DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code §1-307.02 (2016 Repl. & 2019 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) (2018 Repl.)), hereby gives notice of the intent to adopt, on an emergency basis, an amendment to Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

This rulemaking amends Chapter 94 of Title 29 DCMR, the DHCF rules governing the screening, enrollment, and termination of all providers enrolled in, or providing services reimbursed by, the District Medicaid program to align with current federal requirements. The United States Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) has updated the federal Medicaid provider screening and enrollment regulations at 42 CFR Part 455, Subpart E, necessitating corresponding revisions to DHCF's rules. These emergency and proposed rules also codify current DHCF policy and clarify many elements of the District Medicaid provider enrollment, screening, and termination processes that are not sufficiently addressed in current rules.

In accordance with the federal regulations at 42 CFR §§ 455.400 *et seq.*, these emergency and proposed rules set forth the enrollment requirements for ordering, referring, and prescribing providers, and update the categorical risk level classifications for new and existing provider types. To ensure that DHCF can adequately screen the individuals and entities seeking to enroll as providers of services to District Medicaid beneficiaries, these rules increase the time allotted DHCF to review provider enrollment applications, from thirty (30) to ninety (90) calendar days. The rules also update the requirements for completion and submission of provider enrollment applications to reflect the shift from the previously utilized paper-based process to the online process currently utilized by DHCF.

Finally, in addition to the changes made to existing sections of Chapter 94, this emergency and proposed rulemaking adds the following new sections: Section 9412, which describes the criteria and procedure for termination of enrollment due to provider inactivity; Section 9413, which details the requirements for changes in ownership of enrolled providers; Section 9414, which sets forth the financial viability standards and documentation requirements for prospective and enrolled providers, and Section 9415 which sets forth requirements for certain Medicaid enrolled providers to contract with District of Columbia Medicaid managed care organizations. Because "suppliers" is not a term recognized in Medicaid authority, the rule also proposes to delete references to the term "suppliers" throughout the rule.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of District Medicaid beneficiaries eligible for and in need of covered services rendered by enrolled

Medicaid providers. These rules are being enacted on an emergency basis to ensure that beneficiaries continue to have access to those items, services, and providers most appropriate to their individual care needs, health, and safety.

These emergency rules were adopted on September 9, 2020 and shall remain in effect for not longer than one hundred and twenty (120) days from the adoption date or until January 7, 2021, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

The Director also gives notice of the intent to take final rulemaking action to adopt these rules not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Chapter 94 of Title 29 DCMR, PUBLIC WELFARE, is amended to read as follows:

CHAPTER 94 MEDICAID PROVIDER SCREENING, ENROLLMENT, AND TERMINATION

Section 9400 is amended to read as follows:

9400 MEDICAID PROVIDER GENERAL PROVISIONS

9400.1 Health care providers, including individual practitioners, institutional providers, and providers of medical equipment or goods related to care, seeking to provide services or goods to District of Columbia (District) Medicaid beneficiaries shall be screened and enrolled in the District Medicaid program pursuant to the requirements in this chapter. A comprehensive list of the types of providers eligible to enroll in District Medicaid is available online at www.dc-medicaid.com. This chapter also establishes screening and enrollment related circumstances that may lead the Department of Health Care Finance (DHCF) to initiate termination of enrollment of an existing District Medicaid provider. Such terminations shall proceed in accordance with the Medicaid Program Administrative Procedures set forth in 29 DCMR §§ 1300 *et seq.*

9400.2 Only those providers that have received notification from DHCF that screening and enrollment requirements have been met shall be authorized to receive reimbursement for health services and goods delivered to District Medicaid beneficiaries.

9400.3 To initiate the enrollment process, a provider shall submit a completed D.C. Medicaid Provider Application (application) using the online portal accessible via www.dc-medicaid.com and in accordance with all requirements set forth in this chapter.

9400.4 Providers shall be subject to any or all of the following types of screening:

(a) Ownership and Financial Disclosures;

(b) Criminal Background Checks;

(c) Fingerprinting; and

(d) Pre- and Post-Enrollment Site Visits.

9400.5 Each provider shall submit all documentation listed on the application required for that provider type, submit to screening, and adhere to the guidance and timeframes issued by DHCF throughout the process for enrollment or revalidation of enrollment.

9400.6 In accordance with 42 CFR §§ 455.414 and 455.452, DHCF shall revalidate enrollment for all District Medicaid providers as follows:

(a) For Medicaid providers designated as "limited" or "moderate" risk, revalidation shall be required every five (5) years;

(b) For Medicaid providers designated as "high" risk, revalidation shall be required every three (3) years; and

(c) The date for revalidation of enrollment shall be calculated beginning on the effective date of the Medicaid provider agreement, or the date of the Medicaid provider's most recent revalidation, whichever is later.

9400.7 A revalidating provider shall submit to DHCF all information required for revalidation within the thirty (30) calendar days prior to the designated enrollment expiration date, in accordance with the following:

(a) If a revalidating provider fails to submit the required information to DHCF within this timeframe, DHCF shall initiate termination proceedings on or after the enrollment expiration date, in accordance with 29 DCMR §§ 1300 *et seq*;

(b) If DHCF initiates termination proceedings, any claims submitted by the provider for services delivered on or after the enrollment expiration date shall not be eligible for payment by DHCF;

(c) If a provider has been terminated, the provider must submit a new application in order to participate as a District Medicaid provider; and

(d) DHCF will not terminate a provider agreement because it is beyond the expiration date, as long as complete revalidation materials are received thirty (30) calendar days prior to the expiration date and under DHCF review.

9400.8 For the duration of a provider's enrollment in District Medicaid, each provider shall have a continuous obligation to:

(a) Maintain required licensure and submit proof of renewal for any required license prior to its expiration date. Failure to submit such proof of renewal prior to expiration shall result in DHCF's termination of the existing Medicaid provider agreement; and

(b) Maintain an active National Provider Identification (NPI) number.

9400.9 DHCF shall screen all applications for initial enrollment, re-enrollment, and revalidation of enrollment, including those providers who have been screened by Medicare or another state's Medicaid program within the twelve (12) month period preceding the submission of the application.

9400.10 All enrolled providers that are authorized to submit claims to and/or receive payment from Medicaid shall, as a condition of continued enrollment, submit quarterly data to DHCF on the number of individuals served or encountered with Limited English Proficiency (LEP) or Non-English Proficiency (NEP), and the non-English languages spoken by each LEP/NEP individual served or encountered. Information and guidance on how to submit the data is available at www.dc-medicaid.com.

9400.11 In accordance with 42 CFR § 455.470(a), DHCF may impose a temporary moratorium on enrollment under any provider type if the Secretary of the U.S. Department of Health and Human Services (Secretary) imposes a moratorium on the same provider type's participation in the Medicaid program.

9400.12 In accordance with 42 CFR § 455.470(b), DHCF may impose a temporary moratorium on the enrollment of new providers, or otherwise limit the number of enrolled providers, if DHCF identifies significant potential for fraud, waste, and abuse and the Secretary concurs with DHCF's findings.

9400.13 Temporary moratoria imposed by DHCF shall be for an initial period of one hundred eighty (180) days and may be extended by increments of one hundred eighty (180) days. DHCF must document in writing the necessity for extending the moratorium.

9400.14 Out-of-District providers shall be licensed and enrolled by the single state agency for the administration of Medicaid in the state where the provider is located and shall provide documentation of enrollment in that state's Medicaid program, including proof that the provider is currently licensed without restriction.

9400.15 In accordance with § 5005(b)(2) of the 21st Century Cures Act (Pub.L. 114-255; 42 USC § 1396u-2(d)(6)), effective January 1, 2018, all individuals and entities delivering services or items to Medicaid beneficiaries pursuant to a contract with a District Medicaid managed care organization shall be screened and enrolled pursuant to the requirements in this chapter. If such individuals and entities deliver

services or goods, but do not bill Medicaid directly, they may enroll using the procedures outlined in § 9400.16.

9400.16 Any provider who does not bill Medicaid directly for services rendered, but does order, refer, or prescribe services or goods for District Medicaid beneficiaries must:

(a) Maintain current licensure under state law to order, refer, or prescribe the medical services or items that are the subject of the order, referral, or prescription;

(b) Complete and submit a streamlined application for enrollment in District Medicaid;

(c) Be screened and enrolled in District Medicaid as a participating provider pursuant to the requirements set forth in this chapter; and

(d) Abstain from submitting claims to Medicaid for payment of any service.

9400.17 The requirements set forth in § 9400.16(b)-(c) apply only to provider types that are eligible to enroll in District Medicaid, as indicated by their inclusion on the comprehensive list referenced at § 9400.1.

Section 9401 is amended to read as follows:

9401 MEDICAID PROVIDER APPLICATION

9401.1 All provider applications shall be completed consistent with the requirements enumerated in § 9401.6 and submitted using the designated online application system, which may be accessed via www.dc-medicaid.com. Each provider shall complete and submit the application corresponding to the appropriate provider type and designated level of categorical risk assigned by DHCF.

9401.2 In accordance with 42 USC § 1320a-7k(e) and 42 CFR § 431.107(b)(5), each provider shall obtain a National Provider Identification (NPI) number from the U.S. Department of Health and Human Services and include the NPI number on the application submitted to DHCF.

9401.3 Each out-of-District provider must include the following additional information in the application:

(a) The name, business address, and telephone number of its registered agent, in accordance with D.C. Official Code §§ 29-104.01 *et seq.*;

(b) Proof of a physical business address and a business telephone number within the District listed under the name of the business for the purpose of providing Medicaid services and sales; and

(c) An active Medicare provider number, or a Medicaid provider number from the state in which the out-of-District provider's principal place of business is located.

9401.4 A provider seeking enrollment as a provider of services for a Qualified Medicare Beneficiary (QMB) must be Medicare-certified and shall complete and submit the QMB provider application consistent with § 9401.1. A QMB provider shall only be paid for claims submitted for services or items covered by Medicare and delivered to a Medicare program enrollee.

9401.5 All provider applications must include a provider agreement signed with an approved electronic signature, in a manner consistent with the D.C. Uniform Electronic Transactions Act of 2001, as amended, effective October 3, 2001 (D.C. Law 14-28; D.C. Official Code §§ 28-4901 *et seq.*).

9401.6 A complete Medicaid provider application shall include:

(a) A provider agreement signed by the provider in accordance with the requirements of § 9401.5;

(b) Any relevant documents in accordance with the provider's type, including proof that all required licensure is current; and

(c) All other required documents identified in the application.

9401.7 DHCF or its designated agent shall review each complete application within ninety (90) calendar days from the date of submission. If DHCF determines that a provider application is incomplete or contains incorrect information, it shall be returned to the provider for correction and resubmission, subject to the following limitations:

(a) A corrected application must be resubmitted to DHCF within sixty (60) calendar days of the date it was returned to the provider;

(b) DHCF shall allow resubmission of an application returned due to incomplete or incorrect information no more than twice within a twelve (12) month period; and

(c) If DHCF determines that the provider made a false representation or omission of any material fact in the original application, resubmission shall not be allowed.

9401.8 DHCF may deny an application if DHCF determines the provider has:

(a) Been convicted of a criminal offense that relates to the delivery of goods or services to a Medicaid beneficiary;

(b) Been convicted of any criminal offense that relates to a violation of fiduciary responsibility or financial misconduct;

(c) Committed a violation of applicable federal, state, or District laws or regulations governing the Medicaid or Medicare programs;

(d) Been excluded, suspended, or terminated from any program administered under Titles XVIII, XIX, and XXI of the Social Security Act;

(e) Been excluded, suspended, or terminated from any program managed by the District;

(f) Been previously found to have violated the standards or conditions of licensure, certification, or other professional standards;

(g) Made a false representation or omission of any material fact in making the application;

(h) Demonstrated an inability to provide services, conduct business, or operate a financially viable entity;

(i) Submitted an incorrect or incomplete application package to DHCF two (2) times in the past twelve (12) months;

(j) Owns or operates a setting which is subject to the requirements of 42 CFR § 441.301(c)(4) and has failed to demonstrate compliance with the applicable requirements; or

(k) In accordance with the requirements set forth at 42 CFR § 431.51 and with concurrence from the Centers for Medicare and Medicaid Services (CMS) where needed, DHCF may deny an application based on the current availability of services, the need to ensure program integrity, or other reasonable standards.

9401.9 Upon approval of an application, DHCF shall sign a provider agreement and send the provider a welcome letter that indicates the effective date of the signed provider agreement.

9401.10 The provider agreement shall be effective on the date it is signed by DHCF, except in the circumstances described at § 9401.11.

9401.11 In emergency circumstances, DHCF shall retain discretion to make the provider agreement retroactively effective to the date services were rendered. Emergency circumstances exist where a District Medicaid beneficiary is traveling outside the District when an emergency arises from an accident or illness and the health of the beneficiary would be endangered if:

(a) The beneficiary undertook travel to return to the District; or

(b) Medical care were postponed until the beneficiary returned to the District.

Section 9402 is amended to read as follows:

9402 APPLICATION FEE

9402.1 A provider may be required to remit an application fee at the time of submission of the application for initial enrollment, re-enrollment, or revalidation of enrollment. Assignment of application fees shall be subject to the following principles:

(a) The amount of the application fee is established annually by the CMS and published in the Federal Register.

(b) DHCF requires an application fee from all providers except the following:

(1) Individual physicians, non-physician practitioners, or other non-institutional providers;

(2) Providers that are enrolled in Medicare or another state's Medicaid program; and

(3) Providers that have remitted the applicable application fee to Medicare or another state's Medicaid program.

(c) Application fees are non-refundable.

9402.2 A provider may request a hardship exception to the application fee requirement by submitting a request to CMS. Any provider granted a hardship exception to the application fee requirement must include a copy of the notification from CMS with its application submitted to DHCF.

Section 9403 is amended to read as follows:

9403 MEDICAID PROVIDER SCREENING

9403.1 Pursuant to 42 CFR § 455.450, DHCF shall screen all applications for initial enrollment, re-enrollment, or revalidation of enrollment based on the level of categorical risk to which the provider type is assigned.

9403.2 All providers shall be assigned to one of the following categorical risk levels:

(a) Limited (subject to the screening requirements described in § 9404);

(b) Moderate (subject to the screening requirements described in § 9405); or

(c) High (subject to the screening requirements described in § 9406).

9403.3 A provider applying to enroll as multiple provider types shall be screened separately for each application submitted to DHCF.

9403.4 Pursuant to 42 CFR § 455.450(e), DHCF shall elevate the categorical risk level of a particular provider from "limited" or "moderate" to "high" risk when any of the following occurs:

(a) The provider has been excluded from federal health care programs by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services within the previous ten (10) years;

(b) The provider has been excluded from another state's Medicaid program within the previous ten (10) years;

(c) DHCF or CMS lifted a temporary moratorium for the particular provider type during the previous six (6) months, and a provider that had been prevented from enrolling based on the moratorium applies for enrollment at any time within six (6) months from the date the moratorium was lifted;

(d) Medicare elevates the categorical risk level for the provider type;

(e) DHCF has imposed a payment suspension against the provider based on a credible allegation of fraud, waste, or abuse; or

(f) The provider has an existing Medicaid overpayment.

9403.5 DHCF may rely on, but is not limited to, the results of provider screenings performed by:

(a) Medicare contractors;

(b) Federal and State Medicaid agencies, including CMS;

(c) Children's Health Insurance Programs (CHIP); or

(d) Other District agencies, including the Department of Health, the Department of Behavioral Health, and the Department on Disability Services.

Section 9404 is amended to read as follows:

9404 SCREENING PROVIDERS DESIGNATED AS "LIMITED" RISK

9404.1 Pursuant to 42 CFR § 455.450, any provider not designated as "moderate" risk or "high" risk under §§ 9405 or 9406 shall be assigned to the "limited" risk category.

9404.2 Screening for providers designated as "limited" risk shall include the following:

(a) Verification that the provider meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable federal and District laws and regulations;

(b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 CFR § 455.412; and

(c) Both pre- and post-enrollment Federal database checks in order to ensure the provider continues to meet the enrollment criteria that corresponds to its provider type, in accordance with 42 CFR § 455.436.

Section 9405 is amended to read as follows:

9405 SCREENING PROVIDERS DESIGNATED AS "MODERATE" RISK

9405.1 Pursuant to 42 CFR § 455.450, the following provider types shall be assigned to the "moderate" risk category:

(a) Adult day health service providers under the 1915(i) State Plan option;

(b) Ambulance service suppliers;

(c) Community mental health centers;

(d) Comprehensive outpatient rehabilitation facilities;

(e) Hospice organizations;

(f) Independent clinical laboratories;

(g) Independent diagnostic testing facilities;

(h) Intermediate Care Facilities for Individuals with Intellectual Disabilities;

(i) Pharmacies;

(j) Portable x-ray suppliers; and

(k) Providers of Home and Community Based Services (HCBS) under a 1915(c) waiver, including but not limited to the Elderly and Persons with Physical Disabilities (EPD) Waiver and the Individuals with Intellectual and Developmental Disabilities (IDD) Waiver.

9405.2 Screening for providers designated as "moderate" risk shall include the following:

(a) Verification that the provider meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable federal and District laws and regulations, including, where appropriate, the requirements of 42 CFR § 441.301(c);

(b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 CFR § 455.412;

(c) On-site visits conducted in accordance with 42 CFR § 455.432; and

(d) Both pre- and post-enrollment federal database checks in order to ensure the provider continues to meet the enrollment criteria that corresponds to its provider type, in accordance with 42 CFR § 455.436.

Section 9406 is amended to read as follows:

9406 SCREENING PROVIDERS DESIGNATED AS "HIGH" RISK

9406.1 Pursuant to 42 CFR § 455.450, the following provider types shall be assigned to the "high" risk category:

(a) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers;

(b) DMEPOS providers of medical alert devices and services;

(c) Home health agencies; and

(d) Other providers who have been elevated to the "high" risk category in accordance with § 9403.4.

9406.2 Screening for providers designated as "high" risk shall include the following:

(a) Verification that the provider meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25,

1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable federal and District laws and regulations, including, where appropriate, the requirements of 42 CFR § 441.301(c);

(b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 CFR § 455.412;

(c) On-site visits conducted in accordance with 42 CFR § 455.432;

(d) Criminal background checks, pursuant to 42 CFR § 455.434;

(e) Submission of fingerprints, pursuant to 42 CFR § 455.434, for all providers or individuals who maintain a five percent (5%) or greater direct or indirect ownership interest in the provider; and

(f) Both pre- and post-enrollment Federal database checks to ensure the provider meets and continues to meet the enrollment criteria corresponding to its provider type, in accordance with 42 CFR § 455.436.

Section 9407 is amended to read as follows:

9407 OWNERSHIP AND FINANCIAL DISCLOSURES

9407.1 Each disclosing entity, fiscal agent, and managed care entity shall disclose, at the time of application, the following information in accordance with 42 CFR § 455.104(a)-(e):

(a) The name and address of any individual or corporation with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities shall include as applicable primary business address, every business location, and P.O. Box address;

(b) Date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity;

(c) Other tax identification number of any corporation with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent (5%) or more interest;

(d) Whether the individual or corporation with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another individual with ownership or controlling interest in the disclosing entity (or fiscal agent or managed care entity) as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or

control interest in any subcontractor in which disclosing entity (or fiscal agent or managed care entity) has a five percent (5%) or more interest is related to another individual with ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) as a spouse, parent, child, or sibling;

(e) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest; and

(f) The name, address, date of birth, and SSN of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

9407.2 In addition to the disclosures required in § 9407.1, each entity described in § 9407.1 shall disclose at the time of application whether any individual with an ownership or control interest in the entity is an employee of the District government or is related to an employee of the District government as a spouse, parent, child, or sibling, and whether any individual employed by the provider is an employee of the District government.

9407.3 Disclosing entities shall also provide the disclosures and documentation required under §§ 9407.1 and 9407.2 at any of the following times:

(a) Upon submission of the application;

(b) Upon execution of the provider agreement;

(c) Upon request of DHCF during the revalidation of enrollment process; and

(d) Within thirty-five (35) calendar days following any change in ownership of the disclosing entity.

9407.4 Fiscal agents and managed care entities shall also provide the disclosures and documentation required under §§ 9407.1 and 9407.2 at any of the following times:

(a) Upon submission of a proposal in accordance with the District's procurement process;

(b) Upon execution, renewal, or extension of a contract with the District; and

(c) Within thirty-five (35) calendar days following any change in ownership of the fiscal agent or managed care entity.

Section 9408 is amended to read as follows:

9408 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING

9408.1 In accordance with 42 CFR § 455.434, a provider shall consent to criminal background checks, including fingerprinting, when required to do so under District laws and regulations or by the level of screening based on the risk of fraud, waste, or abuse as determined for that category of provider.

9408.2 For a provider categorized as "high" risk, the provider, or each individual with a five percent (5%) or greater direct or indirect ownership interest in the provider, shall submit fingerprints.

9408.3 Any other provider, or individual with a five percent (5%) or greater direct or indirect ownership interest in a provider, shall submit fingerprints upon request, in a form and manner as specified in the application, within thirty (30) calendar days from the date of the request from CMS or DHCF.

Section 9409 is amended to read as follows:

9409 SITE VISITS

9409.1 In accordance with 42 CFR § 455.432, DHCF shall conduct unannounced, pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" risk or "high" risk. Site visits shall be used to verify the following:

(a) The accuracy of the information submitted to DHCF;

(b) The operational status of the provider's business; and

(c) The provider's compliance with all applicable federal and District laws.

9409.2 For in-District providers, DHCF may conduct the required site visits or may, at DHCF's discretion, rely on the results of a site visit conducted by another District government agency.

9409.3 For out-of-District provider, DHCF may rely upon the results of a site visit conducted by either the appropriate government agency of the state in which the provider is located or the Medicare program.

9409.4 In circumstances where all other options have been exhausted, DHCF reserves the right to satisfy the site visit requirement through a telephonic survey.

9409.5 DHCF reserves the right to conduct unannounced site visits of any provider at any point during the screening process and/or period of District Medicaid enrollment.

9409.6 Providers are required to permit on-site inspections conducted by the U.S. Department of Health and Human Services, including CMS, the Department of Health (DOH), DHCF, or any designee selected by any of the aforementioned.

Section 9410 is amended to read as follows:

9410 DENIAL OF ENROLLMENT AND CONDITIONS FOR TERMINATION OF ENROLLMENT

9410.1 Upon the occurrence of any of the circumstances described in this Section, any action taken by DHCF to terminate an existing provider agreement shall occur in accordance with the Medicaid Program Administrative Procedures set forth in 29 DCMR §§ 1300 *et seq.*

9410.2 In accordance with 42 CFR §§ 455.416 and 455.452, DHCF shall deny an application for enrollment or initiate termination of the provider agreement in all of the following circumstances:

(a) The provider was terminated on or after January 1, 2011, under Title XVIII of the Social Security Act, or under the Medicaid program or Children's Health Insurance Program (CHIP) of any other state;

(b) Any individual with a five percent (5%) or greater direct or indirect ownership interest in the provider failed to submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E;

(c) The provider or any individual with an ownership or control interest in the provider, or who is an agent or managing employee of the provider, fails to submit timely or accurate information, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing;

(d) The provider, any individual with a five percent (5%) or greater direct or indirect ownership interest in the provider, or any individual who is an agent or managing employee of the provider, has been convicted of a criminal offense related to Medicare, Medicaid, or CHIP within the last ten (10) years, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing;

(e) The provider, or any individual with a five percent (5%) or greater direct or indirect ownership interest in the provider, fails to submit fingerprints in the form and manner determined by DHCF within thirty (30) calendar days of a request by CMS or DHCF, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing;

(f) The provider fails to permit access to provider locations for any site visits required pursuant to 42 CFR § 455.432, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing; or

(g) The provider fails to comply with the terms of the provider agreement or any applicable District Medicaid program rules or requirements.

9410.3 In accordance with 42 CFR §§ 455.416 and 455.452, DHCF may deny an application for enrollment or initiate termination of the provider agreement of a provider if CMS or DHCF determines any of the following:

(a) The provider falsified any information provided on or in support of the application;

(b) The provider made a material omission on the application; or

(c) The provider's identity cannot be verified.

9410.4 DHCF shall enforce all terminations that result from the Secretary of the U.S. Department of Health and Human Services mandatorily excluding individuals or entities from participating in any federal or state health care program, pursuant to 42 USC § 1320a-7(a), including any of the following:

(a) Conviction of program-related crimes;

(b) Conviction relating to patient abuse;

(c) Felony conviction relating to health care fraud; or

(d) Felony conviction relating to a controlled substance.

9410.5 DHCF shall enforce all terminations that result from the Secretary of the U.S. Department of Health and Human Services permissively excluding individuals and entities from participating in any federal or state health care program, pursuant to 42 USC § 1320a-7(b), for any of the following:

(a) Conviction relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(b) Conviction in connection with the interference with, or obstruction of, any investigation or audit related to the use of funds received, directly or indirectly, from any federally funded health care program;

(c) Misdemeanor conviction relating to a controlled substance;

(d) License revocation or suspension by a state licensing authority, including surrendering of such a license held while formal disciplinary proceeding is pending;

(e) Exclusion, suspension, or sanction from any federal or state program involving the provision of health care, including programs administered by the Department of Defense and Department of Veterans Affairs;

(f) Submission of claims reflecting excessive charges and/or unnecessary services;

(g) Failure to provide medically necessary services, and thereby adversely impacting covered individuals;

(h) Committing acts that constitute fraud, facilitate kickbacks, and/or support other prohibited activities, pursuant to 42 USC §§ 1320a-7a, 1320a-7b, or 1320a-8;

(i) Allowing a sanctioned individual to hold a five percent (5%) or greater direct or indirect ownership or control interest, serve as an officer, director, agent, or managing employee;

(j) Allowing an individual to hold a direct or indirect ownership or control interest in a sanctioned entity when the individual knows, or should know, of the action that resulted in conviction or exclusion from Medicare or a state health care program;

(k) Failure to disclose information required to process an application or revalidate enrollment, including requested information on subcontractors and/or suppliers;

(l) Failure to permit examination of records supporting payment;

(m) Failure to grant immediate access, upon reasonable request, to the Secretary, or designee; the Inspector General of the Department of Health and Human Services; or representatives of DHCF or the Medicaid Fraud Control Unit;

(n) Failure of a hospital to comply substantially with corrective action commenced in accordance with 42 USC § 1395ww(f)(2)(B);

(o) Default on health education loan or scholarship obligations by an individual, except physicians who provide unique services to the community serviced; or

(p) Making false statements or misrepresentation of material facts in any application, agreement, bid, or contract to participate or enroll as a provider or supplier under a federal health care program.

9410.6 DHCF shall adhere to federal guidelines governing terminations that occur pursuant to this Section, as set forth in §§ 1128C through 1128G of the Social Security Act (42 USC §§ 1320a-7c through 1320a-7h).

9410.7 In accordance with 42 CFR § 455.16, DHCF shall initiate termination proceedings against a provider when the results of its own investigation indicate that the provider has done any of the following:

(a) Made or caused to be made any false statement or misrepresentation of material fact in claiming, or in determining the right to, payment under the District Medicaid program;

(b) Furnished or ordered services under the District Medicaid program that are substantially in excess of the beneficiary's needs or that fail to meet professionally recognized standards for health care;

(c) Submitted or caused to be submitted to the District Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(d) Engaged in any other act of fraud or abuse related to the District Medicaid program.

9410.8 Nothing in this section shall supersede or lessen the force of any other laws or regulations that govern provider participation in the Medicaid program, including the Medicaid Fraud Enforcement and Recovery Amendment Act (D.C. Law 19-232; D.C. Official Code §§ 2-381.01 *et seq.* (2016 Repl.)) and any subsequent amendments thereto.

9410.9 Any provider who is classified as "limited" risk and who is denied enrollment or terminated from District Medicaid program participation shall be barred from participation with the District Medicaid program for three (3) years from the date of denial or termination.

9410.10 Any provider who is classified as "high" risk or "moderate" risk and who is denied enrollment or terminated from District Medicaid program participation shall be barred from participation with the District Medicaid program for five (5) years from the date of denial or termination.

9410.11 Any provider who is denied enrollment or terminated from District Medicaid program participation more than one (1) time shall be permanently barred from participation with the District Medicaid program.

9410.12 In accordance with Chapter 37 of Title 27 DCMR and Section III.A of the provider agreement, the Director may terminate a provider's enrollment with the District Medicaid program for convenience by serving written notice upon the provider in a manner that provides proof of receipt or proof of valid attempt to deliver (e.g. certified mail, return receipt requested, hand delivery) at least ninety (90) calendar days in advance of the proposed termination.

Section 9411 is amended to read as follows:

9411 NOTICE AND APPEALS

9411.1 If the Director proposes to deny enrollment to a provider pursuant to this chapter, then the Director shall send written notice to the affected party. The notice shall include the following:

(a) The basis and reasons for the proposed denial of enrollment;

(b) Information regarding the affected party's right to dispute the allegations and to submit evidence to support his or her position; and

(c) Specific reference to the particular sections of relevant statutes, rules, provider agreement, guidance, and provider manuals for any unmet screening requirement and any deficiencies cited.

9411.2 Within thirty (30) calendar days of the date on the notice, the affected party may submit to DHCF documentary evidence and accompanying written argument against the proposed denial of enrollment.

9411.3 If the Director decides to deny enrollment after the provider files a response, then the Director shall send written notice of the denial of enrollment to the provider. The notice shall include the following:

(a) The reason for the decision;

(b) The effective date of the decision;

(c) The earliest date on which the Director shall accept an application for enrollment;

(d) The requirements and procedures for enrollment in the District's Medicaid program; and

(e) Information regarding the provider's right to request a hearing by filing a notice of appeal with the Office of Administrative Hearings.

9411.4 If the provider files a notice of appeal within fifteen (15) calendar days of the date of the denial of enrollment, then the effective date of the proposed action shall be stayed pending a decision following final action by the Office of Administrative Hearings.

A new Section 9412 is added to read as follows:

9412 PROVIDER INACTIVITY

9412.1 DHCF may terminate enrollment of a provider due to inactivity if:

(a) A provider fails to submit the first claim under the provider number initially issued to the provider within a period of twelve (12) months from the date the provider number was issued by DHCF or its designee; or

(b) A provider number that has had at least one (1) Medicaid claim submitted for payment has no claim submitted under that provider number for twelve (12) consecutive months.

9412.2 At the conclusion of a period of twelve (12) consecutive months, during which there were no Medicaid claims submitted for payment under a particular provider number, DHCF shall issue a notice advising the provider of the pending termination of enrollment due to inactivity.

9412.3 A notice of termination due to provider inactivity shall:

(a) Be issued to the provider thirty (30) calendar days prior to action by DHCF;

(b) Be in writing;

(c) Be mailed to a provider's last known mailing address;

(d) State the reason for the termination due to inactivity;

(e) State the effective date of the termination due to inactivity; and

(f) Information regarding the provider's right to request a hearing by filing a notice of appeal with the Office of Administrative Hearings.

9412.4 A provider who seeks to remain in active status shall notify DHCF orally or in writing within thirty (30) calendar days of the date of the notice described at §§ 9412.2 and 9412.3.

9412.5 A provider who fails to notify DHCF pursuant to § 9412.4 shall be terminated upon the effective date stated in the notice described at §§ 9412.2 and 9412.3.

9412.6 DHCF shall not make payments for claims, submitted by any provider whose enrollment in has been terminated due to inactivity, for services rendered on or after the date of termination.

9412.7 All terminations initiated by the Director shall be in accordance with the District Medicaid Program Administrative Procedures set forth in Chapter 13 of Title 29 DCMR.

A new Section 9413 is added to read as follows:

9413 CHANGE OF OWNERSHIP

9413.1 The following shall constitute a change of ownership:

(a) For a Partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree that the removal, addition, or substitution of a partner shall not constitute a change of ownership;

(b) For unincorporated sole proprietorship, the transfer of title and property to another party;

(c) For a Corporation (for- and non-profit), the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership; and

(d) For Leasing, the lease of all or part of a provider facility constitutes change of ownership of the leased portion.

9413.2 For the purposes of this chapter, the change in ownership occurs on the closing date, or on the effective date of the sale/transfer as otherwise indicated in the agreement between the current owner and the prospective new owner.

9413.3 All providers enrolled in District Medicaid, except for those enrolled only as ordering, prescribing, and referring providers, as described at § 9400.16, shall comply with the change of ownership requirements set forth in this section. This includes any out-of-District providers enrolled in District Medicaid, which shall be subject to the same change of ownership requirements as providers located within the District.

9413.4 Nothing in this section exempts an enrolled provider entity from compliance with the bulk sales requirements set forth in 9 DCMR § 4400.

9413.5 The current owner of an enrolled provider entity must notify DHCF of any anticipated change of ownership no fewer than thirty (30) calendar days prior to the change in ownership by completing the required notice form, available on DHCF's

website at www.dc-medicaid.com, and submitting it to DHCF in accordance with the instructions provided on the notice form.

9413.6 The notice of an anticipated change in ownership referenced in § 9413.5 must include the following:

(a) An assurance that disclosure has been made to the prospective new owner that the sale/transfer of the enrolled provider entity includes all known and unknown outstanding Medicaid liabilities; and

(b) An assurance that a plan has been established to ensure continuity of care for all Medicaid beneficiaries currently receiving services from the enrolled provider entity.

9413.7 The prospective new owner must successfully complete enrollment in District Medicaid, in accordance with the requirements set forth in this Chapter, before the change in ownership occurs. DHCF shall not make payments for claims submitted by a provider not enrolled in District Medicaid on the date the services were rendered, in accordance with § 9400.2.

9413.8 DHCF may authorize provisional enrollment in District Medicaid in accordance with the following requirements:

(a) Provisional enrollment is limited to a Home Health Agency or DMEPOS provider awaiting CMS approval of an application for Medicare certification;

(b) The provider must meet all other District Medicaid screening and enrollment requirements set forth in § 9400; and

(c) Provisional enrollment will be limited to a period not to exceed twelve (12) months.

9413.9 When there is a change in ownership of an enrolled provider entity, the new owner shall be subject to the following:

(a) A new District Medicaid provider ID number will be assigned to the new owner of an enrolled provider entity; however, the new owner shall not be considered a "new provider" for the purposes of determining Medicaid reimbursement rates;

(b) A provider agreement will be assigned to the new owner of an enrolled provider entity; however, the new owner shall remain subject to any and all outstanding terms and conditions contained in the existing provider agreement, including any plans of correction and pending audit findings, until such terms are satisfied; and

(c) The new owner of an enrolled provider entity shall acquire any and all outstanding Medicaid liabilities of the previous owner, including any liabilities that were unknown at the time of the sale/transfer. All Medicaid liabilities due or payments made following the change of ownership, regardless of the date on which the corresponding service was rendered, shall be assigned to the new owner.

9413.10 DHCF reserves the right to exempt the sale/transfer of an enrolled provider entity from any of the requirements set forth in this section, including but not limited to the acquisition of outstanding Medicaid liabilities and the assignment of terms and conditions from the existing provider agreement, where DHCF determines that such exemption is in the policy interest, necessary to support continuity of care, necessary to ensure the availability of providers for a certain type of service, or for another reason as identified and approved by the Director.

A new Section 9414 is added to read as follows:

9414 FINANCIAL VIABILITY STANDARDS

9414.1 Each provider shall, at the time of application and upon request by DHCF, provide documented evidence of adequate financial resources to deliver all required services and operate a financially viable business, in accordance with the requirements below:

(a) Financial resources are considered adequate if the provider has available cash reserves or line of credit sufficient to operate for a continuous three (3) month period; and

(b) Documented evidence required of each provider includes current financial statements or pro forma compiled and approved by the managing officers of the corporation and an independent Certified Public Accountant (CPA).

9414.2 At the time of application and upon request by DHCF, each provider designated as "moderate" or "high" risk shall provide documentation of the following as proof of the provider's financial viability:

(a) A business plan, which shall include the following elements:

(1) A description of the provider's business entity (*e.g.*, location, ownership, corporate structure, provider's methods to obtain patients, and its plan to recruit and maintain staff);

(2) The number and functions of professional staff to be employed; and

(3) A listing of services to be provided, either directly by the provider or through contractual arrangements with existing providers.

(b) Financial accounting documents, which include a balance sheet, income and expense statement, and statement of cash flows for the first year of operation. All accounting documents required under this paragraph must be prepared in accordance with generally accepted accounting principles (GAAP);

(c) Copies of the provider's bank statements showing available cash reserves or an available line of credit sufficient to operate the entity for a three (3) month period;

(d) Proof of credit facilities or guarantees obtained from a financial institution or private entity;

(e) Adequate internal controls for safeguarding or avoiding misuse of federal and District government funds;

(f) Fiscal management policies and procedures and maintenance of financial records in accordance with GAAP; and

(g) A Clean Hands certificate issued by the District of Columbia Office of Tax and Revenue.

9414.3 Providers and disclosing entities shall also provide the documentation required under § 9414.2 at each of the following times:

(a) Upon submitting the application;

(b) Upon execution of the provider agreement;

(c) Upon request of DHCF during the revalidation process;

(d) Within thirty-five (35) calendar days following any change in ownership of the disclosing entity.

9414.4 At each revalidation of enrollment, any provider designated as "moderate" or "high" risk shall have a compilation by an independent or certified public accounting firm, and the resulting compilation report shall be consistent with formats recommended by the American Institute of Certified Public Accountants A copy of the compilation report and management letter shall be submitted to DHCF within one hundred twenty (120) calendar days after the close of the provider's fiscal year.

9414.5 Each provider shall maintain proof of liability insurance coverage, which must include malpractice insurance of at least three million dollars ($3,000,000) aggregate and one million dollars ($1,000,000) per incident and comprehensive general coverage of at least three million dollars ($3,000,000) per incident that covers general liability, vehicular liability, and property damage. The insurance shall include coverage of all personnel, consultants, and volunteers working for the provider.

9414.6 Each provider shall ensure that all employees are paid in accordance with all applicable laws governing labor and employment as a condition of participation in the District Medicaid program.

9414.7 Each provider shall ensure that all business records pertaining to costs, payments received and made, and services provided to beneficiaries are maintained for a period of at least ten (10) years or until all audits and ongoing litigation is complete, whichever is longer.

A new Section 9415 is added to read as follows:

9415 UNIVERSAL CONTRACTING

9415.1 Effective October 1, 2020, all enrolled hospitals, hospital-affiliated physician groups, Federally Qualified Health Centers (FQHC), and FQHC Look-Alikes shall be required to contract with District Medicaid managed care organizations for the same scope of services set forth in their Medicaid provider agreements with DHCF.

Section 9499 is amended to read as follows:

9499 DEFINITIONS

9499.1 For the purposes of this chapter, the following terms shall have the meanings ascribed:

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the District Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Disclosing Entity - A prospective or enrolled Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Fiscal Agent - A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Federal Health Care Program - Shall have the meaning ascribed in 42 USC § 1320a-7b(f).

FQHC Look-Alike – Community-based health care providers that meet the requirements of the Health Resources and Services Administration Health Center Program, established in accordance with Section 330 of the Public Health Service Act, but do not receive Health Center Program funding.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person, including any act that constitutes fraud under applicable federal or District law.

Hospital-Affiliated Physician Group – An entity or group of licensed physicians operating under the terms of a contract or other business arrangement with a hospital for the purposes of managing a health care practice or providing medical services to patients.

In-District Provider - A prospective or enrolled Medicaid provider located inside of the District of Columbia Consolidated Metropolitan Statistical Area, as defined by the United States Census Bureau.

Indirect Ownership Interest - An ownership interest in an entity that has any ownership interest, direct or indirect, in the disclosing entity.

Medicaid Provider – Any District Medicaid-enrolled health care provider, including individual practitioners, institutional providers, and suppliers of medical equipment or goods related to care.

Medicaid Provider Application - The general or provider-specific application developed by DHCF and required to initiate participation as a District Medicaid provider.

Out-of-District Provider – A prospective or enrolled Medicaid provider located outside of the District of Columbia Consolidated Metropolitan Statistical Area, as defined by the United States Census Bureau.

Ownership Interest - The possession of equity in the capital, stock or profits of a disclosing entity, including a direct or indirect ownership interest.

Provider – A prospective or enrolled Medicaid provider, including any individual practitioner, institutional provider, suppliers of medical equipment or goods, corporate entity, or principals and directors of such corporate entity.

Provider Agreement - Official enrollment document establishing roles, responsibilities, and rights of a District Medicaid provider.

Qualified Medicare Beneficiary - An individual entitled to Medicare Part A, with or without payment of premiums, whose entitlement is not solely based on

eligibility to enroll under Section 1818A of the Social Security Act and who meets certain financial requirements.

Comments on these rules should be submitted in writing to Melisa Byrd, Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street N.W., Suite 900S, Washington, D.C. 20001, via telephone at (202) 442-8742, or via email at DHCFPubliccomments@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.