

## DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02 (2016 Repl. & 2018 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 adoption of an amendment to Chapter 65 (Medicaid Reimbursement to Nursing Facilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

DHCF is amending the reimbursement methodology to nursing facilities participating in the District's Medicaid program beginning February 1, 2018. These rules set forth the revised methodology and requirements governing Medicaid reimbursement of nursing facilities. Major highlights of the reimbursement methodology include: 1) continuation of prospective rates that are refined to avoid the continuous cycle of adjusting rates and claims; 2) specific per diem rates for each patient; 3) availability of add-on payments for special needs patients who require ventilator or bariatric care or who are behaviorally complex; and 4) the creation of a new quality improvement program, including mandatory reporting and a performance payment for participating District nursing facilities that demonstrate improvement or maintain a high level of performance across a set of quality improvement measures.

This methodology ensures that similar facilities are paid similar reimbursement rates for similar patients, and that facilities receive immediate financial benefit when admitting higher acuity patients. The methodology also eliminates the need for quarterly census and case mix calculation requirements under the prior methodology. Finally, new quality reporting requirements and the availability of quality-related supplemental payments will incent nursing facilities to develop the infrastructure, processes, and reporting mechanisms necessary to implement future quality improvement and payment reform initiatives.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on January 19, 2018, at 65 DCR 000460. One (1) set of comments was received from the District of Columbia Health Care Association (DCHCA). DHCF carefully considered all comments received and made some changes in response to the comments received. In addition, DHCF is making changes pursuant to requests from the Centers for Medicare and Medicaid Services (CMS) to support approval of the accompanying State Plan Amendment (SPA), which was approved by CMS on March 15, 2018. A Notice of Second Emergency and Proposed Rulemaking was published in the *D.C. Register* on March 22, 2019, at 66 DCR 003515. DHCF received no comments and made no changes to this rulemaking.

The estimated aggregate fiscal impact of the new reimbursement methodology is an increase of \$2,771,588.00 in fiscal year (FY) 2018 and an increase of \$2,692,539.00 in FY 2019.

These rules correspond to a related SPA, which was approved by CMS and the Council of the District of Columbia (Council). The Council authorized the SPA in the “Fiscal Year 2017 Budget Support Act of 2016,” effective October 8, 2016 (D.C. Law 21-160; D.C. Official Code § 1-307.02 (2016 Repl.)). The SPA was approved by CMS on March 15, 2018 with an effective date of February 1, 2018.

These rules were adopted as final on October 2, 2019 and shall be effective upon publication in the *D.C. Register*.

**Chapter 65, MEDICAID REIMBURSEMENT TO NURSING FACILITIES, of Title 29 DCMR, PUBLIC WELFARE, is deleted in its entirety and replaced with the following:**

**CHAPTER 65            MEDICAID REIMBURSEMENT TO NURSING FACILITIES**

<b>6500</b>	<b>GENERAL PROVISIONS</b>
<b>6501</b>	<b>REIMBURSEMENT OF DISTRICT NURSING FACILITIES</b>
<b>6502</b>	<b>COMPUTATION OF PRICE AND FLOOR</b>
<b>6503</b>	<b>RESIDENT ASSESSMENT</b>
<b>6504</b>	<b>RESIDENT CLASSIFICATION SYSTEM</b>
<b>6505</b>	<b>FACILITY NURSING AND RESIDENT CARE COSTS PER DIEM CALCULATION</b>
<b>6506</b>	<b>FACILITY ROUTINE AND SUPPORT COSTS PER DIEM CALCULATION</b>
<b>6507</b>	<b>FACILITY CAPITAL-RELATED COSTS PER DIEM CALCULATION</b>
<b>6508</b>	<b>VENTILATOR CARE</b>
<b>6509</b>	<b>VENTILATOR CARE DISCHARGE</b>
<b>6510</b>	<b>VENTILATOR CARE REIMBURSEMENT</b>
<b>6511</b>	<b>BEHAVIORALLY COMPLEX CARE</b>
<b>6512</b>	<b>BEHAVIORALLY COMPLEX CARE REIMBURSEMENT</b>
<b>6513</b>	<b>BARIATRIC CARE</b>
<b>6514</b>	<b>BARIATRIC CARE REIMBURSEMENT</b>
<b>6515</b>	<b>ALLOWABLE COSTS</b>
<b>6516</b>	<b>EXCLUSIONS FROM ALLOWABLE COSTS</b>
<b>6517</b>	<b>REBASING AND ANNUAL RATE ADJUSTMENTS</b>
<b>6518</b>	<b>REIMBURSEMENT FOR NEW PROVIDERS</b>
<b>6519</b>	<b>REIMBURSEMENT FOR REORGANIZED FACILITIES, EXPANDED FACILITIES, REDUCED CAPACITY, OR CHANGE OF OWNERSHIP</b>
<b>6520</b>	<b>REIMBURSEMENT FOR OUT OF STATE FACILITIES</b>
<b>6521</b>	<b>COST REPORTING AND RECORD MAINTENANCE</b>
<b>6522</b>	<b>ACCESS TO RECORDS</b>
<b>6523</b>	<b>APPEALS</b>
<b>6524</b>	<b>NURSING FACILITY QUALITY IMPROVEMENT PROGRAM</b>
<b>6525</b>	<b>PARTICIPATION IN THE NURSING FACILITY QUALITY IMPROVEMENT PROGRAM</b>
<b>6526</b>	<b>NFQII PERFORMANCE SCORING</b>

**6527 NURSING FACILITY QUALITY OF CARE FUND AND NFQII  
6599 PERFORMANCE PAYMENT  
DEFINITIONS**

**6500 GENERAL PROVISIONS**

6500.1 The purpose of this chapter is to establish principles of reimbursement for nursing facilities participating in the District of Columbia Medicaid program.

6500.2 Medicaid reimbursement to nursing facilities for services provided beginning February 1, 2018 shall be on a prospective payment system consistent with the requirements set forth in this chapter.

6500.3 In order to receive Medicaid reimbursement, each nursing facility shall enter into a provider agreement with the Department of Health Care Finance (DHCF) for the provision of nursing facility 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).

6500.4 As a condition of Medicaid reimbursement, each nursing facility shall be licensed as a nursing home pursuant to the requirements set forth in the "Health Care and Community Residence License Act of 1983," effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.* (2012 Repl.)) and meet the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR part 483.

6500.5 Medicaid reimbursement for nursing facility services to a Medicaid beneficiary shall not be provided unless the Medicaid beneficiary has been determined clinically eligible for nursing facility services in accordance with 29 DCMR § 989 and District policy guidance.

**6501 REIMBURSEMENT OF DISTRICT NURSING FACILITIES**

6501.1 Each nursing facility located in the District of Columbia shall be reimbursed by Medicaid for a patient specific per diem rate for each resident in accordance with the formula set forth in § 6501.2. The rate shall be prospective and only include allowable cost described in §§ 6501.9, 6501.10, and 6501.11.

6501.2 The Medicaid reimbursable patient specific per diem rate shall equal the sum of:

- (a) The product of the resident's Resource Utilization Group (RUG) weight as described in § 6504 and the facility specific per diem for nursing and patient care price described in §§ 6502.3 and 6505.7;

- (b) The facility specific per diem for routine and support price described in § 6502.2; and
  - (c) The facility specific per diem for capital cost described in § 6507.
- 6501.3 In addition to the patient specific rate described in § 6501.2, each nursing facility may receive an add-on payment for each resident who is:
- (a) Receiving ventilator care pursuant to the requirements set forth in §§ 6508-6510;
  - (b) Qualifying as behaviorally complex pursuant to the requirements set forth in §§ 6511-6512; and
  - (c) Qualifying as bariatric pursuant to the requirements set forth in §§ 6513-6514.
- 6501.4 The patient specific rate described in § 6501.2 is developed by establishing a base year facility specific per diem rate using three (3) cost categories as described in § 6501.8.
- 6501.5 Each nursing facility shall be classified into three (3) peer groups as described in § 6502.
- 6501.6 The base year per diem price for each peer group is a per diem rate that is calculated using the allowable costs for the base year for all Medicaid-participating nursing facilities in the District. The base year used to establish February 1, 2018 rates is the 2015 cost report year.
- 6501.7 Except for depreciation, amortization, and interest on capital-related expenditures, the base year allowable costs calculated for each nursing facility shall be adjusted to a common end date, the mid-point of the District rate year, using the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System Skilled Nursing Facility Input Price Index.
- 6501.8 The base year per diem rate for nursing and resident care services and routine and support services for each peer group and the facility specific capital cost per diem is based on the allowable base year costs and shall be developed using three (3) cost categories:
- (a) Routine and support expenditures, as described in § 6501.9;
  - (b) Nursing and resident care expenditures as described in § 6501.10; and
  - (c) Capital-related expenditures, as described in § 6501.11.

- 6501.9 Routine and support expenditures shall include expenditures for:
- (a) Dietary and nutrition services, including raw food;
  - (b) Laundry and linen;
  - (c) Housekeeping;
  - (d) Plant operations and related clerical support;
  - (e) Volunteer services;
  - (f) Administrative and general salaries;
  - (g) Professional services - non-healthcare related;
  - (h) Non-capital related insurance;
  - (i) Travel and entertainment;
  - (j) General and administrative costs;
  - (k) Medical Director and related clerical costs;
  - (l) Non-capital related interest expense;
  - (m) Social services;
  - (n) Resident Activities;
  - (o) Staff development;
  - (p) Medical Records;
  - (q) Routine personal hygiene items and services;
  - (r) Utilization review;
  - (s) Central supplies; and
  - (t) Other miscellaneous expenses as noted on the nursing facility's cost report submitted pursuant to § 6521.
- 6501.10 Nursing and resident care costs shall include the costs of:
- (a) Nursing services;

- (b) Non-prescription drugs and pharmacy consultant services;
- (c) Medical supplies;
- (d) Laboratory services;
- (e) Radiology services;
- (f) Physical, speech, and occupational therapy services that are provided to Medicaid beneficiaries;
- (g) Respiratory therapy;
- (h) Behavioral health services; and
- (i) Oxygen therapy.

6501.11 Capital-related costs shall include the costs of:

- (a) Equipment rental;
- (b) Depreciation and amortization;
- (c) Interest on capital debt;
- (d) Facility rental;
- (e) Real estate taxes and capital-related insurance;
- (f) Property insurance; and
- (g) Other capital-related expenses.

6501.12 Provider tax expenses shall not be included in calculating the base year costs.

6501.13 The costs attributable to paid feeding assistants provided in accordance with the requirements set forth in 42 CFR parts 483 and 488 shall be included in nursing and resident care costs for base years beginning on or after October 27, 2003.

6501.14 When necessary, each facility specific per diem rate will be reduced by the same percentage to maintain compliance with the Medicare upper payment limit requirement.

6501.15 DHCF may approve an adjustment to the facility specific per diem rate if the facility demonstrates that it incurred higher costs due to extraordinary

circumstances beyond its control, including but not limited to a strike, fire, flood, earthquake, or similar unusual occurrences with substantial cost effects.

6501.16 Each adjustment pursuant to § 6501.15 shall be made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the facility, and verified by DHCF. Any such adjustment will be applicable only to the affected facility, shall be time limited, and shall not impact the peer group price.

## 6502 COMPUTATION OF PRICE AND FLOOR

6502.1 DHCF shall classify each nursing facility operating in the District and participating in the Medicaid program into three (3) peer groups:

- (a) Peer Group One - All freestanding nursing facilities, with more than seventy-five (75) Medicaid certified beds;
- (b) Peer Group Two - All freestanding nursing facilities with seventy-five (75) or fewer Medicaid certified beds; and
- (c) Peer Group Three - All hospital-based nursing facilities.

6502.2 The routine and support per diem price for each peer group shall be the day-weighted median cost per diem as described in § 6506 multiplied by a peer group specific factor. The peer group specific factors used in this formula will be posted on the DHCF website at <https://dhcf.dc.gov/page/medicaid-reimbursement-nursing-facilities-participating-district-columbia-medicaid-program>. To the extent that changes to these factors are needed in future, DHCF will publish notice in the *D.C. Register* thirty (30) days in advance of any changes and post the updated factors on the DHCF website at the link noted above.

6502.3 The nursing and resident care price for each peer group shall be the day-weighted median case mix neutralized cost per diem as described in § 6505 multiplied by a peer group specific factor. The peer group specific factors used in this formula will be posted on the DHCF website at <https://dhcf.dc.gov/page/medicaid-reimbursement-nursing-facilities-participating-district-columbia-medicaid-program>. To the extent that changes to these factors are needed in future, DHCF will publish notice in the *D.C. Register* thirty (30) days in advance of any changes and post the updated factors on the DHCF website at the link noted above.

6502.4 For the rate period beginning February 1, 2018, DHCF has applied a fixed percentage of the peer group price in calculating the peer group floor. Each facility's case mix adjusted Medicaid cost per day is subject to the floor, which is a fixed percentage of the peer group price. The fixed percentage used in this calculation will be posted on the DHCF website at: <https://dhcf.dc.gov/page/medicaid-reimbursement-nursing-facilities-participating->

district-columbia-medicaid-program. To the extent that changes to this percentage are needed in future, DHCF will publish notice in the *D.C. Register* thirty (30) days in advance of any changes and post the updated percentage on the DHCF website at the link noted above.

- 6502.5 Once nursing facilities have been classified into peer groups for the purpose of establishing the peer group prices, the nursing facility price for each peer group shall apply to all facilities in that peer group until Medicaid rates are rebased, or until DHCF makes an adjustment to the price or floor.
- 6502.6 DHCF shall publish a public notice in the *D.C. Register* and on the DHCF website setting forth the reimbursement methodology for each District nursing facility at least thirty (30) calendar days prior to implementation. In addition, DHCF shall issue individualized notices that detail facility-specific reimbursement rates to each participating nursing facility at least thirty (30) days prior to February 1, 2019. DHCF shall post notice of the final rates on the DHCF website upon approval of the reimbursement methodology by the U.S. Health and Human Services, Centers for Medicare and Medicaid Services (CMS). A public notice of any changes to the reimbursement rates shall be published in the *D.C. Register* at least thirty (30) calendar days in advance of the changes.

### **6503 RESIDENT ASSESSMENT**

- 6503.1 Each nursing facility shall complete an assessment of each resident's functional, medical and psycho-social capacity consistent with the requirements set forth in 42 CFR § 483.20.
- 6503.2 The Minimum Data Set (MDS), Version 3.0 or successor updates to this version, shall be used by each nursing facility.
- 6503.3 Each nursing facility shall comply with the policies set forth in the October 2016 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual for the MDS Version 3.0 or successor updates to this version.

### **6504 RESIDENT CLASSIFICATION SYSTEM**

- 6504.1 DHCF shall use the forty-eight (48)-group resident classification system developed by CMS known as the Resource Utilization Groups IV (RUGS IV), Version 1.03 or successor updates.
- 6504.2 DHCF shall use the Case Mix Indices known as the standard data set F01 developed by CMS or successor updates to this version.
- 6504.3 Each resident assessed under RUGS shall be assigned the highest numeric case mix index (CMI) score for which the resident qualifies. Assessments that cannot



be classified to a RUGS IV category due to errors shall be assigned the category with the lowest numeric CMI score.

- 6504.4 The most recent valid MDS assessment for the resident shall be used by the nursing facility when submitting the RUG category on the claim for services.
- 6504.5 The RUG category shall be included on the claim for services as a valid Health Insurance Prospective Payment System (HIPPS) code.
- 6504.6 The CMI for the submitted RUG category will be used to adjust the nursing and resident care portion of the facility specific per diem during claims adjudication.
- 6504.7 If subsequent review of the medical record, or the MDS reveals that the RUG category submitted as a HIPPS code on the claim is incorrect, the claim will be reprocessed with the appropriate HIPPS code, RUG category, and CMI.

**6505 FACILITY NURSING AND RESIDENT CARE COSTS PER DIEM CALCULATION**

- 6505.1 Each nursing facility's allowable nursing and resident care Medicaid reimbursable costs shall be adjusted in accordance with § 6505.4.
- 6505.2 The total resident days shall be determined in accordance with § 6515.2.
- 6505.3 The amount calculated in § 6505.1 shall be divided by the Total Facility Case Mix Index to establish case mix neutral costs. This process is known as case mix neutralization. For the base year, total facility case mix will be the average facility-wide case mix for the three calendar quarters beginning January 1, 2015 and ending September 30, 2015.
- 6505.4 For nursing and resident care costs other than the cost for speech therapy, occupational therapy, and physical therapy, the case mix neutral costs established in § 6505.3 shall be divided by the resident days calculated in accordance with § 6505.2 to determine each nursing facility's nursing and resident care cost per diem without physical, speech and occupational therapy services.
- 6505.5 Per diem costs for physical, speech and occupational therapy services shall be calculated by dividing such costs by total Medicaid resident days. The resulting per diem shall be added to the per diem for nursing and resident care costs, excluding the costs for speech therapy, occupational therapy, and physical therapy. The resulting sum of the per diems shall comprise each nursing facility's nursing and resident care cost per diem unadjusted for case mix.
- 6505.6 The peer group price established in accordance with § 6505.3 for nursing and resident care costs for each peer group shall be reduced for any facility whose nursing and resident care cost per diem adjusted for Medicaid case mix does not

meet the established minimum percentage of the Medicaid case mix adjusted peer group price (the “floor”).

6505.7 The difference between the facility Medicaid case mix adjusted cost per diem and the floor is subtracted from the Medicaid case mix adjusted peer group price for that facility. The resulting value is divided by the facility Medicaid case mix to determine the facility specific nursing and resident care Medicaid case mix neutral per diem price. In the base year, the Medicaid case mix used in the calculations in §§ 6505.6 and 6505.7 is the average case mix for the quarters ending June 30, 2016 and September 30, 2016.

6505.8 For rebasing periods after February 1, 2018, the nursing and resident care cost per diem shall be adjusted for Medicaid case mix using the day-weighted average Medicaid case mix of the preceding federal fiscal year for each facility, based on the Medicaid case mix of final paid claims for that facility for nursing facility services.

#### **6506 FACILITY ROUTINE AND SUPPORT COSTS PER DIEM CALCULATION**

6506.1 In the base year, each facility’s routine and support cost per diem shall be established by dividing total allowable routine and support base year costs adjusted in accordance with § 6501.7 by total resident days determined in accordance with § 6515.2 for all nursing care residents.

6506.2 Each nursing facility's routine and support price per diem shall be the per diem price calculated for the facility’s assigned peer group in § 6502.2.

#### **6507 FACILITY CAPITAL-RELATED COSTS PER DIEM CALCULATION**

6507.1 Each nursing facility's capital-related cost per diem shall be calculated by dividing total allowable capital-related base year costs adjusted in accordance with § 6501.7 by total resident days determined in accordance with § 6515.2 for all nursing care residents.

6507.2 For all rate periods on or after February 1, 2018, the capital cost per diem calculated in the base year shall apply to all subsequent rate periods, until the next rebasing period.

#### **6508 VENTILATOR CARE**

6508.1 In addition to the patient specific per diem rate described in § 6501.2, DHCF shall pay an additional per diem amount for any day that a resident qualifies for and receives ventilator care pursuant to the requirements set forth in §§ 6508 through 6510.

- 6508.2 Each resident receiving ventilator care shall meet all of the following requirements:
- (a) Be ventilator dependent and not able to breathe without mechanical ventilation;
  - (b) Use the ventilator for life support, sixteen (16) hours per day, seven (7) days per week;
  - (c) Have a tracheostomy or endotracheal tube;
  - (d) At the time of placement the resident has been ventilator dependent during a single stay or continuous stay at a hospital, skilled nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID);
  - (e) Have a determination by the resident's physician and respiratory care team that the service is medically necessary, as well as documentation which describes the type of mechanical ventilation, technique and equipment;
  - (f) Be medically stable, without infections or extreme changes in ventilatory settings and/or duration (increase in respiratory rate by five (5) breaths per minute, increase in FiO<sub>2</sub> of twenty-five percent (25%) or more), and/or increase in tidal volume of two-hundred milliliters (200 mls) or more at time of placement;
  - (g) Require services on a daily basis which cannot be provided at a lower level of care; and
  - (h) Require services be provided under the supervision of a licensed health care professional.
- 6508.3 Each nursing facility shall comply with all of the standards governing ventilator care services set forth in 22-B DCMR § 3215.
- 6508.4 Ventilator care shall be prior-authorized by DHCF. The following documents shall be required for each authorization:
- (a) Level of Care determination;
  - (b) Pre-admission Screening and Annual Resident Review (PASARR) forms;
  - (c) Admission history;
  - (d) Physical examination reports;

- (e) Surgical reports; and
- (f) Consultation reports and ventilator dependent addendum.

6508.5 For purposes of this section the term “medically necessary” shall mean a service that is required to prevent, identify, or treat a resident's illness, injury or disability and meets the following standards:

- (a) Consistency with the resident's symptoms, or with prevention, diagnosis, or treatment of the resident's illness or injury;
- (b) Consistency with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
- (c) Appropriateness with regard to generally accepted standards of medical practice;
- (d) Is not medically contraindicated with regard to the resident's diagnosis, symptoms, or other medically necessary services being provided to the resident;
- (e) Is of proven medical value or usefulness, and is not experimental in nature;
- (f) Is not duplicative with respect to other services being provided to the resident;
- (g) Is not solely for the convenience of the resident;
- (h) Is cost-effective compared to an alternative medically necessary service which is reasonably acceptable to the resident based on coverage determinations; and
- (i) Is the most appropriate supply or level of service that can safely and effectively be provided to the resident.

**6509 VENTILATOR CARE DISCHARGE**

6509.1 Each provider shall ensure that residents are weaned from the ventilator when weaning is determined to be medically appropriate.

6509.2 A provider shall discontinue weaning and resume mechanical ventilation if the resident experiences any of the following:

- (a) Blood pressure elevation of more than twenty (20) millimeters of mercury (mmHg) systolic or more than ten (10) mmHg diastolic;
- (b) Heart rate of more than ten percent (10%) above the baseline or a heart rate of one-hundred twenty (120) beats per minute;
- (c) Respiratory rate increase of more than ten (10) breaths per minute or a rate above thirty (30) breaths per minute;
- (d) Arrhythmias;
- (e) Reduced tidal volume;
- (f) Elevated partial pressure of arterial carbon dioxide;
- (g) Extreme anxiety;
- (h) Dyspnea; or
- (i) Accessory muscle use in breathing or an otherwise deteriorating breathing pattern.

6509.3 Each nursing facility shall have an appropriate program for discharge and weaning from the ventilator.

6509.4 The nursing facility shall ensure that the resident and all caregivers be trained in all aspects of mechanical ventilation and demonstrate proficiency in ventilator care techniques before a ventilator-dependent resident can be discharged home on a mechanical ventilator.

6509.5 The physician and respiratory team shall arrange a schedule for follow-up visits, as indicated by the needs of the resident.

6509.6 A written discharge plan shall be provided to and reviewed with the resident and resident's caregiver and shall include at a minimum the following information:

- (a) Name, address, and telephone number of the primary physician;
- (b) Address and telephone number of the local hospital emergency department;
- (c) Name, address and telephone number of the physician for regular respiratory check-ups, if different from the physician identified in § 6509.6(a);
- (d) The responsibilities of the resident and caregiver in daily ventilator care;

- (e) Identification of financial resources for long-term care;
- (f) Identification of community resources for health, social, educational and vocational needs;
- (g) An itemized list of all equipment and supplies needed for mechanical ventilation;
- (h) Names, addresses and telephone numbers of mechanical ventilation equipment dealers and a list of services that they provide; and
- (i) Contingency plans for emergency situations.

6509.7 The nursing facility shall notify DHCF of the date of discharge from the facility.

#### **6510 VENTILATOR CARE REIMBURSEMENT**

6510.1 The add-on reimbursement rate for ventilator care shall be three hundred eighty dollars (\$380.00) per day for each resident. A public notice of any changes in the ventilator care reimbursement rate shall be published in the *D.C. Register* at least thirty (30) calendar days in advance of the changes.

#### **6511 BEHAVIORALLY COMPLEX CARE**

6511.1 In addition to the patient specific per diem rate described in § 6501.2, DHCF shall pay an additional per diem amount for any day that a resident qualifies as behaviorally complex pursuant to the definition set forth in § 6511.2.

6511.2 A behaviorally complex resident is defined as one who demonstrates two (2) or more of the following categories of behaviors, with at least one (1) behavior occurring four (4) or more days per week:

- (a) Demonstrates self injury, including head banging, self-biting, hitting oneself, or throwing oneself to floor with or without injury;
- (b) Demonstrates physical aggression, including assaulting other residents, staff, or property with or without injury to other residents or staff;
- (c) Demonstrates verbal aggression, including disruptive sounds, noises, screaming that disturbs roommate, staff or other residents;
- (d) Demonstrates aggressive behaviors, including sexual behaviors, disrobing, throwing or smearing food, feces, stealing, hoarding, going through other residents' or staff belongings, or elopement attempts; or

(e) Consistently rejects medical care.

6511.3 Reimbursement for behaviorally complex residents shall be prior authorized by DHCF. Medical records including the MDS, nursing progress notes, and incident reports supporting experience of behavior, including documentation of disruptive behavior within the last thirty (30) days is required for prior authorization. The documentation shall support that a resident meets the definition set forth in § 6511.2.

6511.4 If the resident has transferred within the last thirty (30) days, the documentation shall include the records from the referring facility.

6511.5 DHCF may authorize reimbursement of the add-on rate not to exceed ninety (90) consecutive days. Any subsequent reimbursement after expiration shall require prior authorization.

## **6512 BEHAVIORALLY COMPLEX CARE REIMBURSEMENT**

6512.1 The add-on reimbursement rate for behaviorally complex care shall be eighty-two dollars (\$82.00) per day for each resident. A public notice of any changes in the behaviorally complex care reimbursement rate shall be published in the *D.C. Register* at least thirty (30) calendar days in advance of the changes.

## **6513 BARIATRIC CARE**

6513.1 In addition to the patient specific per diem rate described in § 6501.2, DHCF shall pay an additional per diem amount for any day that a resident qualifies as a bariatric resident pursuant to the requirements set forth in § 6513.2.

6513.2 A bariatric resident is defined as one who:

- (a) Has a body mass index (BMI) of forty (40) or higher; and
- (b) Requires the assistance of two or more staff for three (3) or more Activities of Daily Living (ADL) during the most recent MDS assessment period.

6513.3 Reimbursement for bariatric residents shall be prior authorized by DHCF. The following documentation is required for authorization:

- (a) Medical records including MDS documenting the resident's height, weight and calculation of BMI; and
- (b) A description of the resident's ADL assistance needs, including the relevant section of the most recent MDS assessment demonstrating the need for assistance of two or more staff for three (3) or more ADLs.

**6514 BARIATRIC CARE REIMBURSEMENT**

6514.1 The add-on reimbursement rate for bariatric care shall be thirty-nine dollars (\$39.00) per day for each resident. A public notice of any changes in the bariatric care reimbursement rate shall be published in the *D.C. Register* at least thirty (30) calendar days in advance of the changes.

**6515 ALLOWABLE COSTS**

6515.1 Allowable costs shall include items of expense the provider incurs in the provision of routine services related to resident care including:

- (a) Room and board, including dietary and nutrition services, food, laundry and linen, housekeeping, routine personal hygiene items and services, plant operations and maintenance;
- (b) Medical direction;
- (c) Nursing care;
- (d) Medical and surgical supplies;
- (e) Social services
- (f) Resident activities;
- (g) Special services required by the resident, including physical, occupational, or speech therapy, oxygen therapy, but not dental care;
- (h) Incontinency care;
- (i) Behavioral Health services;
- (j) Canes, crutches, walkers and wheelchairs, excluding customized wheelchairs;
- (k) Traction equipment and other durable medical equipment for multi resident use;
- (l) Special dietary services, including tube or hand feeding and special diets;
- (m) Laundry services, including basic personal laundry; and
- (n) Other allowable expenses as determined by DHCF and identified in policy guidance.



- 6515.2 The occupancy rate used in determining the per diem rate for each cost category shall be the greater of:
- (a) The actual total facility paid occupancy, including paid reserved bed days; or
  - (b) Ninety-three percent (93%) of certified total facility bed days available during the cost reporting period.
- 6515.3 General and administrative expenses shall include but not be limited to:
- (a) Administrative salaries, including fringe benefits;
  - (b) Professional services, including accounting and auditing expenses, fees of management consultants and legal fees;
  - (c) General liability insurance;
  - (d) Telephone;
  - (e) Licenses;
  - (f) Travel and entertainment;
  - (g) Office expenses, including services and supplies;
  - (h) Personnel and procurement;
  - (i) Dues and subscriptions;
  - (j) Home office costs;
  - (k) Interest on working capital; and
  - (l) Occupational Safety and Health Administration costs.
- 6515.4 Depreciation allowance shall be determined in accordance with the Medicare Principles of Reimbursement set forth at 42 CFR part 413 subpart G, except that:
- (a) Only the straight line method shall be used; and
  - (b) The useful life of the assets must comply with the most recent guidelines for hospitals published by the American Hospital Association and approved by the Medicare program.

- 6515.5 Consistent use of either the component or composite asset depreciation schedule shall be required, as follows:
- (a) Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined; and
  - (b) Composite depreciation shall be applied for a newly purchased existing facility.
- 6515.6 Donated assets shall be recorded at fair market value at the time received, based on the lesser of at least two bona fide appraisals.
- 6515.7 Leasehold improvements shall be depreciated over the lesser of the asset's useful life or the remaining life of the lease.
- 6515.8 When a facility is sold, the depreciation basis shall be subject to the limitation of the reevaluation of assets mandated by § 1861(v)(1)(O) of Title XVIII of the Social Security Act.
- 6515.9 Necessary and proper interest on both current and capital indebtedness shall be allowable costs, determined in accordance with the Medicare Principles of Reimbursement set forth at 42 CFR § 413.153.
- 6515.10 Bad debts, charity, and courtesy allowances, as defined at 42 CFR § 413.89(b), shall not be recognized as allowable costs.
- 6515.11 The cost of services, facilities, and supplies furnished to the provider by an organization related to the provider by common ownership or control are included in the allowable cost of the provider at the cost to the related organization. The cost charged by the related organization shall not exceed the price of comparable services, facilities or supplies that could be purchased by independent providers in the Washington metropolitan area.
- 6515.12 Return on equity capital of proprietary providers shall be determined according to the Medicare Principles of Reimbursement.
- 6515.13 Reasonable rental expense shall be an allowable cost for leasing of a facility from a non-related party if it is an arm's length transaction.
- 6515.14 The purchase or rental by a facility of any property, plant, equipment, services and supplies shall not exceed the cost that a prudent buyer would pay in the open market to obtain these items.
- 6515.15 District of Columbia provider tax costs shall be excluded from allowable costs.

- 6515.16 Home office costs and management fees shall be subject to the following conditions and limitations:
- (a) Home office cost allocations and management fees between related parties shall be reported without mark-up by the nursing facility;
  - (b) Costs that are not allowable, such as those related to nonworking officers or officers' life insurance, shall not be included in home office allocations or management fees; and
  - (c) The nursing facility's audited certified cost allocation plan relating to home office and management fees shall be provided.
- 6515.17 Respiratory therapy costs including equipment rental, supplies and labor and staffing costs associated with providing ventilator care shall be excluded from allowable costs.
- 6515.18 For purposes of this section, the phrases "related to the provider," "common ownership" and "control" shall have the same meaning as set forth in 42 CFR § 413.17(b).

**6516 EXCLUSIONS FROM ALLOWABLE COSTS**

- 6516.1 The following categories of expense shall be excluded from allowable operating costs because they are not normally incurred in providing resident care:
- (a) Fundraising expenses in excess of ten percent (10%) of the amount raised;
  - (b) Parties and social activities not related to resident care;
  - (c) Personal telephone, radio, and television services;
  - (d) Gift, flower and coffee shop expenses;
  - (e) Vending machines;
  - (f) Interest expenses and penalties due to late payment of bills or taxes, or for licensure violations;
  - (g) Prescription drug costs;
  - (h) Personal resident purchases; and
  - (i) Beauty and barber shop costs.
- 6516.2 The following expenditures shall reduce allowable costs:

- (a) The greater of the revenues generated from employee and guest meals or the cost of the meals;
- (b) The greater of the revenues generated from rental space in the facility or the cost of the rental space;
- (c) Purchase discounts and allowances;
- (d) Investment income for unrestricted funds to the extent that it exceeds interest expense on investments;
- (e) Recovery of an insured loss;
- (f) Grants, gift and income from endowments designated by the donor for specific operating expenses; and
- (g) Any other income or expense item determined to reduce allowable costs pursuant to the Medicare Principles of Reimbursement. DHCF shall not offset performance based payments made to nursing facilities participating in the Nursing Facility Quality Improvement Program and add-on payments for ventilator care, bariatric care, and care for the behaviorally complex against allowable costs.

**6517 REBASING AND ANNUAL RATE ADJUSTMENTS**

- 6517.1 Not later than October 1, 2021, and every four (4) years thereafter, the base year data, medians, day-weighted medians and peer group prices shall be updated.
- 6517.2 DHCF retains authority to update the routine and support and the nursing and resident care components of the peer group nursing facility rates annually.

**6518 REIMBURSEMENT FOR NEW PROVIDERS**

- 6518.1 Each new provider shall be assigned to the appropriate peer group as set forth in § 6502.1.
- 6518.2 The per diem rate for each new provider shall be the base year day-weighted average case mix neutral peer group price for nursing and resident care and the peer group price for routine and support services.
- 6518.3 The capital per diem for each new provider shall be the greater of the base year day-weighted average per diem of facilities in the assigned peer group, or the median per diem for the peer group.

6518.4 Each new provider may receive an add-on payment for each resident that qualifies and receives ventilator care pursuant to §§ 6508 - 6510 or for residents qualifying for reimbursement as behaviorally complex pursuant to §§ 6511- 6512 or bariatric care, pursuant to §§ 6513 - 6514.

6518.5 DHCF shall notify, in writing, each new nursing facility of its payment rate calculated in accordance with this section. The rate letter to a new provider shall include the per diem payment rate calculated in accordance with this section.

**6519 REIMBURSEMENT FOR REORGANIZED FACILITIES, EXPANDED FACILITIES, REDUCED CAPACITY, OR CHANGE OF OWNERSHIP**

6519.1 A nursing facility that has been reorganized pursuant to Chapter 11 of Title 11 of the United States Bankruptcy Code on or after September 30, 2000 shall be reimbursed at the same rate in effect prior to the date the reorganized facility filed its petition for bankruptcy.

6519.2 A nursing facility with a change of ownership on or after September 30, 2000 shall be reimbursed at the same rate established for the nursing facility prior to the change of ownership, except the capital per diem shall be the greater of the base year day-weighted average per diem of facilities in the assigned peer group or the capital rate for the nursing facility prior to the change of ownership.

6519.3 A nursing facility that expands its bed capacity shall be reimbursed for its newly added beds at the same rate established for the nursing facility prior to the expansion until the next rebasing effective date, unless the addition of beds qualifies the expanded facility for a different peer group.

6519.4 If the expanded facility qualifies for a different peer group, the facility rates will be adjusted to comply with the new peer group rates one (1) year after the new beds are put into service, or on the next rebasing date, whichever comes first.

6519.5 A nursing facility that reduces its bed capacity shall continue to be reimbursed at the same rate established for the nursing facility prior to the bed reduction until the next rebasing effective date, unless the bed reduction qualifies the facility for a different peer group.

6519.6 If a reduction in the number of beds qualifies the facility for a different peer group, the facility rates will be adjusted to comply with the new peer group rates as soon as the reduction is effective.

**6520 REIMBURSEMENT FOR OUT OF STATE FACILITIES**

6520.1 If a District Medicaid beneficiary is placed in an out-of-state facility in accordance with the requirements of § 6520.5, DHCF shall reimburse the facility in accordance with the Medicaid reimbursement rate of the state in which the

facility is located or a negotiated rate, provided that it is not greater than the estimated Medicaid reimbursement rate of the state in which the facility is located.

- 6520.2 DHCF shall notify each out-of-state facility, in writing, of its payment rate calculated in accordance with this section.
- 6520.3 An out-of-state facility is not required to file cost reports with DHCF.
- 6520.4 Each out-of-state facility shall obtain written authorization from DHCF prior to admission of a District Medicaid beneficiary.
- 6520.5 DHCF may approve placement of a District Medicaid beneficiary in an out-of-state facility only if DHCF determines there are not nursing facilities in the District with immediate capacity to admit that can provide the appropriate level of care for the beneficiary.

#### **6521 COST REPORTING AND RECORD MAINTENANCE**

- 6521.1 Each nursing facility shall submit an annual cost report to the Medicaid program within one hundred twenty days (120) days of the close of the facility's cost reporting period, which shall be concurrent with its fiscal year used for all other financial reporting purposes.
- 6521.2 Cost reports shall be submitted on the DHCF approved form, and shall be completed according to the published cost report instruction manual. DHCF reserves the right to modify the cost reporting forms and instructions and shall send written notification to each nursing facility regarding any changes to the forms, instructions and copies of the revised cost reporting forms.
- 6521.3 A delinquency notice shall be issued if the facility does not submit the cost report on time and has not received an extension of the deadline for good cause.
- 6521.4 Only one (1) extension of time shall be granted to a facility for a cost reporting year and no extension of time shall exceed thirty (30) days. DHCF shall honor all extensions of time granted to hospital-based facilities by the Medicare program.
- 6521.5 If the cost report is not submitted within thirty (30) days of the date of the notice of delinquency, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the cost report is received.
- 6521.6 Each nursing facility shall submit one (1) original hard-copy and (1) one electronic copy of the cost report. Each copy shall have an original signature.

- 6521.7 The requirements for cost reports shall be detailed in the DHCF nursing facility cost report instruction manual. Each cost report shall meet the following requirements:
- (a) Be properly completed in accordance with program instructions and forms and accompanied by supporting documentation;
  - (b) Include copies of audited financial statements or other official documents submitted to a governmental agency justifying revenues and expenses;
  - (c) Include and disclose payments made to related parties in accordance with § 6515.11 and the reason for each payment to a related party; and
  - (d) Include audited cost allocation plans for nursing facilities with home office costs, if applicable.
- 6521.8 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 these rules.
- 6521.9 In the absence of specific instructions or definitions contained in these rules or cost reporting forms and instructions, the decision of whether a cost is allowable shall be determined in accordance with the Medicare Principles of Reimbursement and the guidelines set forth in Medicare Provider Reimbursement Manual.
- 6521.10 All cost reports shall cover a twelve (12) month cost reporting period, which shall be the same as the facility's fiscal year, unless DHCF has approved an exception.
- 6521.11 A cost report that is not complete, as required by §§ 6521.6 through 6521.8, shall be considered an incomplete filing and the nursing facility shall be so notified.
- 6521.12 If, within thirty (30) days of the notice of incomplete filing, the facility fails to file a completed cost report and no extension of time has been granted by DHCF, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the filing is complete.
- 6521.13 DHCF shall pay the withheld funds promptly after receipt of the completed cost report and documentation required meeting the requirements of this section.
- 6521.14 Each facility 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 facility'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.

- 6521.15 Each nursing facility shall maintain the records pertaining to each cost report as described in § 6521.14 for a period of not less than seven (7) 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.
- 6521.16 All records and other information may be subject to periodic verification and review. Each cost report may be subject to a desk review.
- 6521.17 Each nursing facility shall:
- (a) Use the accrual method of accounting; and
  - (b) Prepare the cost report in accordance with generally accepted accounting principles and all program instructions.
- 6521.18 Audits shall be conducted to establish the rates upon rebasing as set forth in § 6517.

## **6522 ACCESS TO RECORDS**

- 6522.1 In accordance with the Health Insurance Portability and Accountability Act of 1996 and other privacy laws, each nursing facility shall allow appropriate DHCF personnel, representatives of the federal 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.

## **6523 APPEALS**

- 6523.1 At the conclusion of each base year audit or any other required audit, a nursing facility shall receive an audited cost report including a description of each audit adjustment and the reason for each adjustment.
- 6523.2 Within thirty (30) days of the date of receipt of the audited cost report, any nursing facility that disagrees with the audited cost report may request an administrative review by sending a written request for administrative review to DHCF.
- 6523.3 The 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.
- 6523.4 DHCF shall mail a formal response to the nursing facility no later than forty-five (45) days from the date of receipt of the written request for administrative review pursuant to § 6523.2.



6523.5 Decisions made by DHCF and communicated in the formal response described in § 6523.4 may be appealed to the Office of Administrative Hearings within thirty (30) days of the date of issuance of the formal response.

6523.6 DHCF shall issue a rate letter to each nursing facility that includes the relevant rate parameters used to determine the final rate components consistent with the requirements set forth in this chapter.

**6524 NURSING FACILITY QUALITY IMPROVEMENT PROGRAM**

6524.1 Beginning February 1, 2018, DHCF will implement the Nursing Facility Quality Improvement (NFQIP) Program.

6524.2 Participation in the Nursing Facility Quality Improvement Reporting Track is mandatory for all nursing facilities in the District. Participation in the Nursing Facility Quality Improvement Incentive Track is optional. The two tracks are set forth below:

- (a) Nursing Facility Quality Improvement Reporting (NFQIR) Track: This track only reports performance measures set forth in § 6524.3 and does not provide a supplemental Medicaid payment; and
- (b) Nursing Facility Quality Improvement Incentive (NFQII) Track: This track provides a supplemental Medicaid payment for participating nursing facilities that report performance measures set forth in §§ 6524.3 and 6524.3 and provide services that result in better care and higher quality of life for their residents; or

6524.3 Quality reporting is mandatory for all District nursing facilities. Each nursing facility shall report to DHCF, annually, on the performance measures set forth below, which shall be calculated and reported as follows:

Nursing Facility Quality Improvement Reporting Performance Measures				
Measure Number/ Name	Measurement Domain	NQF #	Steward	Description

<p>1. Percent of high risk, long-stay residents with pressure ulcers</p>	<p>Quality of Care</p>	<p>0679</p>	<p>CMS</p>	<p><b>Numerator:</b> The number of all long-stay residents with a selected target assessment that meets both of the following conditions:</p> <ul style="list-style-type: none"> <li>• Condition #1: There is a high risk for pressure ulcers, as “high-risk” is defined in the denominator definition below.</li> <li>• Condition #2: Stage II-IV or unstageable pressure ulcers are present, as indicated by any of the following six (6) conditions:                             <ul style="list-style-type: none"> <li>○ 2.1 (M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]) or</li> <li>○ 2.2 (M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]) or</li> <li>○ 2.3 (M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, 9]).</li> </ul> </li> </ul> <p><b>Denominator:</b> The number of all long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions.</p> <p>Residents are defined as high-risk if they meet one (1) or more of the following three (3) criteria on the target assessment:</p> <ul style="list-style-type: none"> <li>• Impaired bed mobility or transfer indicated, by either or both of the following:                             <ul style="list-style-type: none"> <li>○ Bed mobility, self-performance (G0110A1 = [3, 4, 7, 8]) or</li> <li>○ Transfer, self-performance (G0110B1 = [3, 4, 7, 8]) or</li> </ul> </li> <li>• Comatose (B0100 = [1]) or</li> <li>• Malnutrition or at risk of malnutrition (I5600 = [1]) (checked).</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Target assessments that define a long-stay resident as high risk under this measure should be excluded from the denominator calculation if the target assessment is an admission assessment (A0310A = [01]) or a Prospective Payment System (PPS) 5-day or readmission/return assessment (A0310B = [01, 06]).</li> <li>• If the resident is not included in the calculation of the numerator (the resident did not meet the pressure ulcer conditions for the numerator) and any of the following conditions are true:                             <ul style="list-style-type: none"> <li>○ (M0300B1 = [-]).</li> <li>○ (M0300C1 = [-]).</li> <li>○ (M0300D1 = [-]).</li> </ul> </li> </ul>
--	------------------------	-------------	------------	---

<p>2. Percentage of long-stay residents who received an antipsychotic medication</p>	<p>Quality of Care</p>	<p>N/A</p>	<p>CMS</p>	<p><b>Numerator:</b> The number of long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows:</p> <ul style="list-style-type: none"> <li>• For assessments with target dates on or before 03/31/2012: (N0400A = [1]).</li> <li>• For assessments with target dates on or after 04/01/2012: (N0410A = [1, 2, 3, 4, 5, 6, 7]).</li> </ul> <p><b>Denominator:</b> The number of long-stay residents with a selected target assessment, except those with exclusions.</p> <p><b>Exclusions:</b> Residents are excluded from the calculation of the numerator if any of the following is true:</p> <ul style="list-style-type: none"> <li>• For assessments with target dates on or before 03/31/2012: (N0400A = [-]).</li> <li>• For assessments with target dates on or after 04/01/2012: (N0410A = [-]).</li> </ul> <p>Residents are also excluded if any of the following related conditions are present on the target assessment (unless otherwise indicated):</p> <ul style="list-style-type: none"> <li>• Schizophrenia (I6000 = [1]).</li> <li>• Tourette’s syndrome (I5350 = [1]).</li> <li>• Tourette’s syndrome is considered to be (I5350 = [1]) if this item is not active on a prior the target assessment or if a prior assessment is available; or.</li> <li>• Huntington’s disease (I5250 = [1]).</li> </ul>
<p>3. Percent of long-stay residents with a urinary tract infection</p>	<p>Quality of Care</p>	<p>0684</p>	<p>CMS</p>	<p><b>Numerator:</b> The number of long-stay residents with a selected target assessment that indicates urinary tract infection within the last thirty (30) days (I2300 = [1]).</p> <p><b>Denominator:</b> The number of all long-stay residents with a selected target assessment, except those with exclusions.</p> <p><b>Exclusions:</b> Residents are excluded from the denominator calculation if:</p> <ul style="list-style-type: none"> <li>• Target assessment is an admission assessment of (A0310A = [01]) or a PPS 5-day or readmission/return assessment (A0310B = [01, 06]); or</li> <li>• Urinary tract infection value is missing (I2300 = [-]).</li> </ul>

<p>4. Percent of low risk long-stay residents who lose control of their bowels or bladder</p>	<p>Quality of Care</p>	<p>N/A</p>	<p>CMS</p>	<p><b>Numerator:</b> The number of long-stay residents with a selected target assessment that indicates frequently or always incontinence of the bladder (H0300 = [2, 3]) or bowel (H0400 = [2, 3]).</p> <p><b>Denominator:</b> The number of all long-stay residents with a selected target assessment, except those with exclusions.</p> <p><b>Exclusions:</b> Residents are excluded from the calculation of the denominator if:</p> <ul style="list-style-type: none"> <li>• Resident’s target assessment is an admission assessment (A0310A = [01]) or a PPS five (5-) day or readmission/return assessment (A0310B = [01, 06]); .</li> <li>• Resident is not in numerator and H0300 = [-] OR H0400 = [-].</li> <li>• Residents have any of the following high risk conditions: a. Severe cognitive impairment on the target assessment as indicated by (C1000 = [3] and C0700 = [1]) OR (C0500 ≤ [7]); b. Totally dependent in bed mobility self-performance (G0110A1 = [4, 7, 8]);. c. Totally dependent in transfer self-performance (G0110B1 = [4, 7, 8])’or . d. Totally dependent in locomotion on unit self-performance (G0110E1 = [4, 7, 8]).</li> <li>• Resident does not qualify as high risk (see #3 above) and both of the following two (2) conditions are true for the target assessment: a. C0500 = [99, ^, -]; and b. C0700 = [^, -] or C1000 = [^, -].</li> <li>• Resident does not qualify as high risk (see #3 above) and any of the following three (3) conditions are true: a. G0110A1 = [-]; b. G0110B1 = [-]; and c. G0110E1 = [-].</li> <li>• Resident is comatose (B0100 = [1]) or comatose status is missing (B0100 = [-]) on the target assessment.</li> <li>• Resident has an indwelling catheter (H0100A = [1]) or indwelling catheter status is missing (H0100A = [-]) on the target assessment.</li> <li>• Resident has an ostomy (H0100C = [1]) or ostomy status is missing (H0100C = [-]) on the target assessment.</li> </ul>
---	------------------------	------------	------------	--

<p>5. Percent of long-stay residents experiencing one or more falls with major injury</p>	<p>Quality of Care</p>	<p>0674</p>	<p>CMS</p>	<p><b>Numerator:</b> The number of long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).</p> <p><b>Denominator:</b> The number of all long-stay nursing home residents with a one or more look-back scan assessments except those with exclusions.</p> <p><b>Exclusions:</b> Residents are excluded from the calculation of the denominator if one of the following is true for all of the look-back scan assessments:</p> <ul style="list-style-type: none"> <li>• The occurrence of falls was not assessed (J1800 = [-]), or</li> <li>• The assessment indicates that a fall occurred (J1800 = [1]) and the number of falls with major injury was not assessed (J1900C = [-])</li> </ul>
<p>6. Resident/Family Satisfaction Survey</p>	<p>Quality of Life</p>	<p>N/A</p>	<p>DHCF or its representative</p>	<p>The survey will document resident/family satisfaction with the services provided by the nursing facility. The survey will be:</p> <ul style="list-style-type: none"> <li>• The AHRQ standardized nursing home CAHPS survey tool; and</li> <li>• Annually administered and tabulated by an external entity from the nursing facility and DHCF.</li> </ul> <p>A summary report of the survey and response rate will be made publicly available.</p>

7. End of Life Program	Quality of Life	N/A	DHCF	<p>The facility must develop a program for all residents (including but not limited to those with a terminal diagnosis) that serves the staff, residents, and family members in preparation for the time when beneficiary is unable to communicate their wishes for themselves regardless of anticipated length of stay .</p> <p>Supporting documentation for the program provided by the nursing facility to DHCF must provide:</p> <ul style="list-style-type: none"> <li>• A detailed narrative of the facility's end of life program that identifies individual preferences, spiritual needs, wishes, expectations, specific grief counseling, a plan for honoring those that have died, and a process to inform the facility residents of such death;</li> <li>• Documentation of no less than four (4) and no greater than ten (10) residents' individual wishes and how the facility honored them; and</li> <li>• Proof of staff education on the facility's end of life planning program.</li> </ul>
8. Low-acuity Non-emergent ED visits	Utilization	N/A	DHCF	<p>Percentage of inpatient admissions among nursing facility long stay residents for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.</p>
9. All-cause 30-day Readmissions	Utilization	1768	NCQA	<p>The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within thirty (30) calendar days and the predicted probability of an acute readmission. Data are reported in the following categories:</p> <ul style="list-style-type: none"> <li>• Count of Index Hospital Stays (denominator);</li> <li>• Count of thirty (30)-Day Readmissions (numerator); and</li> <li>• Average adjusted Probability of Readmission.</li> </ul>
10. Potentially Preventable Hospital Admissions	Utilization	N/A	AHRQ	<p>Percentage of inpatient admissions among nursing facility residents for specific ambulatory care conditions that may have been prevented through appropriate outpatient care. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.</p>

11. Staff Continuing Education in MDS Training	Infrastructure	N/A	DHCF	Provide documentation that staff is trained to document MDS assessment in a uniform and consistent manner.
12. Staff Turnover	Infrastructure	N/A	DHCF	The percentage of direct care staff <sup>^</sup> who have been terminated <sup>^^</sup> during the measurement period, calculated as follows: 100*(Number of nursing terminations at the nursing home during the period / (average number of nursing staff employees) – 100. <sup>^</sup> Direct Care Staff - All full-time, part-time, permanent, short-term, seasonal, salaried and hourly RN, LPN, and CNA staff. Staff of temporary agencies and outside contractors are not included. <sup>^^</sup> Terminated - Any person who is no longer employed by the nursing facility for any reason.
13. RN hours per resident day	Infrastructure	N/A	DHCF	RN hours per resident day is calculated by adding RN hours plus fifty (50) percent of Direct of Nursing (DON) hours worked by nursing home employees plus eighty (80) percent of RN hours worked by contract agency staff, and dividing by total resident days for the reporting period.
14. Quality Improvement Plan (This measure will be retired in FY2020 and will become a participation requirement for the NFQII program.)	Infrastructure	N/A	DHCF	Documentation on how the nursing facility will address transitions of care and optimize on performance measures. The measure will review the nursing facility's Quality Assurance and Performance Improvement program utilizing the ACA required guidelines.

6524.4 In addition to the reporting requirements set forth in § 6524.3, each nursing facility participating in NFQII shall report to DHCF, annually, on an additional set of requirements and performance measures set forth below:

Nursing Facility Quality Initiative Incentive Performance Measures				
Measure Number/ Name	Measurement Domain	NQF #	Steward	Description
1. Certified EHR Adoption (NFQII only)	Infrastructure	N/A	DHCF	Demonstrate use of electronic health record (EHR) technology to support the creation and execution of a person-centered plan of care for each beneficiary that will facilitate transitions of care.

<p>2. Enrollment and Integration in the Chesapeake Regional Information System for our Patients (CRISP) to receive ENS (NFQII only)</p>	<p>Infrastructure</p>	<p>N/A</p>	<p>DHCF</p>	<p>Demonstrate use of enrollment in and use of Health Information Exchange tools as detailed below:</p> <ul style="list-style-type: none"> <li>• In year 1 nursing facilities provide proof of enrollment in the Chesapeake Regional Information System for our Patients (CRISP) or comparable system, to receive hospital and emergency department alerts for enrolled beneficiaries.</li> <li>• In year 2 nursing facilities provide narrative of how the facility has integrated the HIE connectivity into its workflow</li> </ul>
---	-----------------------	------------	-------------	---

6524.5 Results on all performance measures referenced in § 6524.3 shall be publicly posted on the DHCF website.

**6525 PARTICIPATION IN THE NURSING FACILITY QUALITY IMPROVEMENT PROGRAM**

6525.1 To participate in the NFQIR track, the nursing facility must:

- (a) Be located in the District of Columbia;
- (b) Be enrolled in and seek reimbursement from the District's Medicaid Program as a nursing facility; and
- (c) Report data pursuant to § 6524.3.

6525.2 To participate in the NFQII track, the nursing facility must:

- (a) Meet requirements pursuant to § 6525.1;
- (b) Submit a letter indicating intent to participate in the NFQII track by September 1, 2018 and annually thereafter; and
- (c) Beginning fiscal year 2020 and annually thereafter, submit a quality improvement plan on the nursing facility plans to address improved transition of care and optimize its workflow to achieve optimal performance on performance measures set forth in § 6524.3.

6525.3 DHCF shall notify the nursing facilities if all participation requirements have been met no later than thirty (30) business days after the receipt of the required materials.



- 6525.4 Measures specifications for the performance payment shall consist of a set of guidelines set forth by DHCF. Measure specifications for the baseline period and first performance measurement period are set forth in § 6524.3.
- 6525.5 DHCF reserves the right to change performance measures, measure specifications, and participation requirements. DHCF will notify nursing facilities of the performance measures, measure specifications, and any changes through transmittals issued to the nursing facilities no later than sixty (60) calendar days prior to October 1st of each measurement year (MY).
- 6525.6 Data from the following periods will be used to determine the initial performance payment in fiscal year 2020:
- (a) The baseline period shall begin on February 1, 2018 and end on September 30, 2018; and
  - (b) Fiscal year 2019, the period beginning October 1, 2018 and ending September 30, 2019, is the first performance measurement period.

## **6526 NFAQII PERFORMANCE SCORING**

- 6526.1 Nursing facilities electing to participate in the NFAQII will be assessed for the performance payment based on the facility:
- (a) Submitting a written statement attesting to compliance or completion of a performance measure accompanied by supporting documentation;
  - (b) Attaining the seventy-fifth (75<sup>th</sup>) percentile based on all nursing facility performance from the previous measurement period; or
  - (c) Improving on the individual nursing facility performance relative to the previous year by any margin.
- 6526.2 DHCF will establish performance benchmarks for attainment based on data collected in the baseline period. The performance payment program's baseline period will be the period from February 1, 2018 to September 30, 2018, in which nursing facility performance is initially measured. For each subsequent measurement year, benchmarks will be based on data collected from the prior measurement year. If a participating nursing facility did not attain its goal, then DHCF shall assess whether the participating nursing facility's performance with regard to measures set forth in § 6524 improved from the previous measurement year.
- 6526.3 For domain measures where attainment is measured, an eligible nursing facility must achieve the attainment benchmark of the seventy-fifth (75<sup>th</sup>) percentile for the initial baseline period or for the previous measurement year to receive the

points allotted for those measures in accordance with § 6526.6. Setting the threshold at the seventy-fifth (75th) percentile means that only nursing facilities performing at the level of the top quartile for the previous year would earn points for attainment. Participating nursing facilities performing below the attainment benchmark will also be able to receive the total points allotted for that measure if they have improved measure performance from the previous year by any amount.

- 6526.4 DHCF will determine an annual performance score using the data available in the measurement year for each eligible nursing facility. The score is based on the number of points that a facility earns for its performance in meeting the benchmarks for each measure described in §§ 6524.3 and 6524.4.
- 6526.5 For domain measures where improvement can be measured, the improvement benchmark will be any improvement in performance of the measure compared to the prior year's performance by any margin.
- 6526.6 DHCF shall determine the distribution of points to calculate annual performance score based on a maximum of one hundred (100) points. DHCF shall apply weights to each of the domains and measures. Each measure in the domain is assigned points by dividing the total points amongst measures in each domain as outlined below:

(a)

<b>Nursing Facility Performance Measure Point Distribution Methodology</b>			
<b>Domains</b>	<b>Measures</b>	MY 2019	MY 2020
<b>Quality of Care</b>	Pressure Ulcers	6	6
	Anti-psychotic Medications	6	6
	Urinary Tract	6	6
	Loss of bowels or bladder	6	6
	Falls w/ injury	6	6
	<b>Domain Total</b>	<b>30</b>	<b>30</b>
<b>Quality of Life</b>	Resident survey	8	10
	End of Life Program	2	10
	<b>Domain Total</b>	<b>10</b>	<b>20</b>
<b>Utilization</b>	Low-Acuity Non-emergent ED Visits	3.3	3.3
	All-cause 30-day Readmissions	3.3	3.3
	Potentially Preventable Hospital Admissions	3.3	3.3
	<b>Domain Total</b>	<b>10</b>	<b>10</b>
<b>Infrastructure</b>	Staff Continuing Education in MDS Training	5	6
	Staff Turnover Rate	5	6
	RN Nursing Hours per Resident Day	5	6
	EHR Adoption	10	11
	HIE Connectivity	10	11
	Quality Improvement Plan	15	N/A
	<b>Domain Total</b>	<b>50</b>	<b>40</b>
<b>Total</b>	Total NFOII Points	<b>100</b>	<b>100</b>

(b) DHCF shall retain the right to adjust relative weights assigned to domains and measures. DHCF shall issue a transmittal notifying nursing facilities of assigned weights no later than sixty (60) calendar days prior to the beginning of the measurement year.

6526.7

If a nursing facility attests to compliance with or completion of a given measure, attains the seventy-fifth (75<sup>th</sup>) percentile for a given measure, or improves performance on a given measure, as appropriate, then the nursing facility will be awarded the total amount of points allotted for that measure as set forth in § 6526.6. If a nursing facility neither attest to compliance or completion of a given measure, attains the seventy-fifth (75<sup>th</sup>) percentile for a given measure, nor

improves performance on a given measure, as appropriate, no points will be awarded for that measure. The total score for a nursing facility will be the sum of the total points earned through either attainment, attestation, or improvement across measures set forth in §§ 6524.3 and 6524.4.

6526.8 A transmittal will be issued to each nursing facility no later than ninety (90) calendar days after the start of the measurement year with information on the benchmarks that will be used to measure a facility's performance (attainment or improvement).

6526.9 DHCF shall provide written notification of the attainment and individualized improvement thresholds to each eligible nursing facility no later than one hundred eighty (180) calendar days after the conclusion of the previous measurement year after all performance measures are received and validated.

**6527 NURSING FACILITY QUALITY OF CARE FUND AND NFQII PERFORMANCE PAYMENT**

6527.1 DHCF shall calculate and distribute performance payments based on available funds from the Nursing Facility Quality of Care Fund.

6527.2 DHCF shall calculate the amount of funds available for distribution to nursing facilities after the conclusion of each measurement year for the subsequent year in accordance with the requirements set forth below:

- (a) The amount of funds available for DHCF to distribute to nursing facilities shall be a percentage of the total assessments collected under the Nursing Facility Quality of Care Fund during the fiscal year; and
- (b) DHCF shall provide public notice of the amount of funds available for distribution at least sixty (60) days ahead of the beginning of the measurement year.

6527.3 DHCF will distribute performance payments to eligible nursing facilities based on the participating facility's proportionate share of the total Medicaid resident days of all nursing facilities and the facility's annual performance score during the measurement year.

6527.4 Beginning with measurement year 2019, and annually thereafter, performance payments shall be calculated and distributed no later than one hundred eighty (180) calendar days after the conclusion of each measurement year once all performance measures are received and have been validated. A payment letter will include the facility's performance score and the amount of the award.

6527.5 Any unused funds from the prior fiscal year shall be returned to the Nursing Facility Quality of Care Fund.

## 6599 DEFINITIONS

6599.1 When used in this chapter, the following terms shall have the meanings ascribed:

**Accrual Method of Accounting** - a method of accounting pursuant to which revenue is recorded in the period earned, regardless of when collected and expenses are recorded in the period, regardless of when paid.

**Arm's Length Transaction** – a transaction between the nursing facility and another party where both parties are acting in their own best interests and there is no established relationship except the mutual involvement of the parties in the transaction itself.

**Base Year** - the standardized year on which rates for all facilities are calculated to derive a prospective reimbursement rate.

**Case Mix Index** - a number value score that describes the relative resource use for the average resident in each of the groups under the RUGS IV classification system based on the assessed needs of the resident.

**Case Mix Neutralization** - the process of removing cost variations between nursing facilities nursing and resident care costs resulting from different levels of case mix.

**Change of Ownership** shall have the same meaning as “acquiring of effective control” as set forth in D.C. Official Code § 44-401(1).

**Clinically Eligible** - means that the beneficiary meets the criteria for a nursing facility level of care, as determined by an assessment completed by DHCF or its assign. The assessment includes a determination from clinicians that the beneficiary requires a nursing facility level of care.

**Day-Weighted Median** - the point in an array from high to low of the per diem costs for all facilities at which half of the days have equal or higher per diem costs and half have equal or lower per diem costs.

**Department of Health Care Finance (DHCF)** - the single state agency responsible for the administration and oversight of the District's Medicaid program.

**Expanded Facility** - a facility that puts additional Medicaid certified beds into service.

**F01** - the case mix index scores developed by the Centers for Medicare and Medicaid Services for the Medicaid 48-group Resource Utilization Groups (RUGS-IV) classification system.

**FiO<sub>2</sub>** - (**fraction of inspired oxygen**) - the ratio of the concentration of oxygen to the total pressure of other gases in inspired air.

**Facility Medicaid Case Mix** - the arithmetic mean of the individual resident case mix index for all residents, for whom DHCF is the payer source, admitted and present in the nursing facility on one (1) day per quarter in each fiscal year, as selected by DHCF. The arithmetic mean shall be carried to four (4) decimal places.

**Fair Market Value** - the value at which an asset could be sold in the open market in a transaction between unrelated parties.

**Long-Stay Resident** – A resident who resides in nursing facility for one hundred and one (101) resident days or more.

**Mechanical Ventilation** - a method for using machines to help an individual to breathe when that individual is unable to breathe sufficiently on his or her own to sustain life.

**Median** - the point in an ordered array from lowest to highest of nursing facility per diem costs at which the facilities are divided into equal halves.

**Medicaid Resident Day** - one (1) continuous twenty-four (24)-hour period of care furnished by a nursing facility that concludes at midnight each calendar day, where DHCF is the primary payor. Calendar days include reserved bed days that are paid for by DHCF. The day of the resident's admission is counted as a resident day. The day of discharge is not counted as a resident day.

**Minimum Data Set (MDS), Version 3.0** means the resident assessment instrument and data used to determine the RUGS classification of each resident.

**New Provider** – a nursing facility that, at the time of application to enroll as a Medicaid provider, has not been a provider during the previous twelve (12)-month period or, for rates effective February 1, 2018 and after, does not have a cost report as set forth in § 6521 of this chapter; and a nursing facility not defined as a reorganized facility or a facility that has changed ownership.

**Nursing Facility** - a facility that is licensed as a nursing home pursuant to the requirements set forth in the “Health Care and Community Residence

License Act of 1983,” effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.*) and meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR part 483.

**Nursing Facility Quality of Care Fund** – District fund established in accordance with the “Fiscal Year 2005 Budget Support Act of 2004,” effective December 7, 2004 (D.C. Law 15-205; 51 DCR 8441 (September 3, 2004)), as amended by the “Fiscal Year 2006 Budget Support Act of 2006,” effective March 2, 2007 (D.C. Law 16-192; 53 DCR 6899 (August 25, 2006)) and the “Technical Amendments Act of 2008,” effective March 25, 2009 (D.C. Law 17-687; 56 DCR 1117 (February 4, 2009)).

**Out of State Facility** - a nursing facility located outside the District of Columbia which meets the licensure standards in the jurisdiction where services are provided and meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR part 483.

**Peer Group** - a group of nursing facilities sharing the same characteristics.

**Per Diem Rate** - a rate of payment to the nursing facility for covered services in a resident day.

**Reorganized Facility** - a nursing facility that has filed for bankruptcy in accordance with the requirements set forth by Chapter 11 (Reorganization) of Title 11 of the United State Bankruptcy Code and is managing debts and operations pursuant to a confirmed reorganization plan.

**Resident** - an individual who resides in a nursing facility due to physical, mental, familial or social circumstances, or intellectual disability.

**Resident Day** - one (1) continuous twenty-four (24) hour period of care furnished by a nursing facility and reimbursed by any payor that concludes at midnight each calendar day. Calendar days include reserved bed days that are paid for by DHCF. The day of the resident's admission is counted as a resident day. The day of discharge is not counted as a resident day.

**Resource Utilization Groups (RUGS IV)** - a category-based resident classification system developed by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) used to classify nursing facility residents into groups based on each resident's needs and functional, mental and psychosocial characteristics.

**Tidal Volume** - the volume of air inspired and expired during a normal respiratory cycle.

**Total Facility Average Case Mix** - the arithmetic mean of the individual resident case mix indices for all residents, regardless of payer, admitted and present in the nursing facility on one (1) day per quarter in each fiscal year, as selected by DHCF. The arithmetic mean shall be carried to four (4) decimal places.

**Tracheostomy** - a surgical opening in the trachea or windpipe through which a tube is channeled to assist breathing.

**Ventilator Dependent** - a resident who requires at least sixteen (16) hours per day of mechanically assisted respiration to maintain a stable respiratory status.

**Weaning** - the process of gradually removing an individual from the ventilator and restoring spontaneous breathing after a period of mechanical ventilation.