DEPARTMENT OF HEALTH CARE FINANCE

STATE PLAN AMENDMENT ESTABLISHING REIMBURSEMENT PRINCIPLES AND METHODS FOR NURSING FACILITIES

The entire Attachment 4.19D, Part I of the Medicaid State Plan is being replaced by this Amendment, #17-009, effective February 1, 2018. This Part sets forth the reimbursement methodology for services referenced in Section 3.1A-4a (Nursing Facility Services), page 2 and Section 3.1B-4a (Nursing Facility Services), page 2 of the Medicaid State Plan.

I. GENERAL PROVISIONS

A. The purpose of this State Plan Amendment is to establish principles of reimbursement for nursing facilities participating in the District of Columbia Medicaid Program.

B. 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 State Plan Amendment.

C. In order to receive Medicaid reimbursement, each nursing facility shall enter into a provider agreement with the Department of Health Care Finance for the provision of nursing facility services and comply with the screening and enrollment requirements set forth by DHCF.

D. 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 meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR Part 483.

E. 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.

II. REIMBURSEMENT OF DISTRICT NURSING FACILITIES

A. Each nursing facility located in the District of Columbia shall be reimbursed by Medicaid a patient specific per diem rate for each resident in accordance with the formula set forth in § II.B. The rate shall be prospective and only include allowable costs described in § II.H.

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

(i) The product of the resident's Resource Utilization Group (RUG) weight as describe in § V and the facility specific per diem nursing and patient care price described in §§ III.C and VI.G;

(ii) The facility specific per diem for routine and support price described in § III.B; and

(iii) The facility specific per diem for capital cost described in § VIII.

C. In addition to the patient specific rate described in § II.B, each nursing facility may also receive an add-on payment for each resident who is:

(i) Receiving ventilator care pursuant to the requirements set forth in §§ IX through XI;

(ii) Qualifying as behaviorally complex pursuant to the requirements set forth in §§ XII through XIII; and

(iii) Qualifying as bariatric pursuant to the requirements set forth in §§ XIV through XV.

D. The patient specific rate described in § II.B is developed by establishing a base year facility specific per diem rate using three (3) cost categories as described in § II.H.

E. Each nursing facility shall be classified into three (3) peer groups as described in § III.

F. 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.

G. 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.

H. 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 listed below, further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements:

(i) Routine and support expenditures;

(ii) Nursing and resident care expenditures; and

(iii) Capital related expenditures.

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

J. 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.

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

L. 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 strikes, fire, flood, earthquake, or similar unusual occurrences with substantial cost effects.

M. Each adjustment pursuant to § II.L 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.

III. COMPUTATION OF PRICE AND FLOOR

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

(i) Peer Group One - All freestanding nursing facilities, with more than seventy-five (75) Medicaid certified beds;

(ii) Peer Group Two - All freestanding nursing facilities with seventy-five (75) or fewer Medicaid certified beds; and

(iii) Peer Group Three - All hospital-based nursing facilities.

B. The routine and support per diem price for each peer group shall be the day-weighted median cost per diem for all facilities as described in § VII times 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. DHCF guidance on peer group specific factors will apply consistent with federal requirements.

C. The nursing and resident care price for each peer group shall be the day-weighted median case mix neutralized cost per diem for all facilities as described in § VI times 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. DHCF guidance on peer group specific factors will apply consistent with federal requirements.

D. 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. DHCF guidance on the fixed percentage will apply consistent with federal requirements.

E. 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.

F. DHCF shall publish a public notice in the *D.C. Register* setting forth the reimbursement methodology for District nursing facilities prior to February 1, 2018. 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, 2018.

G. DHCF shall post notice of the final rates on the DHCF website upon approval of the nursing facility reimbursement methodology by 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 any rate changes.

IV. RESIDENT ASSESSMENT

A. 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.

B. The Minimum Data Set (MDS), Version 3.0 or successor updates to this version, shall be used by each nursing facility.

C. 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.

V. RESIDENT CLASSIFICATION SYSTEM

A. 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.

B. DHCF shall use the Case Mix Indices known as the standard data set F01 developed by CMS or successor updates to this version.

C. 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.

D. 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.

E. The RUG category shall be included on the claim for services as a valid Health Insurance Prospective Payment System (HIPPS) code.

F. The CMI for the submitted RUG category will be used to adjust the nursing and resident care portion of the facility per diem during claims adjudication.

G. 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.

VI. FACILITY NURSING AND RESIDENT CARE COSTS PER DIEM CALCULATION

A. Each nursing facility's allowable nursing and resident care costs shall be adjusted in accordance with § VI.D.

B. The total resident days shall be determined in accordance with § XVI.B.

C. The amount calculated in § VI.A 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.

D. 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 § VI.C. shall be divided by the resident days calculated in accordance with § VI.B to determine each nursing facility's nursing and resident care cost per diem without physical, speech and occupational therapy services.

E. Per diem costs for physical therapy, speech therapy, 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.

F. The peer group price established in accordance with § III.C 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").

G. 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 per diem price. In the base year, the Medicaid case mix used in the calculations in §§ VI.F and VI.G is the average case mix for the quarters ending June 30, 2016 and September 30, 2016.

H. 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.

VII. FACILITY ROUTINE AND SUPPORT COSTS PER DIEM CALCULATION

A. In the base year, each facility's routine and support costs per diem shall be established by dividing total allowable routine and support base year costs adjusted in accordance with § II.G by total resident days determined in accordance with § XVI.B for all nursing care residents.

B. 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 § III.B.

VIII. FACILITY CAPITAL-RELATED COSTS PER DIEM CALCULATION

A. 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 § II.G by total resident days determined in accordance with § XVI.B for all nursing care residents.

B. 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.

IX. VENTILATOR CARE

A. In addition to the patient specific per diem rate, 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 §§ IX-XI.

B. Each resident receiving ventilator care shall meet all of the following requirements:

(i) Be ventilator dependent and not able to breathe without mechanical ventilation;

(ii) Use the ventilator for life support, sixteen (16) hours per day, seven 7 days per week;

(iii) Have a tracheostomy or endotracheal rube;

(iv) 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 intermedia the care facility for the mentally retarded;

(v) 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;

(vi) Be medically stable, without infections or extreme changes in ventilatory settings and/or duration (increase in respiratory rate by 5 breaths per minute, increase in FI02 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;

(vii) Require services on a daily basis which cannot be provided at a lower level of care; and

(viii) Require services be provided under the supervision of a licensed health care professional.

C. Each nursing facility shall comply with all of the standards governing ventilator care services set forth by the District's Department of Health. Further guidance found at https://www.dcregs.dc.gov/Common/DCMR/SectionList.aspx?SectionId=10416 will apply consistent with federal requirements.

D. Ventilator care shall be prior-authorized by DHCF. The following documents shall be required for each authorization:

(i) Level of Care determination;

(ii) Pre-admission Screening and Annual Resident Review (PASARR) forms;

(iii) Admission history;

(iv) Physical examination reports;

(v) Surgical reports; and

(vi) Consultation reports and ventilator dependent addendum.

E. 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:

(i) Consistency with the resident's symptoms, or with prevention, diagnosis, or treatment of the resident's illness or injury;

(ii) 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;

(iii) Appropriateness with regard to generally accepted standards of medical practice;

(iv) Is not medically contraindicated with regard to the resident's diagnosis, symptoms, or other medically necessary services being provided to the resident;

(v) Is of proven medical value or usefulness, and is not experimental in nature;

(vi) Is not duplicative with respect to other services being provided to the resident;

(vii) Is not solely for the convenience of the resident;

(viii) Is cost-effective compared to an alternative medically necessary service which is reasonably acceptable to the resident based on coverage determinations; and

(ix) Is the most appropriate supply or level of service that can safely and effectively be provided to the resident.

X. VENTILATOR CARE DISCHARGE

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

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

(i) Blood pressure elevation of more than twenty (20) millimeters of mercury (mmHg) systolic or more than ten (10) mmHg diastolic;

(ii) Heart rate of more than ten percent (10%) above the baseline or a heart rate of one hundred twenty (120) beats per minute;

(iii) Respiratory rate increase of more than ten (10) breaths per minute or a rate above thirty (30) breaths per minute;

(iv) Arrhythmias;

(v) Reduced tidal volume;

(vi) Elevated partial pressure of arterial carbon dioxide;

(vii) Extreme anxiety;

(viii) Dyspnea; or

(ix) Accessory muscle use in breathing or an otherwise deteriorating breathing pattern.

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

D. 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.

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

F. 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:

(i) Name, address, and telephone number of the primary physician;

(ii) Address and telephone number of the local hospital emergency department;

(iii) Name, address, and telephone number of the physician for regular respiratory check-ups, if different from the physician identified in § X.F.(i);

(iv) The responsibilities of the resident and caregiver in daily ventilator care;

(v) Identification of financial resources for long-term care;

(vi) Identification of community resources for health, social, educational and vocational needs;

(vii) An itemized list of all equipment and supplies needed for mechanical ventilation;

(viii) Names, addresses and telephone numbers of mechanical ventilation equipment dealers and a list of services that they provide; and

(ix) Contingency plans for emergency situations.

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

XI. VENTILATOR CARE REIMBURSEMENT

The add-on reimbursement rate for ventilator care shall consist of a set per diem, as set forth in the DHCF fee schedule, published at: http://dc-medicaid.com. 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.

XII. BEHAVIORALLY COMPLEX CARE

A. In addition to the patient specific per diem rate described in § II.B, 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 § XII.B.

B. 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:

(i) Injures self: Head banging, self-biting, hitting oneself, or throwing oneself to floor with or without injury;

(ii) Demonstrates physical aggression: Assaultive to other residents, staff, or property with or without injury to other residents or staff;

(iii) Demonstrates verbal aggression: Disruptive sounds, noises, screaming that disturbs roommate, staff or other residents;

(v) Demonstrates aggressive behaviors: Sexual behaviors, disrobing, throwing/smearing food, feces, stealing, hoarding, going through other residents' or staff belongings, or elopement attempts; or

(vi) Consistently rejects medical care.

C. Reimbursement for behaviorally complex residents shall be prior authorized by DHCF. Documentation that a resident meets the definition set forth in § XII.B is required for prior authorization. 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 § XII.B.

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

E. 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.

XIII. BEHAVIORALLY COMPLEX REIMBURSEMENT

The add-on reimbursement rate for behaviorally complex residents shall consist of a set per diem, as set forth in the DHCF fee schedule, published at: http://dc-medicaid.com. 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.

XIV. BARIATRIC CARE

A. In addition to the patient specific per diem rate, 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 § XIV.B.

B. A bariatric resident is defined as one who:

(i) Has a body mass index (BMI) of forty (40) or higher; and

(ii) 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.

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

(i) Medical records including MDS documenting the resident's height, weight and calculation of BMI; and

(ii) 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 3 or more ADLs.

XV. BARIATRIC REIMBURSEMENT

The add-on reimbursement rate for bariatric residents shall consist of a set per diem, as set forth in the DHCF fee schedule, published at: http://dc-medicaid.com. 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.

XVI. ALLOWABLE COSTS

A. Allowable costs shall include items of expense the provider incurs in the provision of routine services related to resident care. Allowable cost categories are detailed in regulation and in the cost report instructions. Further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

B. The occupancy rate used in determining the total facility per diem cost for each cost category shall be the greater of:

(i) The actual total facility paid occupancy, including paid reserve bed days; or

(ii) Ninety-three percent (93%) of certified total facility bed days available during the cost reporting period.

XVII EXCLUSIONS FROM ALLOWABLE COSTS

Exclusions from allowable costs shall include items of expense excluded from allowable operating costs because they are not normally incurred in providing resident care. Categories of expense excluded from allowable cost categories are detailed in regulation and in the cost report instructions. Further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

XVIII. REBASING AND ANNUAL RATE ADJUSTMENTS

A. 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.

B. DHCF retains authority to update the routine and support and the nursing and patient care components of the peer group nursing facility rates annually.

XIX. REIMBURSEMENT FOR NEW PROVIDERS

A. Each new provider shall be assigned to the appropriate peer group as set forth in § III.A.

B. 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.

C. 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 capital rate for the peer group.

D. Each new provider may receive an add-on payment for each resident that qualifies and receives ventilator care pursuant to § IX-XI or for residents qualifying for reimbursement as behaviorally complex pursuant to § XII-XIII or bariatric, pursuant to § XIV-XV.

E. 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.

XX. REIMBURSEMENT FOR REORGANIZED FACILITIES, EXPANDED FACILITIES, REDUCED CAPACITY, OR CHANGE OF OWNERSHIP

A. A nursing facility that has been reorganized pursuant to Chapter 11 of Title 11 of the United States Bankruptcy Code on or after a specific date determined by DHCF shall be reimbursed at the same rate in effect prior to the date the reorganized facility filed its petition for bankruptcy.

B. A nursing facility with a change of ownership on or after a specific date determined by DHCF 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.

C. A nursing facility that expands its bed capacity shall be reimbursed for its the 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.

D. 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.

E. 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.

F. 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.

XXI. REIMBURSEMENT FOR OUT OF STATE FACILITIES

A. If a District Medicaid beneficiary facility is placed in an out-of-state facility outside the District of Columbia ("District") in accordance with the requirements of § XXI.E, DHCF shall reimburse the facility in accordance with the Medicaid reimbursement policy 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.

B. DHCF shall notify each out-of-state facility, in writing, of its payment rate calculated in accordance with this section.

C. An out-of-state facility is not required to file cost reports with DHCF.

D. Each out-of-state facility shall obtain written authorization from DHCF prior to admission of a District Medicaid beneficiary.

E. 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.

XXII. COST REPORTING AND RECORD MAINTENANCE

A. Each nursing facility shall submit an annual cost report to DHCF within one hundred and 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.

B. 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.

C. 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.

D. 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.

E. If the cost report is not submitted within thirty (30) days of the date of the notice of delinquency, up to twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the cost report is received.

F. Each nursing facility shall submit (1) original hard-copy and (1) one electronic copy of the cost report. Each copy shall have an original signature.

G. 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:

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

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

(iii) Include and disclose payments made to related parties in accordance with § XVI. and the reason for each payment to a related party; and

(iv) Include audited cost allocation plans for nursing facilities with home office costs, if applicable.

H. Computations included in the cost report shall be accurate and consistent with other related computations and the treatment of costs shall be consistent with the requirements set forth in this State Plan Amendment.

I. In the absence of specific instructions or definitions contained in this State Plan Amendment 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.

J. 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.

K. A cost report that is not complete as required by § XXII.F. through XXII.H. shall be considered an incomplete filing and the nursing facility shall be so notified.

L. 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, up to twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the filing is complete.

M. DHCF shall pay the withheld funds promptly after receipt of the completed cost report and documentation required meeting the requirements of this section.

N. 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.

O. Each nursing facility shall maintain the records pertaining to each cost report 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.

P. All records and other information may be subject to periodic verification

and review. Each cost report may be subject to a desk review.

Q. Each nursing facility shall:

(i) Use the accrual method of accounting; and
(ii) Prepare the cost report in accordance with generally accepted accounting principles.

R. Audits shall be conducted to establish the rates upon rebasing, as set forth in § XXVIII.

XXIII. ACCESS TO RECORDS

In accordance with the Health Insurance Portability and Accountability Act of 1996 and other privacy laws, each nursing facility shall allow appropriate personnel of the Department of Health, representatives of the Department of Health Care Finance 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.

XXIV. APPEALS

A. 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.

B. 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 of the audited cost report by sending a written request for administrative review to DHCF.

C. 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 supporting documentation.

D. 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 § XXIV.C.

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

F. 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 Part.

XXV. NURSING FACILITY QUALITY IMPROVEMENT PROGRAM

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

B. 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:

(i) Nursing Facility Quality Improvement Reporting (NFQIR) Track: This track only reports performance measures and does not provide a supplemental Medicaid payment; and

(ii) Nursing Facility Quality Improvement Incentive (NFQII) Track: This track provides a supplemental Medicaid payment for participating nursing facilities that report performance measures and provide services that result in better care and higher quality of life for their residents.

C. Quality reporting is mandatory for all District nursing facilities. Each nursing facility participating in the NFQIR shall report to DHCF, annually, on a set of requirements and performance measures set forth by DHCF. Results on performance measures will be publicly posted on the DHCF website. Performance measures and further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

D. In addition to the reporting requirements set forth in § XXV.B, each nursing facility participating in the NFQII shall report to DHCF, annually, on an additional set of requirements and performance measures set forth by DHCF. Performance measures and further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

XXVI. PARTICIPATION IN THE NURSING FACILITY QUALITY IMPROVEMENT PROGRAM

A. To participate in the NFQIR track, the nursing facility must:

(i) Be located in the District of Columbia;

(ii) Be enrolled in and bill the District's Medicaid Program as a nursing facility;

(iii) Report data pursuant to § XXV.C.

B. To participate in the NFQII track, the nursing facility must:

(i) Meet requirements pursuant to § XXVI.A;

(ii) Submit a letter indicating intent to participate in the NFQII track by September 1, 2018 and annually thereafter; and

(iii) 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.

C. 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.

D. Measure specifications for the performance payment shall consist of a set of guidelines set forth by DHCF. Further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

E. 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).

F. Data from the following periods will be used to affect the initial performance payment in fiscal year 2020:

(i) The baseline period shall begin on February 1, 2018 and end on September 30, 2018; and

(ii) Fiscal year 2019, the period beginning October 1, 2018 and ending September 30, 2019, is the first performance measurement period.

XXVII. NFQII PERFORMANCE SCORING

A. Nursing facilities electing to participate in the NFQII will be assessed for the performance payment based on either the facility:

(i) Submitting a written statement attesting to compliance or completion of a performance measure accompanied by supporting documentation;

(ii) Attaining the seventy-fifth (75th) percentile based on all nursing facility performance from the previous measurement period; or

(iii) Improving on the individual nursing facility performance relative to the previous year by any margin.

B. 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 improved from the previous measurement year based on a defined threshold.

C. For domain measures where attainment is measured, an eligible nursing facility must achieve the attainment benchmark of the seventy-fifth (75th) percentile for the initial baseline period or for the previous measurement year to receive points for measures. 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 may be able to receive points if they have improved measure performance.

D. 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 §§ XXV.C and XXV.D.

E. For domain measures where improvement can be measured, the improvement benchmark will be a relative improvement in performance of the measure compared to the prior year's performance.

F. 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 of measures in each domain. Further guidance found at https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-65 will apply consistent with federal requirements.

G. 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

H. The total number of points for a nursing facility will be the sum of the total points earned, through either attainment, attestation or improvement on a measure. If a nursing facility neither achieves attestation, attainment nor improves performance on a given measure, no points will be awarded for that measure.

I. 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).

J. 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.

XXVII. NFQII PERFORMANCE PAYMENT AND NURSING FACILITY QUALITY OF CARE FUND

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

B. 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:

(i) 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

(ii) 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.

C. 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.

D. 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.

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

XXIX. DEFINITIONS

When used in this State Plan Amendment, the following terms and phrases 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 incurred, regardless of when paid.

Base Year- the standardized year, as set forth in rules published by DHCF, on which rates for all freestanding or hospital-based 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.

F102 - (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 he sold in the open market in a transaction between unrelated parties.

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 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 - 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 12-month period or, for rates effective February 1, 2018 and after, does not have a cost report as set forth in § XXII of this Part; and a 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, 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 483.1 et *seq.*

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) as amended by the "Fiscal Year 2006 Budget Support Act of 2005," effective March 2, 2007 (D.C. Law 16-192; 53 DCR 6899) and the "Technical Amendments Act of 2008," effective March 2, 2009 (D.C. Law 17-353; 56 DCR 1117).

Out of State Facility- a nursing facility located outside the District of Columbia who 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 483.1 *et seq.*

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.