DEPARTMENT OF HEALTH
STATE PLAN AMENDMENT
GOVERNING
NURSING FACILITY CASE-MIX REIMBURSEMENT SYSTEM

The entire Attachment 4.19 D Part I of the Medicaid State Plan is being replaced by this Amendment, #05-04, effective January 1, 2006.

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 January 1, 2006 shall be on a prospective payment system consistent with the requirements set forth in this State Plan Amendment.

C. Each nursing facility shall enter into a provider agreement with the Department of Health, Medical Assistance Administration (MAA) for the provision of nursing facility services.

II. REIMBURSEMENT OF NURSING FACILITIES

A. Each nursing facility shall be reimbursed on a prospective basis at a facility-specific per diem rate for all services provided, except prescription drugs. The facility-specific per diem rate shall be developed by establishing a base year per diem rate for each facility, subject to a ceiling, adjusted semi-annually for case mix and subject to other adjustments, as defined in attached 4.19-D. A facility may also receive an add-on payment for each resident receiving ventilator care pursuant to the requirements as set forth in Sections X through XII.

B. The base year costs for each free-standing or hospital-based nursing facility shall be calculated using a nursing facility's actual audited allowable costs.

C. Except for depreciation, amortization and interest on capital-related expenditures, the base year costs for each nursing facility shall be adjusted to a common year-end using the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System Skilled Nursing Facility Input Price Index.

D. The base year per diem rate for each facility is based on its audited allowable base year costs and shall be developed using three (3) cost categories: routine and

support expenditures; nursing and resident care expenditures; and capital related expenditures.

E. Routine and support expenditures shall include expenditures for:

(i) Dietary items, except raw food;

(ii) Laundry and linen;

(iii) Housekeeping;

(iv) Plant operations and related clerical support;

(v) Volunteer services;

(vi) Administrative and general salaries;

(vii) Professional services – non-healthcare related;

(viii) Non-capital related insurance;

(ix) Travel and entertainment;

(x) General and administrative costs;

(xi) Non-capital related interest expense; and

(xii) Other miscellaneous expenses as noted on the cost report submitted pursuant to Section XIX.

F. Nursing and resident care costs shall include the costs of:

(i) Raw food;

(ii) Nursing and physician services and their related clerical support services;

(iii) Non-prescription drugs and pharmacy consultant services;

(iv) Medical supplies;

(v) Laboratory services;

(vi) Radiology services;

(vii) Physical, speech, and occupational therapy services that are provided to Medicaid beneficiaries;

(viii) Social services;

(ix) Resident activities;

(x) Oxygen therapy; and

(xi) Utilization and medical review.

G. Capital related costs shall include the costs of:

(i) Equipment rental;

(ii) Depreciation and amortization;

(iii) Interest on capital debt;

(iv) Facility rental;

(v) Real-estate taxes and capital related insurance;

(vi) Property insurance; and

(vii) Other capital-related expenses.

H. The total base year per diem for a facility for each Medicaid resident day shall be the sum of:

(i) the nursing and resident care costs per diem, subject to a ceiling and adjusted semi-annually for case mix;

(ii) the routine and support costs per diem, subject to a ceiling;

(iii) any incentive payment; and

(iv) capital related costs per diem.

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.

III. COMPUTATION OF CEILINGS

A. The Medicaid Program shall classify each nursing facility operating in the District of Columbia and participating in the Medicaid Program into the following three (3) peer groups:

(i) Peer Group One - All freestanding nursing facilities, with the exception of facilities owned or operated by the District of Columbia government;

(ii) Peer Group Two - All hospital-based nursing facilities; and

(iii) Peer Group Three - All freestanding nursing facilities owned or operated by the District of Columbia government.

B. The ceiling for routine and support costs per diem for Peer Groups One and Two shall be the day-weighted median cost per diem for routine and support costs for all facilities in Peer Groups One and Two.

C. The ceiling for routine and support costs per diem for Peer Group Three shall be the day-weighted median cost per diem for routine and support costs for all facilities in Peer Group Three.

D. The ceiling for nursing and resident care costs per diem for Peer Group One shall be the day-weighted median case mix neutralized cost per diem for nursing and resident care costs for all facilities in Peer Group One.

E. The ceiling for nursing and resident care costs per diem for Peer Group Three shall be the day-weighted median case mix neutralized cost per diem for nursing and resident care costs for all facilities in Peer Group Three.

F. The ceiling for nursing and resident care costs per diem for Peer Group Two shall be the median case mix neutralized cost per diem for nursing and resident care costs for all facilities in Peer Group Two.

G. If a peer group has an even number of nursing facilities or resident days, the median or day-weighted median peer group ceiling shall be the arithmetic mean of the costs of the two nursing facilities or two resident days holding the middle position in the peer group array.

H. Once nursing facilities have been classified into peer groups for the purposes of establishing the medians and ceiling, the nursing facility costs for those facilities shall remain in that peer group until Medicaid rates are rebased.

I. If a nursing facility changes classification status, the facility shall be reassigned from the peer group used to establish the base year rates to the new peer group based on the revised certification status as of the beginning of the District's subsequent fiscal year.

J. The amount of the ceilings calculated pursuant to Sections III. B. through III. F. shall be published in rules governing Medicaid reimbursement to nursing facilities (Chapter 65 of Title 29 of the District of Columbia Municipal Regulations (DCMR)) .

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 2.0 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 December 2002 Revised Long Term Care Resident Assessment Instrument User's Manual for the MDS Version 2.0 or successor updates to this version.

V. RESIDENT CLASSIFICATION SYSTEM

A. MAA shall use the 34-group resident classification system developed by CMS known as the Resource Utilization Groups III, (RUGS III), Version 5.12 or successor updates.

B. MAA shall use the Case Mix Indices known as the standard data set BO1 developed by CMS or successor updates to this version. The BO1 scores shall be normalized by dividing the BO1 case mix scores by the District-wide Average Case Mix Index.

C. MAA shall assign a case mix index (CMI) to each resident in the nursing facility on the picture date in accordance with the RUGS III classification system and corresponding BO1 normalized case mix index score based upon the resident assessment conducted pursuant to Section IV.

D. Each resident assessed under RUGS III shall be assigned the highest numeric CMI score for which the resident qualifies. Assessments that cannot be classified to a RUGS III category due to errors shall be assigned the lowest numeric CMI score.

E. The most recent valid MDS assessment in the District's MDS database for those residents that are present in the nursing facility on the picture date shall be included in the CMI calculations. Residents who are discharged on the picture date shall not be included in the CMI calculations. Residents who are on paid

bedhold leave on the picture date and are expected to return to the facility shall be included in the CMI calculations.

F. The Department of Health Care Finance (DHCF) shall issue to each nursing facility a draft report no later than ninety (90) days following each picture date with the following information:

(i) The RUGS III classification and CMI score for each resident on the picture date;
(ii) Identifying information (resident's name, social security number, Medicaid identification number and date of birth) for each resident; and
(iii) The payer status for each resident (Medicaid or Non-Medicaid).

G. Each nursing facility shall have thirty (30) days after receipt of the report issued pursuant to Section V.F. to submit corrections of identifying information or payer status for each resident listed in the report. The nursing facility shall also submit documentation in support of each correction.

H. No nursing facility shall make any corrections to the RUGS III classification or CMI score.

I. Corrections submitted and determined by DHCF to be appropriate shall be included in the final report of the CMI scores used in establishing the nursing facility's reimbursement rate.

J. DHCF shall not make any corrections to the report for information received from the nursing facility after the thirty (3) day period set forth in Section V.G.

VI. 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 subsection VI.D.

B. The total resident days shall be determined in accordance with Section XIII.B.

C. The amount calculated in Section 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.

D. For nursing and resident care costs other than those defined at II.F.vii, the case mix neutral costs established in Section VI.C. shall be divided by the resident days calculated in accordance with Section VI.B to determine each nursing facility's nursing and resident care cost per diem without physical, speech and occupational therapy services. The resulting per diem shall be added to the per diem for nursing and resident care costs defined at II.F.vii. Per diems for PT, Speech, and OT therapy services shall be calculated by dividing such costs by total Medicaid resident days. The resulting sum of the per diems shall comprise each nursing facility's nursing and resident care cost per diem unadjusted for case mix.

E. The ceiling established in accordance with Section III.D. through F. for nursing and resident care costs for each peer group shall be multiplied by a percentage

that shall be published in rules governing Medicaid reimbursement to nursing facilities (Chapter 65 of Title 29 DCMR).

F. The nursing and resident care cost per diem rate unadjusted for case mix, shall be the lower of the facility-specific per diem calculated pursuant to Section VI. D or the adjusted ceiling relative to each nursing facility calculated in accordance with Section VI. E.

G. Each nursing facility shall be entitled to an incentive payment of 40 percent (40%) of the difference between the facility-specific per diem rate established in Section VI. D. and the adjusted ceiling calculated in accordance with Section VI. E., if the facility-specific per diem rate calculated in accordance with Section VI. D. is lower than the adjusted ceiling relative to each nursing facility established pursuant to Section VI. E.

H. The nursing and resident care cost per diem adjusted for case mix shall be determined by multiplying the nursing and resident care cost per diem calculated in accordance with Section VI. F., or if applicable, the nursing and resident care cost per diem adjusted for incentive, if applicable, as set forth in Section VI. G. by the Facility Medicaid Case Mix Index.

I. The Facility Medicaid Case Mix Index used to establish the rates at implementation shall be developed from resident assessment data taken from the time period beginning October 1, 2001 through September 30, 2002.

J. The nursing and resident care cost per diem shall be adjusted for case mix beginning April 1, 2006 and every six months thereafter. The data used to establish the Facility Medicaid Case Mix Index for the semi-annual adjustment shall be developed as follows:

(a) October 1st shall be the average of the preceding year fourth calendar quarter and first calendar quarter picture dates.

(b) April 1st shall be the average of the preceding year second calendar quarter and third calendar quarter picture dates.

K. MAA shall substitute the Facility Medicaid Case Mix Index with the District-wide Medicaid Case Mix Index if there are no valid assessments for a nursing facility during a picture date.

VII. ROUTINE AND SUPPORT COSTS PER DIEM CALCULATION

A. Each nursing 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 Section II.C. by total resident days determined in accordance with Section XIII.B. for all nursing care residents.

B. The ceiling established in accordance with Section III.B. and C. for routine and support costs for each peer group shall be multiplied by a percentage that shall be published in rules governing Medicaid reimbursement to nursing facilities (Chapter 65 of Title 29 DCMR).

C. Each nursing facility's routine and support cost per diem shall be the lower of the facility-specific per diem calculated in Section VII. A. or the adjusted ceiling relative to each nursing facility calculated in accordance with Section VII.B.

D. Each nursing facility shall be entitled to an incentive add-on of 25 percent (25%) of the difference between the facility-specific per diem rate established in Section VII.A. and the adjusted ceiling calculated in accordance with Section VII.B., if the facility-specific per diem rate calculated in accordance with Section VII.A. is lower than the adjusted ceiling established in Section VII.B.

VIII. CAPITAL-RELATED COSTS PER DIEM CALCULATION

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 Section II.C. by total resident days determined in accordance with Section XIII.B. for all nursing care residents.

IX. FINAL PER DIEM RATE CALCULATION

A. Each nursing facility's per diem rate effective January 1, 2006 shall be the sum of (i), (ii), and (iii) as set forth below:

(i) The nursing and resident care base year cost per diem

(a) Effective January 1, 2006 through September 30, 2007, the nursing and resident care base year cost per diem established pursuant to Section VI, adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index").

(b) Effective October 1, 2007 through September 30, 2008, the nursing and resident care base year cost per diem calculated according to IX.A.(i)(a) adjusted for inflation using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index") for District Fiscal years 2006, 2007, and 2008.

(c) Effective October 1, 2008 through September 30, 2009, the nursing and resident care base year cost per diem calculated according to IX.A.(i)(b) adjusted for inflation using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index").

(d) Effective October 1, 2009 through December 31, 2010, the nursing and resident care base year cost per diem calculated according to IX.A.(i)(c), adjusted for inflation using the CMS Index.

(e) Effective January 1, 2011 through September 30, 2013, the annual inflation adjustment shall be eliminated.

(f) Effective October 1, 2013, the nursing and resident care base year cost per diem calculated pursuant to IX.A. (i)(d), shall be annually adjusted for inflation using the CMS Index. This inflation adjustment shall not apply or be calculated for the period in which the inflation adjustment was eliminated in IX.A. (i)(e).

(ii) The routine and support base year cost per diem

(a) Effective January 1, 2006 through September 30, 2007, the routine and support base year cost per diem established pursuant to Section VII, adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index").

(b) Effective October 1, 2007 through September 30, 2008, the routine and support base year cost per diem calculated according to IX.A.(ii)(a) adjusted for inflation using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index") for District Fiscal years 2006, 2007, and 2008.

(c) Effective October 1, 2008 through September 30, 2009, the routine and support base year cost per diem calculated according to IX.A.(ii)(b), adjusted for inflation using the CMS Index.

(d) Effective October 1, 2009 through December 31, 2010, the routine and support base year cost per diem calculated according to IX.A. (ii)(c), adjusted for inflation using the CMS Index.

(e) Effective January 1, 2011 through September 30, 2013, the annual inflation adjustment shall be eliminated.

(f) Effective October 1, 2013, the routine and support base year cost per diem calculated pursuant to IX.A. (ii)(d), shall be annually adjusted for inflation using the CMS Index. This inflation adjustment shall not apply or be calculated for the period in which the inflation adjustment was eliminated in IX.A. (ii)(e).

(iii) The capital-related base year cost per diem

(a) Effective January 1, 2006 through September 30, 2007, the capital-related base year cost per diem established pursuant to Section VIII, adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index"). The inflation adjustment in this subparagraph shall not be applied to depreciation, amortization and interest on capital-related expenditures.

(b) Effective October 1, 2007 through September 30, 2008, the capital-related base year cost per diem calculated according to IX.A.(iii)(a) adjusted for inflation using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index ("CMS Index") for District Fiscal Years 2006, 2007, and 2008. The inflation adjustment in this subparagraph shall not be applied to depreciation, amortization and interest on capital-related expenditures.

(c) Effective October 1, 2008, through September 30, 2009, the capital-related base year cost per diem calculated pursuant to IX.(iii)(b), adjusted for inflation using the CMS Index. The inflation adjustment in this subparagraph shall not be applied to depreciation, amortization and interest on capital related expenditures.

(d) Effective October 1, 2009 through December 31, 2010, the capital-related base year cost per diem calculated according to IX.A. (iii)(c) adjusted for inflation using the CMS Index. The inflation adjustment in this subparagraph shall not be applied to depreciation, amortization and interest on capital-related expenditures.

(e) Effective January 1, 2011 through September 30, 2013, the annual inflation adjustment is eliminated.

(f) Effective October 1, 2013, the capital-related base year cost per diem calculated pursuant to IX.A. (iii)(d), shall be annually adjusted for inflation using the CMS Index. This inflation adjustment shall not apply or be calculated for the period in which the inflation adjustment was eliminated in IX.A. (iii)(e). The inflation adjustment in this subsection shall not be applied to depreciation, amortization and interest on capital-related expenditures.

B. Effective April 1, 2006 and every six months thereafter, the nursing and resident care costs per diem shall be re-calculated in accordance with section VI. The per diem rates established for routine and support costs and capital-related costs established pursuant to Section IX.A. shall be carried forward until costs are rebased.

C. When necessary, each facility's per diem rate will be reduced by the same

percentage to maintain compliance with the Medicare upper payment limit requirement.

D. MAA may approve an adjustment to the facility's 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.

E. Each adjustment pursuant to Section IX.D. shall be made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the facility, and verified by MAA.

X. VENTILATOR CARE

A. In addition to the facility-specific base year per diem rate, MAA 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 Sections X through XII.

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, 16 hours per day, 7 days per week;
(iii) Have a tracheostomy or endotracheal tube;
(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 intermediate 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 F102 of 25% or more, and/or increase in tidal volume of 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 in section 3215 of Title 22 DCMR.

D. Ventilator care shall be prior-authorized by MAA. 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.

XI. 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 20 mmHg Systolic or more than 10 mmHg diastolic;

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

(iii) Respiratory rate increase of more than 10 breaths per minute or a rate above 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 Section XI. 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 MAA of the date of discharge from the facility.

XII. VENTILATOR CARE REIMBURSEMENT

The add-on reimbursement rate for ventilator care shall consist of a set per diem, as set forth in published rules governing Medicaid reimbursement to nursing facilities (Chapter 65 of Title 29 DCMR).

XIII. ALLOWABLE COSTS

A. Allowable costs shall include, but not be limited to all items of expense the provider incurs in the provision of routine services related to resident care including:

(i) Room and board, including dietary, food, laundry and linen, housekeeping, plant operations and maintenance;

(ii) Medical direction;

(iii) Nursing care;

(iv) Minor medical and surgical supplies;

(v) Social and resident activity services;

(vi) Special services required by the resident, including physical, occupational, or speech therapy, oxygen therapy, but not dental care;

(vii) Incontinency care;

(viii) Tray service;

(ix) Resident gowns;

(x) Canes, crutches, walkers and wheelchairs, excluding customized wheelchairs;

(xi) Traction equipment and other durable medical equipment for multi-resident use;

(xii) Special dietary services, including tube or hand feeding and special diets; and

(xiii) Laundry services, except personal laundry.

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

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

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

C. General and administrative expenses shall include but not be limited to:

(i) Administrative salaries, including fringe benefits;

(ii) Professional services, including accounting and auditing expenses, fees of management consultants and legal fees;

(iii) General liability insurance;

(iv) Telephone;

(v) Licenses;

(vi) Travel and entertainment;

(vii) Office expenses, including services and supplies;

(viii) Personnel and procurement;

(ix) Dues and subscriptions;

(x) Interest on working capital;

(xi) Home office costs; and

(xii) OSHA costs.

D. Depreciation allowance shall be determined in accordance with the Medicare Principles of Reimbursement set forth at 42 CFR Part 413 Subpart G, except that:

(i) Only the straight line method shall be used; and

(ii) 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.

E. Consistent use of either the component or composite asset depreciation schedule shall be required, as follows:

(i) 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

(ii) Composite depreciation shall be applied for a newly purchased existing facility.

F. Donated assets shall be recorded at fair market value at the time received, based on the lesser of at least two bona fide appraisals.

G. Leasehold improvements shall be depreciated over the lesser of the asset's useful life or the remaining life of the lease.

H. When a facility is sold, the depreciation basis shall be subject to the limitation of the reevaluation of assets mandated by section 1861 (v)(1)(o) of Title 18 of the Social Security Act.

I. 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.

J. Bad debts, charity, and courtesy allowances, as defined at 42 CFR 413.80(b), shall not be recognized as allowable costs.

K. 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 shall not exceed the price of comparable services, facilities or supplies that could be purchased by independent providers in the Washington metropolitan area.

L. Return equity capital of proprietary providers shall be determined according to the Medicare Principles of Reimbursement.

M. 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.

N. 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.

O. District of Columbia provider tax costs shall be excluded from allowable costs.

P. Home office costs and managements fees shall be subject to the following conditions and limitations:

(i) Home office cost allocations and management fees between related parties shall be reported without mark-up by the nursing facility;

(ii) 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

(iii) The nursing facility's audited certified cost allocation plan relating to home office and management fees shall be provided.

Q. Respiratory therapy costs including equipment rental, supplies and labor and staffing costs associated with providing ventilator care shall be excluded from allowable costs.

R. 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).

XIV. EXCLUSIONS FROM ALLOWABLE COSTS

A. The following categories of expense shall be excluded from allowable operating costs because they are not normally incurred in providing resident care:

(i) Fund raising expenses in excess of ten percent (10%) of the amount raised;

(ii) Parties and social activities not related to resident care;

(iii) Personal telephone, radio, and television services;

(iv) Gift, flower and coffee shop expenses;

(v) Vending machines;

(vi) Interest expenses and penalties due to late payment of bills or taxes, or for licensure violations; and

(vii) Prescription drug costs.

B. The following expenditures shall reduce allowable costs:

(i) The greater of the revenues generated from employee and guest meals or the cost of the meals;

(ii) The greater of the revenues generated from rental space in the facility or the cost of the rental space:

(iii) Purchase discounts and allowances;

(iv) Investment income for unrestricted funds to the extent that it exceeds interest expense on investments;

(v) Recovery of an insured loss:

(vi) Grants, gift and income from endowments designated by the donor for specific operating expenses; and

(vii) Any other income or expense item determined to reduce allowable costs pursuant to the Medicare Principles of Reimbursement.

XV. REIMBURSEMENT FOR NEW PROVIDERS

A. New providers shall submit a pro forma cost report based on a budget of estimated first year costs. MAA has the right to review and adjust each nursing facility's pro forma cost report.

B. The interim per diem rate for each new provider shall be the sum of the routine and support costs per diem, nursing and resident care costs per diem and capital related costs per diem as calculated pursuant to this section. The interim facility specific rate for each new provider shall remain in effect until the new provider's one full year of operational costs has been audited. Each new provider may receive an add-on payment for each resident that qualifies and receives ventilator care pursuant to Sections X through XII.

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

D. The interim rate for routine and support costs per diem for a new provider assigned to Peer Groups One or Two shall be equal to the day-weighted median cost per diem for routine and support costs for all facilities in Peer Groups One and Two. The interim rate for routine and support costs per diem for a new provider assigned to Peer Group Three shall be equal to the day-weighted median cost per diem for routine and support costs for all facilities in Peer Group Three.

E. The interim rate for nursing and resident care costs per diem for a new provider assigned to Peer Group One shall be determined by multiplying the day-weighted median cost per diem for nursing and patient care costs for all facilities in Peer Group One by the District-wide Medicaid average case mix index. The interim rate for nursing and resident care costs per diem for a new provider assigned to

Peer Group Two shall be determined by multiplying the median cost per diem for nursing and resident care costs for all facilities in Peer Group Two by the District-wide Medicaid average case mix index. The interim rate for nursing and resident care costs per diem for a new provider assigned to Peer Group Three shall be determined by multiplying the day-weighted median cost per diem for nursing and patient care costs for all facilities in Peer Group Three by the District-wide Medicaid average case mix index.

F. The interim rate for capital-related costs per diem shall be established by dividing the lower of capital-related reported costs as determined by MAA pursuant to Section XV.A.or capital costs set forth in a written finding by the State Health Planning and Development Agency in its approval of the certificate of need issued in accordance with D.C. Official Code § 44-401 *et seq.* if available, by the number of resident days reported in Section XV.A. adjusted in accordance with Section XIII.B.

G. Following the results of the audited cost report, the new provider's reimbursement rate for routine and support costs per diem shall be the lower of the audited routine and support costs per diem and the related ceiling for each of the respective cost categories. The reimbursement rate for nursing and resident costs per diem shall be the lower of the audited nursing and resident cost per diem and related ceilings adjusted for case mix by the facility Medicaid case mix index for each of the respective cost categories. The capitol cost per diem shall be calculated in accordance with the requirements set forth in Section XV.F. The peer group ceilings shall not be adjusted until the rates are rebased.

H. After completion of the audit, a new provider shall have the right to appeal the audit adjustments consistent with the requirements set forth in Section XXI.

I. MAA shall collect any overpayment or pay any difference as a result of the difference between the audited final rate and interim rate paid to a new provider.

J. MAA 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. The rate letter shall also include the District-wide Medicaid average case mix index or the facility Medicaid case mix index as appropriate.

K. Within thirty days of the date of receipt of the rate letter, a new provider that disagrees with the mathematical calculation of the District-wide Medicaid case mix index or if appropriate, the facility Medicaid case mix index may request an administrative review by sending a written request for administrative review to the Fiscal Officer, Audit and Finance, Medical Assistance Administration, Department of Health, 825 North Capitol Street, NE, Suite 5135, Washington, D.C. 20002

L. RUGS III classifications or CMI scores are not subject to appeal.

M. The written request for an administrative review shall include a specific explanation of why the nursing facility believes the calculation is in error, the relief requested and documentation in support of the relief requested.

N. MAA 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.

O. Decisions made by MAA and communicated in the formal response may be appealed, within thirty (30) days of the date of MAA's letter notifying the facility of the decision, to the Office of Administrative Hearings.

P. Filing an appeal with the Office of Administrative Hearings pursuant to this section shall not stay any action by MAA to recover any overpayment to the nursing facility.

XVI. REIMBURSEMENT FOR REORGANIZED FACILITIES OR CHANGE OF OWNERSHIP

A. A nursing facility that has been re-organized pursuant to Chapter 11 of the United States Bankruptcy Code on or after a specific date determined by MAA, and set forth in rules published in Chapter 65 of Title 29 DCMR , shall be reimbursed at the same rate in effect prior to the date of filing its petition.

B. A nursing facility with a change of ownership on or after a specific date determined by MAA and set forth in rules, shall be reimbursed at the same rate established for the nursing facility prior to the change of ownership.

XVII. REIMBURSEMENT FOR OUT OF STATE FACILITIES

A. If a facility is located outside the District of Columbia ("District"), MAA shall reimburse the facility for care rendered to a District Medicaid resident in accordance with the Medicaid reimbursement policy of the state in which the facility is located.

B. MAA 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 MAA.

D. Each out-of-state facility shall obtain written authorization from MAA prior to admission of a District Medicaid recipient in accordance with the requirements set forth in sections 905.3 and 905.4 of Title 29 DCMR.

XVIII. REBASING

Not later than October 1, 2008, and every three years thereafter, the base year data, medians, day-weighted medians and ceilings shall be updated.

XIX. COST REPORTING AND RECORD MAINTENANCE

A. Each nursing facility shall submit an annual cost report to the Medicaid Program 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. MAA 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 extension of time shall be granted to a facility for a cost reporting year and no extension of time shall exceed thirty (30) days. MAA 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, 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 on CD-ROM format of the cost report. Each copy shall have an original signature.

G. 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 Section XIII. K. 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.

SEP-25-2007 10:41 DHHS CMS CMSO HBG 717 782 4968 P.08

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 15.

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 MAA has approved an exception.

K. A cost report that is not complete as required by Section XIX. F. through 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 MAA, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the filing is complete.

M. MAA 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 and all program instructions.

R. Audits shall be conducted to establish the initial rates and upon rebasing, as set forth in Section XVIII.

XX. ACCESS TO RECORDS

Each nursing facility shall allow appropriate personnel of the Department of Health, representatives of the 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.

XXI. 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 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 the Agency Fiscal Officer, Audit and Finance, Medical Assistance Administration, Department of Health, 825 North Capitol Street, NE, Suite 5135, Washington, D.C. 20002.

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. MAA 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.

E. Decisions made by MAA and communicated in the formal response may be appealed, within thirty (30) days of the date of MAA's letter notifying the facility of the decision, to the Office of Administrative Hearings.

F. MAA shall issue a rate letter to each nursing facility at least 30 days prior to the initial implementation, semi-annual rate adjustments, or when rates are rebased. In addition to the required rate letter, MAA shall also issue a transmittal to each nursing facility which sets forth the reimbursement rates of each District nursing facility.

G. The rate letter shall include the final per diem payment rate. The rate letter shall also include the Facility Medicaid case mix index.

H. Within fifteen days of the date of receipt of the rate letter any nursing facility that disagrees with the mathematical calculation of the facility Medicaid case mix index may request an administrative review by sending a written request for administrative review to the Fiscal Officer, Audit and Finance, Medical Assistance Administration, Department of Health, 825 North Capitol Street, NE, Suite 5135, Washington, D.C. 20002.

I. The RUGS III classification or CMI score assigned to each resident are not subject to appeal.

J. The written request for an administrative review shall include a specific explanation of why the nursing facility believes the calculation is in error, the relief requested and documentation in support of the relief requested.

K. MAA 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.

L. Decisions made by MAA and communicated in the formal response may be appealed, within thirty (30) days of the date of MAA's letter notifying the facility of the decision, to the Office of Administrative Hearings.

M. Filing an appeal with the Office of Administrative Hearings pursuant to this section shall not stay any action by MAA to recover any overpayment to the nursing facility.

XXII. 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 MAA, on which rates for all freestanding or hospital-based facilities are calculated to derive a prospective reimbursement rate.

BO1- the case mix index scores developed by the Centers for Medicare and Medicaid Services for the Medicaid 34-group Resource Utilization Groups (RUGS-III) classification system.

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-III 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.

Ceiling- a pre-determined rate that sets the upper limit of reimbursement.

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

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.

District-wide Average Case Mix Index- the arithmetic mean of the individual residents case mix indices for all residents, regardless of payer, admitted and present in all nursing facilities located in the District of Columbia on the picture date. The arithmetic mean shall be carried to four decimal places.

District-wide Medicaid Average Case Mix Index - the arithmetic mean of the individual resident's case mix indices for all residents admitted and present in all nursing facilities on the picture date for which the Department of Health Care Finance (DHCF) is the payer source. The arithmetic mean shall be carried to four decimal places.

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 Index- 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 the picture date. The arithmetic mean shall be carried to four decimal places.

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

Leasehold Improvements- the improvements made by the owners of a facility to leased land, buildings or equipment.

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.

Medical Assistance Administration (MAA)- an administration within the Department of Health that is responsible for the day-to-day administration and oversight of the District's Medicaid Program.

Minimum Data Set (MDS), Version 2.0- the resident assessment instrument and data used to determine the RUGS classification of each resident.

New Provider- a nursing facility that entered the Medicaid Program on or after a specific date determined by MAA as set forth in rules and whose costs have not been audited and included in MAA's database for purposes of establishing the base year rates.

Normalized- the process by which the average case mix for the District is set to 1.0. This process shall only be performed at implementation and rebasing.

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*.

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.

Picture Date- one day per quarter in each fiscal year, as selected by the Medical Assistance Administration.

Prudent Buyer Concept- the price paid by a prudent buyer in the open market under competitive conditions.

Reserved Bed Day- a day for hospitalization or therapeutic leaves of absence, when provided for in the resident's plan of care and when there is a reasonable expectation that the resident will return to the nursing facility. Reserved bed days may not exceed a total of 18 days during any 12- month period that begins on October 1st and ends on September 30th. A therapeutic leave of absence includes

visits with relatives and friends and leave to participate in a State-approved therapeutic and rehabilitative program.

Resident-an individual who, because of physical, mental, familial or social circumstances or mental retardation, is residing in a nursing facility.

Resident Day- one continuous 24-hour period of care furnished by a nursing facility that concludes at midnight each calendar day, including reserved bed days that are paid for by MAA. 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, Version III (RUGS III)- 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 Index- the arithmetic mean of the individual resident case mix indices for all residents, regardless of payer, admitted and present in the nursing facility on the picture date. The arithmetic mean shall be carried to four 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.