

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code § 1-307.02 (2012 Repl. & 2013 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption of an amendment to Section 943 of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (“DCMR”), entitled “Medicaid Clinic Services and Reimbursement.”

These final rules will: (1) expand the types of providers delivering services from physician and nurse practitioners to a broader category encompassing all appropriate health care practitioners delivering services within their scope of practice; (2) establish the health care practitioner’s relationship to the clinic as an employee or contractor; and (3) authorize reimbursement to private clinics pursuant to Section 995 of 29 DCMR.

A Notice of Proposed Rulemaking was published on March 22, 2013 at 60 DCR 004205. No comments were received. No substantive changes have been made. Subsection 943.4(c) was amended to clarify that nurse midwives and nurse practitioners are eligible to deliver services in a clinic-setting consistent with Subsection 943.1. The Director adopted these rules as final on May 8, 2014, and they shall become effective on the date of publication of this notice in the *D.C. Register*.

**Section 943 (Medicaid Clinic Services and Reimbursement) of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the DCMR is amended to read as follows:**

**943 MEDICAID CLINIC SERVICES AND REIMBURSEMENT**

943.1 Clinic services for Medicaid beneficiaries shall be furnished in a public or private medically-based facility, under the direction of a physician, nurse midwife or nurse practitioner.

943.2 Clinic services provided by a nurse midwife or nurse practitioner shall be governed in accordance with the rules governing advanced practice registered nurses issued pursuant to the authority set forth in the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*).

943.3 Clinic services shall consist of the following:

- (a) Preventive services;

- (b) Diagnostic services;
- (c) Therapeutic services;
- (d) Rehabilitative services; or
- (e) Palliative services.

943.4 Clinic services shall be provided as follows:

- (a) To beneficiaries in an outpatient setting;
- (b) By a facility that is not part of a hospital; and
- (c) By or under the direction of a physician, nurse midwife or nurse practitioner.

943.5 Clinic services shall only be provided inside the clinic facility.

943.6 A clinic shall have a medical staff that is licensed by the laws of the District of Columbia pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*), to provide medical services to Medicaid beneficiaries.

943.7 Clinic services rendered by other health care practitioners shall be provided in accordance with the requirements set forth in District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*), to provide medical services to Medicaid beneficiaries.

943.8 A physician who directs clinic services shall not be required to be an employee of the clinic, but shall have a direct affiliation with the clinic.

943.9 A physician shall be considered to have a direct affiliation with a clinic when a contractual agreement or some other type of formal arrangement exists between the clinic and the physician. The agreement shall state the amount of time to be spent within the clinic in accordance with accepted standards of medical practice.

943.10 A health care practitioner who delivers service in a clinic may be an employee of a clinic or have a direct affiliation with a clinic when a contractual agreement or some other type of formal arrangement exists between the clinic and the health practitioner. The agreement shall state the amount of time to be spent within the clinic in accordance with accepted standards of medical practice.

- 943.11 A physician who directs clinic services shall not be required to stay on the clinic premises, but shall assure that the services provided are medically necessary and shall assume professional responsibility for the services provided.
- 943.12 A physician or other health care practitioner who is either employed or affiliated with a clinic and deemed appropriate to deliver service based upon their scope of practice shall:
- (a) See each beneficiary at least once;
  - (b) Prescribe the type of care provided by the clinic; and
  - (c) Periodically review the need for continued clinic care, if the clinic services are not limited by the prescription.
- 943.13 Public clinics shall receive an interim rate for clinic services on a per unit basis, which shall be the lesser of the provider's billed charges or the statewide enterprise interim rate. The unit of service shall be consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. 104-191; 42 U.S.C. 201 *et seq.*), and comply with the current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.
- 943.14 The final reimbursement rates for medical services delivered in a public clinic shall be one hundred percent (100%) of the reasonable costs of providing services to Medicaid beneficiaries as reported in the Public Clinic and Clinic Laboratory Cost (PCCLC) Report.
- 943.15 Reasonable costs shall be divided into two (2) categories:
- (a) Direct costs or expenses that can be charged to a direct medical service cost center. Direct costs may include but are not limited to salaries, benefits, medically-related contracted services, medically-related supplies and materials or any other cost that can be charged to a direct medical cost center. Direct costs shall be reduced by the amount of any federal payments received by the provider for these costs; and
  - (b) Indirect costs or expenses that are not directly related to a direct medical service cost center. Indirect costs include overhead and other costs common to an operational clinic, and may include but are limited to, administration, financial, public relations, data processing, housekeeping, maintenance, security, insurance, utilities, legal, seminars, conferences, training and meetings. Indirect costs shall be determined by applying the public clinic unrestricted indirect costs rates to its adjusted direct costs.

- 943.16 Statistical or other evidence shall be used as the basis for allocating costs to public clinic services and determining the Medicaid eligibility rate. The Medicaid eligibility rate shall be based on the percentage of Medicaid beneficiaries receiving service in each individual clinic relative to the entire population receiving service in each individual clinic.
- 943.17 The cost reconciliation process shall be conducted for the reporting period covered by the annual PCCLC Report. Interim payments to public clinics shall be compared to Medicaid reimbursable costs at the federal financial participation level to compute the amount due to or from the program.
- 943.18 Each public clinic shall certify on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each public clinic shall certify on an annual basis through its cost report its total, actual incurred allowable costs and expenditures, including the federal share and non federal share. Public clinics shall only be permitted to certify Medicaid-allowable costs and shall not be permitted to certify any indirect costs that are not included on the annual cost report.
- 943.19 Each public clinic shall complete the annual PCCLC Report for all clinic services delivered during the fiscal year covering October 1 through September 30. The cost report shall be due on or before June 30 of the following year, with the cost reconciliation and settlement process completed by September 30 of the subsequent year.
- 943.20 If a public clinic's interim payments exceed its actual, certified costs, the public clinic shall return an amount equal to the overpayment to Department of Health Care Finance (DHCF). If the actual certified costs exceed the interim Medicaid payments, the federal share of the difference shall be paid to the public clinic. DHCF shall issue a notice of settlement indicating the amount to be received from the provider or paid to the provider.
- 943.21 Reimbursement for private clinic medical services shall be governed in accordance with the provisions set forth in 29 DCMR § 995. Medicaid fee schedules for private clinics shall be published on the DHCF website at [www.dhcf.dc.gov](http://www.dhcf.dc.gov).
- 943.22 Federally qualified health centers shall be reimbursed pursuant to 29 DCMR Chapter 45.
- 943.23 Dental services shall be reimbursed pursuant to 29 DCMR Chapter 9.
- 943.24 Free standing mental health clinic services shall be reimbursed pursuant to the methodology set forth in 29 DCMR Chapter 8.

943.99 When used in this section, the following terms and phrases shall have the meanings ascribed:

**Diagnostic service** – a medical procedure or supply recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state or District law, to enable him or her to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

**Palliative service** – a patient and family-centered service that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative services involve addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

**Preventive service** – a service provided by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state or District law to prevent disease, disability, or other health conditions or their progression, prolong life, or promote physical and mental health and efficiency.

**Private clinic** – a clinic within the District of Columbia that is enrolled as a District Medicaid provider and is not a public clinic.

**Public clinic** – a clinic within the District of Columbia, which is a governmental entity that is owned, operated, managed, or leased by the District of Columbia government, providing Medicaid reimbursable services.

**Rehabilitative service** – a medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state or District law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level.

**Therapeutic Service** – a service and support for an individual with a principal diagnosis of mental illness, a serious emotional or behavioral disorder, or a substance-related disorder.

Comments on these rules should be submitted in writing to Linda Elam, Ph.D., Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 899 North Capitol Street, NE, 6<sup>th</sup> Floor, Washington, DC 20002, via telephone on (202) 442-9115, via e-mail at [DHCFPubliccomment@dc.gov](mailto:DHCFPubliccomment@dc.gov), or online at [www.dcregs.dc.gov](http://www.dcregs.dc.gov), within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.