. The cost per medical transport rate shall equal the sum of actual allowable direct and indirect costs of providing emergency medical ground transportation services and dry runs (or treat and refer services)to Medicaid-enrolled beneficiaries, divided by the number of actual medical transports in the applicable service period. Nonmedical consults that do not result in transportation to a medical facility are excluded from the numerator.

D. Direct costs for the provision of emergency medical ground transportation services shall only include: the unallocated payroll costs for personnel who dedicate one hundred percent (100%) of their time to providing medical transport services; medical equipment and supplies; and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training.

E. Indirect costs shall be determined in accordance with one of the options, as authorized by DHCF prior to the start of the reporting period:

i. Eligible providers that receive more than thirty-five million dollars ($35 million) in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the eligible provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost;

ii. Eligible providers that receive less than thirty-five million dollars ($35 million) of direct federal awards are required to develop and maintain an indirect proposal for purposes of audit. In the absence of an indirect rate proposal, the eligible provider may use methods originating from a CAP to identify its indirect cost. If the eligible provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost;

iii. Eligible providers that receive no direct federal funding may use any of the following previously established methodologies to identify indirect cost:

a. A CAP with DHCF or the District government;

b. An indirect rate negotiated with DHCF or the District government; or

c. Direct identification through use of a cost report; or

iv. If the eligible provider never established any of the above methodologies, it may do so, or it may elect to use the ten percent (10%) de minimis rate to identify its indirect cost.

F. Total allowable costs, determined in accordance with the requirements of § V, shall equal the cost per medical transport, identified in §§ VI.B and VI.C, times the total number of Medicaid fee-for-service transports.

G. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursement data is the Medicaid Management Information System (MMIS). The number of

paid Medicaid fee-for-service transports, as identified in is § VI.F, is derived from and supported by the MMIS reports for services during the applicable reporting period.

H. Payment of reconciled costs, by DHCF or the eligible provider, shall be made in accordance with the requirements set forth in §§ II.F or II.G.

I. Payment of reconciled costs by DHCF, shall be made in accordance with timely reimbursement and claiming requirements set forth at 42 CFR § 447 and 45 CFR § 95, Subpart A.

VII. COST REPORTING, AUDITS, AND RECORD MAINTENANCE

A. Eligible providers shall submit an annual cost report to DHCF within one hundred eighty days (180) days of the close of the provider's cost reporting period, which shall be concurrent with the District of Columbia government's fiscal year.

B. Cost reports shall be submitted on the DHCF approved form and shall be completed according to the cost report instruction manual. If forms and instructions are modified, DHCF will provide advance notice in writing to each eligible provider and on the DHCF website.

C. If an eligible provider does not submit the cost report within the timeframe indicated in §VII.A and has not received an extension of the deadline from DHCF based upon a showing of good cause for the delay, DHCF may issue a delinquency notice to the eligible provider.

D. Only one (1) extension of time shall be granted to a provider for a cost reporting year and no extension of time shall exceed sixty (60) days.

E. Eligible providers shall submit one (1) original hard-copy and (1) one electronic copy (in excel format) of the cost report. The eligible provider shall submit an original hard copy to DHCF that is signed by an authorized representative.

F. The requirements for cost reports shall be detailed in the DHCF Emergency Ground Medical Transportation Services cost report instruction manual. Each cost report shall meet the following requirements:

   i. Be properly completed in accordance with program instructions and forms and accompanied by supporting documentation; and

   ii. Include copies of financial statements or other official documents submitted to a governmental agency justifying revenues and expenses;

G Eligible providers must ensure that computations included in the cost report shall be accurate and consistent with other related computations and the treatment of costs shall be consistent with the requirements set forth in this Section.

H. In the absence of specific instructions or definitions contained in these rules or cost reporting forms and instructions, DHCF's decision of whether a cost is allowable shall be determined in accordance with the Medicare Principles of Reimbursement and the guidelines set forth in the Centers for Medicare and Medicaid Services Medicare Provider Reimbursement Manual as identified in § V.D.

I. All cost reports shall cover, at most, a twelve (12) month cost reporting period, which shall be the same as the District's fiscal year, unless DHCF has approved an exception.

J. A cost report that is not complete shall be considered an incomplete filing and the eligible provider shall be notified of the deficiency and requested to submit a corrected and complete version.

K. Each eligible provider 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 provider'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 original documents which pertain to the determination of costs.

L. Eligible providers shall maintain the records pertaining to each cost report as described in § VII.K 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.

M. All records and other information may be subject to periodic verification and review. Each cost report may be subject to a desk review.

N. Eligible providers shall:

i. Use the accrual method of accounting; and

ii. Prepare the cost report in accordance with generally accepted accounting principles, the requirements of § V.D, and DHCF program instructions.

VIII. ACCESS TO RECORDS

A. Eligible providers shall allow appropriate DHCF personnel, representatives of the United States Department of Health and Human Services and other authorized agents or officials of the District of Columbia government and federal government full access to all records during announced and unannounced audits and reviews.

IX. APPEALS

A. At the conclusion of each audit, an eligible provider shall receive an audited cost report including a description of each audit adjustment and the reason for each adjustment.

B. Within thirty (30) days of the date of receipt of the audited cost report, an eligible provider that disagrees with the audited cost report may request an administrative review by sending a written request for administrative review to DHCF.

C. Any written request for an administrative review shall include an identification of the specific audit adjustment to be reviewed, the reason for the request for review of each audit adjustment and documentation supporting the request.

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

E. Decisions made by DHCF and communicated in the formal response described in § IX.D may be appealed to the District of Columbia Office of Administrative Hearings within thirty (30) days of the date of issuance of the formal response.

X. DEFINITIONS

When used in this Section, the following terms shall have the meanings ascribed:

Accrual Method of Accounting - A method of accounting where revenue is recorded in the period earned, regardless of when collected and expenses are recorded in the period incurred, regardless of when paid.

Advanced Life Support - Special services designed to provide definitive prehospital emergency medical care, such as, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

Basic Life Support - Emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

Cognizant Agency – Shall have the same meaning as set forth in Title 2 of the Code of Federal Regulations Part 200 Section 19.

Direct Costs - Costs incurred for the sole objective of meeting emergency medical transportation requirements or delivering covered medical transport services, such as: unallocated payroll costs for the shifts of personnel, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to the delivery of covered medical transport services.

Dry Run (**or Treat and Refer**) - Services (basic and advanced life support services) provided by the eligible provider to an individual who is released on the scene without transportation by ambulance to a medical facility.

Indirect Costs - Costs incurred for a common or joint purpose benefitting more than one District entity which are allocated using an agency-approved indirect rate or an allocation methodology.

Reporting Period - The span of time from which financial information is gathered to be recorded in cost reports; typically, October 1 through September 30 of each District of Columbia fiscal year.