

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Registrar, Department of Health, pursuant to the authority set forth in § 27 of the Vital Records Act of 1981 (Act), effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-226) (2001), hereby gives notice of final rulemaking. The Registrar took final rulemaking action on February 10, 2006, to adopt the following amendments to section 2800 of Title 29 of the District of Columbia Municipal Regulations (DCMR). The purpose of the rulemaking is to clarify the procedures for recording a child's name on birth information supplied to the Registrar for the purpose of generating a birth certificate and registering the birth consistent with the requirements of the Act as amended by the Surname Choice Amendment Act of 2002 (D.C. Law 14-299). A Notice of Proposed Rulemaking was published December 30, 2005 at 52 DCR 11295. No comments were received respecting the proposed rule, and no changes have been made since publication of the proposed rule. This rule will become effective on the date that this notice is published in the *D.C. Register*.

Section 2800.6 of Title 29 (Public Welfare) (May 1987) of the DCMR is amended to read as follows:

- 2800.6 A child's surname shall be entered on the birth certificate as follows:
- (a) A child's surname, if the father's name is included on the birth certificate, may be:
 - (1) The mother's surname;
 - (2) The father's surname;
 - (3) A combination of the mother's surname and the father's surname in any order, or in hyphenated or unhyphenated form; or
 - (4) A surname that has a familial connection to either the father or the mother.
 - (b) A child's surname, if the father is not named on the birth certificate, may be:
 - (1) The mother's surname; or
 - (2) A surname that has a familial connection to the mother.
 - (c) If a child's surname is not the surname of the mother or the father, or a combination of all or part of both surnames, either the father

or the mother shall provide an affidavit stating that the child's surname is the name of a relative or ancestor or has some other clearly stated familial connection.

- (d) A person who submits an affidavit with false information pursuant to subsection (c) shall be subject to a fine of not more than two hundred dollars (\$200), imprisonment of not more than ninety (90) days, or both.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code §1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new Chapter 65 of Title 29 of the District of Columbia Municipal Regulations (DCMR) entitled "Medicaid Reimbursement to Nursing Facilities". These rules repeal the current rules governing reimbursement to nursing facilities by the District of Columbia Medicaid Program ("Medicaid Program") set forth in Chapter 9 of Title 29 DCMR. The effect of these rules is to change the current prospective payment reimbursement methodology for District nursing facilities participating in the Medicaid Program to a prospective payment model that will compensate based on resident acuity.

The Medicaid Program will reimburse each District nursing facility on a prospective basis at a facility-specific per diem rate for all services provided, except prescription drugs. Prescription drugs will be reimbursed through a point-of-sale system. The facility-specific per diem rate is developed by establishing a base year per diem rate for each facility, subject to a ceiling and subject to adjustments. The per diem rate will be adjusted semi-annually for case mix. In addition to the per diem rate, a facility may receive an add-on payment for each resident receiving ventilator care.

The District is changing its methodology to operate a more equitable reimbursement system and to recognize and compensate facilities that provide services to residents requiring a higher intensity of care. The Medicaid Program estimates an increase of \$16,534,449 in annual aggregate expenditures.

The United States Congress in 2003 enacted the "Medicare Prescription Drug Improvement and Modernization Act of 2003", which established the Medicare Prescription Drug Program known as "Part D". All Medicaid recipients eligible for Medicare Part A or enrolled in Medicare Part B are entitled to the new Part D drug benefit. The States are required to implement Part D on January 1, 2006. This new reimbursement model also allows the Medicaid Program the flexibility to implement the mandates required for the Part D benefit.

The corresponding amendment to the District of Columbia State Plan (State Plan) was approved by the Council of the District of Columbia. The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved the attendant State Plan amendment on December 5, 2005.

A notice of emergency and proposed rulemaking was published in the *D.C. Register* on December 30, 2005 (52 DCR 11315). No comments on the proposed rules were

received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *D.C. Register*.

Title 29 is amended as follows:

Delete sections 950 through 963 (Reimbursement of Nursing Facilities) of Chapter 9 in their entirety; and

Add the following new Chapter 65 to read as follows:

**CHAPTER 65 MEDICAID REIMBURSEMENT TO
NURSING FACILITIES**

6500 GENERAL PROVISIONS

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

6500.2 Medicaid reimbursement to nursing facilities for services provided beginning January 1, 2006 shall be on a prospective payment system consistent with the requirements set forth in these rules.

6500.3 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.

6501 REIMBURSEMENT OF NURSING FACILITIES

6501.1 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. A facility may also receive an add-on payment for each resident receiving ventilator care pursuant to the requirements set forth in sections 6509 through 6511.

6501.2 The base year costs for each free-standing nursing facility shall be calculated using actual audited allowable costs for the nursing facility's fiscal year that ends on or after January 1, 2000, but no later than December 31, 2000.

6501.3 The base year costs for each hospital-based nursing facility shall be calculated using actual audited allowable costs for the nursing facility's

fiscal year that ends on or after January 1, 1999, but no later than January 31, 1999.

6501.4 Except for depreciation, amortization and interest on capital-related expenditures, the base year costs for each nursing facility shall be adjusted to October 1, 2000 using the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System Skilled Nursing Facility Input Price Index.

6501.5 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:

6501.6 Routine and support expenditures shall include expenditures for:

- (a) Dietary items, except raw food;
- (b) Laundry and linen;
- (c) Housekeeping;
- (d) Plant operations and related clerical support;
- (e) Volunteer Services;
- (f) Administrative and general salaries;
- (g) Professional services - non-healthcare related;
- (h) Non-capital related insurance;
- (i) Travel and entertainment;
- (j) General and administrative costs;
- (k) Non-capital related interest expense; and
- (l) Other miscellaneous expenses as noted on the cost report submitted pursuant to section 6518.

6501.7 Nursing and resident care costs shall include the costs of:

- (a) Raw food;

- (b) Nursing and physician services and their related clerical support services;
- (c) Non-prescription drugs and pharmacy consultant services;
- (d) Medical supplies;
- (e) Laboratory services;
- (f) Radiology services;
- (g) Physical, speech and occupational therapy;
- (h) Social services;
- (i) Resident activities;
- (j) Respiratory therapy;
- (k) Oxygen therapy; and
- (l) Utilization and medical review.

6501.8 Capital related costs shall include the costs of:

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

6501.9 The total base year per diem for a facility for each Medicaid resident day shall be the sum of:

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

- (c) any incentive payment; and
- (d) capital related costs per diem.

6501.10 Provider tax expenses shall not be included in calculating the base year costs.

6501.11 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.

6502 COMPUTATION OF CEILINGS

6502.1 MAA shall classify each nursing facility operating in the District of Columbia and participating in the Medicaid Program into the following three (3) peer groups:

- (a) Peer Group One - All freestanding nursing facilities, with the exception of facilities owned or operated by the District of Columbia government;
- (b) Peer Group Two - All hospital-based nursing facilities; and
- (c) Peer Group Three - All freestanding nursing facilities owned or operated by the District of Columbia government.

6502.2 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, which is calculated to be fifty dollars and fifty-three cents (\$50.53).

6502.3 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, which is calculated to be sixty-two dollars and twelve cents (\$62.12).

6502.4 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, which is calculated to be seventy-four dollars and twelve cents (\$74.12).

6502.5 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, which is calculated to be eighty-four dollars and eighty-three cents (\$84.83).

- 6502.6 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, which is calculated to be one hundred and fifty-five dollars and seventy-nine cents (\$155.79).
- 6502.7 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.
- 6502.8 Once nursing facilities have been classified into peer groups for purposes of establishing the medians and ceilings, the nursing facility costs for those facilities shall remain in that peer group until Medicaid rates are rebased.
- 6502.9 If a nursing facility changes classification status, the facility shall be re-assigned 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.

6503 RESIDENT ASSESSMENT

- 6503.1 Each nursing facility shall complete an assessment of each resident's functional, medical and psycho-social capacity consistent with the requirements set forth in 42 CFR § 483.20.
- 6503.2 The Minimum Data Set (MDS), Version 2.0 or successor updates to this version, shall be used by each nursing facility.
- 6503.3 Each nursing facility shall comply with the policies set forth in the December 2002 Revised Long Term Care Resident Assessment Instrument User's Manual for the MDS, Version 2.0 or successor updates to this version.

6504 RESIDENT CLASSIFICATION SYSTEM

- 6504.1 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.
- 6504.2 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.

- 6504.3 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 6503.
- 6504.4 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.
- 6504.5 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.
- 6504.6 MAA shall issue to each nursing facility a draft report no later than ninety (90) days following each picture date with the following information:
- (a) The RUGS III classification and CMI score for each resident on the picture date;
 - (b) Identifying information (resident's name, social security number, Medicaid identification number and date of birth) for each resident; and
 - (c) The payer status for each resident (Medicaid or Non-Medicaid).
- 6504.7 Each nursing facility shall have thirty (30) days after receipt of the report issued pursuant to subsection 6504.6 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.
- 6504.8 No nursing facility shall make any corrections to the RUGS III classification or CMI score.
- 6504.9 Corrections submitted and determined by MAA to be appropriate shall be included in the final report of the CMI scores used in establishing the nursing facility's reimbursement rate.
- 6504.10 MAA shall not make any corrections to the report for information received from the nursing facility after the thirty (30) day period set forth in subsection 6504.7.

- 6505 NURSING AND RESIDENT CARE COSTS PER DIEM CALCULATION**
- 6505.1 Each nursing facility's allowable nursing and resident care costs shall be adjusted in accordance with subsection 6501.4.
- 6505.2 Total resident days shall be determined in accordance with subsection 6512.2.
- 6505.3 The amount calculated in subsection 6505.1 shall be divided by the Total Facility Case Mix Index to establish case mix neutral costs. This process is known as case mix neutralization.
- 6505.4 The case mix neutral costs established in subsection 6505.3 shall be divided by the resident days calculated in accordance with subsection 6505.2 to determine each nursing facility's nursing and resident care cost per diem unadjusted for case mix.
- 6505.5 The ceiling established in accordance with subsections 6502.4 through 6502.6 for nursing and resident care costs for each peer group shall be multiplied by 163 percent (163 %).
- 6505.6 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 subsection 6505.4 or the adjusted ceiling relative to each nursing facility calculated in accordance with subsection 6505.5.
- 6505.7 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 subsection 6505.4 and the adjusted ceiling calculated in accordance with subsection 6505.5, if the facility-specific per diem rate calculated in accordance with subsection 6505.4 is lower than the adjusted ceiling relative to each nursing facility established pursuant to subsection 6505.5.
- 6505.8 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 subsection 6505.6, or, if applicable, the nursing and resident care cost per diem adjusted for incentive, as set forth in subsection 6505.7, by the Facility Medicaid Case Mix Index.
- 6505.9 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.

- 6505.10 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.
- 6505.11 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.
- 6506 ROUTINE AND SUPPORT COSTS PER DIEM CALCULATION**
- 6506.1 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 subsection 6501.4 by total resident days determined in accordance with subsection 6512.2 for all nursing care residents.
- 6506.2 The ceiling established in accordance with subsections 6502.2 and 6502.3 for routine and support costs for each peer group shall be multiplied by 139.3 percent (139.3%).
- 6506.3 Each nursing facility's routine and support cost per diem shall be the lower of the facility-specific per diem calculated in subsection 6506.1 or the adjusted ceiling relative to each nursing facility calculated in accordance with subsection 6506.2.
- 6506.4 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 subsection 6506.1 and the adjusted ceiling calculated in accordance with subsection 6506.2, if the facility-specific per diem rate calculated in accordance with subsection 6506.1 is lower than the adjusted ceiling established in subsection 6506.2.
- 6507 CAPITAL-RELATED COSTS PER DIEM CALCULATION**
- 6507.1 Each nursing facility's capital-related cost per diem shall be calculated by dividing total allowable capital-related base year costs adjusted in accordance with subsection 6501.4 by total resident days determined in accordance with subsection 6512.2 for all nursing care residents.

6508 FINAL PER DIEM RATE CALCULATION

6508.1 Each nursing facility's per diem rate effective January 1, 2006 shall be the sum of (a), (b) and (c) as set forth below:

- (a) the nursing and resident care base year cost per diem established pursuant to subsection 6505.6 adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index;
- (b) the routine and support cost base year cost per diem established pursuant to subsection 6506.3, or subsection 6506.4 if applicable, adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index; and
- (c) the capital related base year cost per diem established pursuant to section 6507 adjusted for inflation to March 30, 2003 using the CMS Prospective Payment System Skilled Nursing Facility Input Price Index. The inflation adjustment in this subsection shall not be applied to depreciation, amortization and interest on capital related expenditures.

6508.2 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 6505. The per diem rates established for routine and support costs and capital-related costs established pursuant to subsection 6508.1 shall be carried forward until costs are rebased.

6508.3 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.

6508.4 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.

6508.5 Each adjustment pursuant to subsection 6508.4 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.

6509 VENTILATOR CARE

- 6509.1 In addition to the facility-specific base year per diem rate calculated in accordance with subsection 6508.1 (a) through (c), 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 6509 through 6511.
- 6509.2 Each resident receiving ventilator care shall meet all of the following requirements:
- (a) Be ventilator dependent and not able to breathe without mechanical ventilation;
 - (b) Use the ventilator for life support, 16 hours per day, 7 days per week;
 - (c) Have a tracheostomy or endotracheal tube;
 - (d) At the time of placement the resident has been ventilator dependent during a single stay or continuous stay at a hospital, skilled nursing facility or intermediate care facility for the mentally retarded;
 - (e) Have a determination by the resident's physician and respiratory care team that the service is medically necessary, as well as documentation which describes the type of mechanical ventilation, technique and equipment;
 - (f) Be medically stable, without infections or extreme changes in ventilatory settings and/or duration (increase in respiratory rate by 5 breaths per minute, increase in F1O2 of 25% or more, and/or increase in tidal volume of 200 mls or more) at time of placement;
 - (g) Require services on a daily basis which cannot be provided at a lower level of care; and
 - (h) Require services be provided under the supervision of a licensed health care professional.
- 6509.3 Each nursing facility shall comply with all of the standards governing ventilator care services set forth in section 3215 of Title 22 DCMR.
- 6509.4 Ventilator care shall be prior-authorized by the Department of Health, Medical Assistance Administration (MAA). The following documents shall be required for each authorization:
- (a) Level of Care determination;

- (b) Pre-admission Screening and Annual Resident Review (PASARR) forms;
- (c) Admission history;
- (d) Physical examination reports;
- (e) Surgical reports; and
- (f) Consultation reports and ventilator dependent addendum.

6509.5 For purposes of this section the term "medically necessary" shall mean a service that is required to prevent, identify, or treat a resident's illness, injury or disability and meets the following standards:

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

6510

VENTILATOR CARE DISCHARGE

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- 6510.1 Each provider shall ensure that residents are weaned from the ventilator when weaning is determined to be medically appropriate.
- 6510.2 A provider shall discontinue weaning and resume mechanical ventilation if the resident experiences any of the following:
- (a) Blood pressure elevation of more than 20 mmHg Systolic or more than 10 mmHg diastolic;
 - (b) Heart rate of more than 10% above the baseline or a heart rate of 120 beats per minute;
 - (c) Respiratory rate increase of more than 10 breaths per minute or a rate above 30 breaths per minute;
 - (d) Arrhythmias;
 - (e) Reduced tidal volume;
 - (f) Elevated partial pressure of arterial carbon dioxide;
 - (g) Extreme anxiety;
 - (h) Dyspnea; or
 - (i) Accessory muscle use in breathing or an otherwise deteriorating breathing pattern.
- 6510.3 Each nursing facility shall have an appropriate program for discharge and weaning from the ventilator.
- 6510.4 The nursing facility shall ensure that the resident and all caregivers be trained in all aspects of mechanical ventilation and demonstrate proficiency in ventilator care techniques before a ventilator-dependent resident can be discharged home on a mechanical ventilator.
- 6510.5 The physician and respiratory team shall arrange a schedule for follow-up visits, as indicated by the needs of the resident.
- 6510.6 A written discharge plan shall be provided to and reviewed with the resident and resident's caregiver and shall include at a minimum the following information:
- (a) Name, address and telephone number of the primary physician;

- (b) Address and telephone number of the local hospital emergency department;
- (c) Name, address and telephone number of the physician for regular respiratory check-ups, if different from the physician identified in 6510.4(a);
- (d) The responsibilities of the resident and caregiver in daily ventilator care;
- (e) Identification of financial resources for long-term care;
- (f) Identification of community resources for health, social, educational and vocational needs;
- (g) An itemized list of all equipment and supplies needed for mechanical ventilation;
- (h) Names, addresses and telephone numbers of mechanical ventilation equipment dealers and a list of services that they provide; and
- (i) Contingency plans for emergency situations.

6510.7 The nursing facility shall notify MAA of the date of discharge from the facility.

6511 VENTILATOR CARE REIMBURSEMENT

6511.1 The add-on reimbursement rate for ventilator care shall be \$380.00 per day for each resident.

6512 ALLOWABLE COSTS

6512.1 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:

- (a) Room and board, including dietary, food, laundry and linen, housekeeping, plant operations and maintenance;
- (b) Medical direction;
- (c) Nursing care;
- (d) Minor medical and surgical supplies;

- (e) Social and resident activity services;
- (f) Special services required by the resident, including physical, occupational, or speech therapy, oxygen therapy, but not dental care;
- (g) Incontinency care;
- (h) Tray service;
- (i) Resident gowns;
- (j) Canes, crutches, walkers and wheelchairs, excluding customized wheelchairs;
- (k) Traction equipment and other durable medical equipment for multi-resident use;
- (l) Special dietary services, including tube or hand feeding and special diets; and
- (m) Laundry services, except personal laundry.

6512.2 The occupancy rate used in determining the per diem rate for each cost category shall be the greater of:

- (a) The actual paid occupancy, including paid reserve bed days; or
- (b) Ninety-three percent (93%) of certified bed days available during the cost reporting period.

6512.3 General and administrative expenses shall include but not be limited to:

- (a) Administrative salaries, including fringe benefits;
- (b) Professional services, including accounting and auditing expenses, fees of management consultants and legal fees;
- (c) General liability insurance;
- (d) Telephone;
- (e) Licenses;
- (f) Travel and entertainment;

- (g) Office expenses, including services and supplies;
 - (h) Personnel and procurement;
 - (i) Dues and subscriptions;
 - (j) Home office costs;
 - (k) Interest on working capital; and
 - (l) OSHA costs.
- 6512.4 Depreciation allowance shall be determined in accordance with the Medicare Principles of Reimbursement set forth at 42 CFR Part 413 Subpart G, except that:
- (a) Only the straight line method shall be used; and
 - (b) The useful life of the assets must comply with the most recent guidelines for hospitals published by the American Hospital Association, and approved by the Medicare program.
- 6512.5 Consistent use of either the component or composite asset depreciation schedule shall be required, as follows:
- (a) Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined; and
 - (b) Composite depreciation shall be applied for a newly purchased existing facility.
- 6512.6 Donated assets shall be recorded at fair market value at the time received, based on the lesser of at least two bona fide appraisals.
- 6512.7 Leasehold improvements shall be depreciated over the lesser of the asset's useful life or the remaining life of the lease.
- 6512.8 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 XVIII of the Social Security Act.

- 6512.9 Necessary and proper interest on both current and capital indebtedness shall be allowable costs, determined in accordance with the Medicare Principles of Reimbursement set forth at 42 CFR 413.153.
- 6512.10 Bad debts, charity, and courtesy allowances, as defined at 42 CFR 413.80(b), shall not be recognized as allowable costs.
- 6512.11 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.
- 6512.12 Return on equity capital of proprietary providers shall be determined according to the Medicare Principles of Reimbursement.
- 6512.13 Reasonable rental expense shall be an allowable cost for leasing of a facility from a non-related party if it is an arm's length transaction.
- 6512.14 The purchase or rental by a facility of any property, plant, equipment, services and supplies shall not exceed the cost that a prudent buyer would pay in the open market to obtain these items.
- 6512.15 District of Columbia provider tax costs shall be excluded from allowable costs.
- 6512.16 Home office costs and management fees shall be subject to the following conditions and limitations:
- (a) Home office cost allocations and management fees between related parties shall be reported without mark-up by the nursing facility;
 - (b) Costs that are not allowable, such as those related to nonworking officers or officers' life insurance, shall not be included in home office allocations or management fees;
 - (c) The nursing facility's audited certified cost allocation plan relating to home office and management fees shall be provided.
- 6512.17 Respiratory therapy costs including equipment rental, supplies and labor and staffing costs associated with providing ventilator care shall be excluded from allowable costs.

6512.18 For purposes of this section, the phrases "related to the provider", "common ownership" and "control" shall have the same meaning as set forth in 42 CFR 413.17(b).

6513 EXCLUSIONS FROM ALLOWABLE COSTS

6513.1 The following categories of expense shall be excluded from allowable operating costs because they are not normally incurred in providing resident care:

- (a) Fund raising expenses in excess of ten percent (10%) of the amount raised;
- (b) Parties and social activities not related to resident care;
- (c) Personal telephone, radio, and television services;
- (d) Gift, flower and coffee shop expenses;
- (e) Vending machines;
- (f) Interest expenses and penalties due to late payment of bills or taxes, or for licensure violations; and
- (g) Prescription drug costs.

6513.2 The following expenditures shall reduce allowable costs:

- (a) The greater of the revenues generated from employee and guest meals or the cost of the meals;
- (b) The greater of the revenues generated from rental space in the facility or the cost of the rental space;
- (c) Purchase discounts and allowances;
- (d) Investment income for unrestricted funds to the extent that it exceeds interest expense on investments;
- (e) Recovery of an insured loss;
- (f) Grants, gift and income from endowments designated by the donor for specific operating expenses; and
- (g) Any other income or expense item determined to reduce allowable costs pursuant to the Medicare Principles of Reimbursement.

- 6514 REIMBURSEMENT FOR NEW PROVIDERS**
- 6514.1 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.
- 6514.2 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 6509 through 6511.
- 6514.3 Each new provider shall be assigned to the appropriate peer group as set forth in subsection 6502.1.
- 6514.4 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.
- 6514.5 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.
- 6514.6 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 subsection 6514.1 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 subsection 6514.1 adjusted in accordance with subsection 6512.2.

- 6514.7 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 6514.6. The peer group ceilings shall not be adjusted until the rates are rebased.
- 6514.8 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 6520.
- 6514.9 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.
- 6514.10 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.
- 6514.11 Within thirty days of the date of receipt of the rate letter issued pursuant to subsection 6514.10, 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.
- 6514.12 RUGS III classifications or CMI scores are not subject to appeal.
- 6514.13 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.

- 6514.14 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 pursuant to subsection 6514.13.
- 6514.15 Decisions made by MAA and communicated in the formal response described in subsection 6514.14 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.
- 6514.16 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.

6515 REIMBURSEMENT FOR REORGANIZED FACILITIES OR CHANGE OF OWNERSHIP

- 6515.1 A nursing facility that has been re-organized pursuant to Chapter 11 of the United States Bankruptcy Code after September 30, 2000 shall be reimbursed at the same rate in effect prior to the date of filing its petition.
- 6515.2 A nursing facility with a change of ownership after September 30, 2000 shall be reimbursed at the same rate established for the nursing facility prior to the change of ownership.

6516 REIMBURSEMENT FOR OUT OF STATE FACILITIES

- 6516.1 If a facility is located outside the District of Columbia ("District"), MAA shall reimburse the facility for care rendered to a District Medicaid recipient in accordance with the Medicaid reimbursement policy of the state in which the facility is located.
- 6516.2 MAA shall notify each out-of-state facility, in writing, of its payment rate calculated in accordance with this section.
- 6516.3 An out-of-state facility is not required to file cost reports with MAA.
- 6516.4 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.

6517 REBASING

- 6517.1 Not later than October 1, 2009 and every four years thereafter, the base year data, medians, day-weighted medians and ceilings shall be updated.

- 6518 COST REPORTING AND RECORD MAINTENANCE**
- 6518.1 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.
- 6518.2 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.
- 6518.3 A delinquency notice shall be issued if the facility does not submit the cost report on time and has not received an extension of the deadline for good cause.
- 6518.4 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.
- 6518.5 If the cost report is not submitted within thirty (30) days of the date of the notice of delinquency, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the cost report is received.
- 6518.6 Each nursing facility shall submit one (1) original hard-copy and (1) one electronic copy on CD-ROM format of the cost report. Each copy shall have an original signature.
- 6518.7 Each cost report shall meet the following requirements:
- (a) Be properly completed in accordance with program instructions and forms and accompanied by supporting documentation;
 - (b) Include copies of audited financial statements or other official documents submitted to a governmental agency justifying revenues and expenses;
 - (c) Include and disclose payments made to related parties in accordance with section 6512.11 and the reason for each payment to a related party; and
 - (d) Include audited cost allocation plans for nursing facilities with home office costs, if applicable.
- 6518.8 Computations included in the cost report shall be accurate and consistent with other related computations and the treatment of costs shall be consistent with the requirements set forth in these rules.

- 6518.9 In the absence of specific instructions or definitions contained in these rules or cost reporting forms and instructions, the decision of whether a cost is allowable shall be determined in accordance with the Medicare Principles of Reimbursement and the guidelines set forth in Medicare Provider Reimbursement Manual 15.
- 6518.10 All cost reports shall cover a twelve (12) month cost reporting period, which shall be the same as the facility's fiscal year, unless MAA has approved an exception.
- 6518.11 A cost report that is not complete as required by subsections 6518.6 through 6518.8 shall be considered an incomplete filing and the nursing facility shall be so notified.
- 6518.12 If, within thirty (30) days of the notice of incomplete filing, the facility fails to file a completed cost report and no extension of time has been granted by MAA, twenty percent (20%) of the facility's regular monthly payment shall be withheld each month until the filing is complete.
- 6518.13 MAA shall pay the withheld funds promptly after receipt of the completed cost report and documentation required meeting the requirements of this section.
- 6518.14 Each facility shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the facility's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and any original documents which pertain to the determination of costs.
- 6518.15 Each nursing facility shall maintain the records pertaining to each cost report as described in subsection 6518.14 for a period of not less than seven (7) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.
- 6518.16 All records and other information may be subject to periodic verification and review. Each cost report may be subject to a desk review.
- 6518.17 Each nursing facility shall:
- (a) Use the accrual method of accounting; and

- (b) Prepare the cost report in accordance with generally accepted accounting principles and all program instructions.

6518.18 Audits shall be conducted to establish the initial rates and upon rebasing as set forth in section 6517.

6519 ACCESS TO RECORDS

6519.1 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.

6520 APPEALS

6520.1 At the conclusion of each base year audit or any other required audit, a nursing facility shall receive an audited cost report including a description of each audit adjustment and the reason for each adjustment.

6520.2 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.

6520.3 The written request for an administrative review shall include an identification of the specific audit adjustment to be reviewed, the reason for the request for review of each audit adjustment and supporting documentation.

6520.4 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 pursuant to subsection 6520.2.

6520.5 Decisions made by MAA and communicated in the formal response described in subsection 6520.4 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.

6520.6 MAA shall issue a rate letter to each nursing facility prior to the initial implementation and at least 30 days prior to the semi-annual rate adjustments set forth in subsection 6508.2 or when rates are rebased pursuant to section 6517. 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.

- 6520.7 The rate letter shall include the final per diem payment rate as calculated pursuant to section 6508. The rate letter shall also include the Facility Medicaid case mix index.
- 6520.8 Within fifteen days of the date of receipt of the rate letter issued pursuant to subsection 6520.6, 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 Agency Fiscal Officer, Audit and Finance, Medical Assistance Administration, Department of Health, 825 North Capitol Street, NE, Suite 5135, Washington, D.C. 20002.
- 6520.9 The RUGS III classification or CMI score assigned to each resident are not subject to appeal.
- 6520.10 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.
- 6520.11 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 pursuant to subsection 6520.10.
- 6520.12 Decisions made by MAA and communicated in the formal response described in subsection 6520.11 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.
- 6520.13 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.

6599 DEFINITIONS

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

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

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

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

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

Ceiling means 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 means 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.

District-wide Average Case Mix Index means 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 means the arithmetic mean of the individual residents case mix indices for all residents admitted and present in all nursing facilities on the picture date for whom the Medical Assistance Administration is the payer source. The arithmetic mean shall be carried to four decimal places.

F102 (fraction of inspired oxygen) means the ratio of the concentration of oxygen to the total pressure of other gases in inspired air.

Facility Medicaid Case Mix Index means the arithmetic mean of the individual resident case mix index for all residents, for whom the Medical Assistance Administration (MAA) 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 means the value at which an asset could be sold in the open market in a transaction between unrelated parties.

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

Mechanical Ventilation means 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 means 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) means 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 means the resident assessment instrument and data used to determine the RUGS classification of each resident.

New Provider means a nursing facility that entered the Medicaid Program after September 30, 2000.

Normalized means 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 means a facility that is licensed as a nursing home pursuant to the requirements set forth in the "Health Care and Community Residence License Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 *et seq.*) and meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR 483.1 *et seq.*

Out of State Facility means a nursing facility located outside the District of Columbia which meets the licensure standards in the jurisdiction where services are provided and meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 CFR 483.1 *et seq.*

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

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

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

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

Reserved Bed Day means a day for hospitalization or therapeutic leave 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 means an individual who, because of physical, mental, familial or social circumstances, or mental retardation, resides in a nursing facility.

Resident Day means 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) means 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 means the volume of air inspired and expired during a normal respiratory cycle.

Total Facility Average Case Mix Index means 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 means a surgical opening in the trachea or windpipe through which a tube is channeled to assist breathing.

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

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

**DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

NOTICE OF FINAL RULEMAKING

The Commissioner of the Department of Insurance, Securities and Banking ("Commissioner"), pursuant to the authority set forth in section 117 of the Continuing Care Retirement Communities Act of 2004 (Act), effective April 6, 2005, (D.C. Law 15-270; D.C. Official Code § 44-151.01 *et seq.*), hereby gives notice of the adoption of a new Chapter 82, entitled Continuing Care Retirement Communities, to Title 26 of the D.C. Municipal Regulations (Insurance). The purpose of this new chapter is to implement the Act to establish the licensing process for continuing care retirement communities; to establish the conditions to be included in the disclosure statement; to list the criteria to be included in the financial forecast; to establish standards for revocation of a start-up certificate, preliminary certificate, permanent license, and restricted or conditional license; and to establish standards for the Commissioner to determine whether a continuing care retirement community is insolvent or in a hazardous financial condition. Notice of Proposed Rulemaking was published on December 2, 2005 at 52 DCR 10572. No comments were received concerning these rules and no changes have been made since publication as a Notice of Proposed Rulemaking. These final rules will be effective upon publication of this notice in the D.C. Register.

Title 26 DCMR (Insurance) is amended by adding a new Chapter 82, Continuing Care Retirement Communities to read as follows:

Chapter 82 CONTINUING CARE RETIREMENT COMMUNITIES

8200 LICENSURE PROCEDURE

8200.1 An applicant shall apply for licensure in accordance with the following steps:

- (a) For new or development stage facilities:
 - (1) The applicant shall initially submit the following items to the Commissioner for review:
 - (a) The applicant's name, address and telephone number;
 - (b) A copy of a non-binding reservation agreement form (a nonbinding agreement between a continuing care retirement community and future resident (or his representative) to reserve a unit in the continuing care retirement facility);

- (c) Escrow agreement;
 - (d) Narrative describing the facility, its mode of operation, and its location; and
 - (e) Any advertising materials to be used.
- (b) Upon completion of step (1)(a), the applicant may:
- (1) Disseminate materials describing the intent to develop a Continuing Care facility; and
 - (2) Enter into fully refundable non-binding reservation agreements for up to \$1,000.00. All funds received shall be escrowed.
- (c) For a Start-Up Certificate:
- (1) In order to obtain a Start-Up Certificate, the applicant or provider shall submit the following to the Commissioner for review:
 - (a) An Application for Licensure;
 - (b) A Disclosure Statement;
 - (c) A copy of a binding reservation agreement or resident agreement; and
 - (d) A market feasibility study.
 - (2) Upon issuance of the Start-Up Certificate, the applicant or provider may:
 - (a) Enter into binding reservation agreements or resident agreements;
 - (b) Accept entrance fees and entrance fee deposits over \$1,000.00. Any funds received shall be escrowed and shall be released with the approval of the Commissioner;
 - (c) Begin site preparation work; and
 - (d) Construct model units for marketing.
- (d) For a Preliminary Certificate:

- (1) In order to obtain a Preliminary Certificate, the applicant or provider shall submit the following to the Commissioner for review:
 - (a) An explanation of any material differences between actual costs and projected costs contained in the Start-Up Certificate submission (not required for existing operational Continuing Care facilities that are expanding);
 - (b) An updated Disclosure Statement;
 - (c) Current interim financial statements; and
 - (d) Confirmation of signed agreements for at least 50 percent of the new units, reserved by a deposit equal to at least 10 percent of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two months for facilities that have no entrance fee.
- (2) Upon issuance of the Preliminary Certificate, the applicant or provider may:
 - (a) Purchase or construct a Continuing Care facility;
 - (b) Renovate or develop structure(s) not already licensed as Continuing Care facility; and
 - (c) Expand existing Continuing Care facilities in excess of 10 percent of the current number of available Independent Living Units (ILU's) or available health related units/beds.
- (e) For a Permanent License:
 - (1) In order to obtain a Permanent License, the applicant or provider shall submit the following to the Commissioner for review at least 60 days before the facility opening:
 - (a) An updated Application for Licensure;
 - (b) An updated Disclosure Statement;
 - (c) Confirmation of signed agreements for new units required by the Continuing Care facility to break-even, reserved by a deposit equal to at least 10 percent of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two months for facilities that have no entrance fee;

- (d) All reports as required by an approved accrediting organization for the continuing care retirement community to maintain its accreditation; and
 - (e) A summary of the report of an actuary estimating the capacity of the applicant to meet its contractual obligation to the residents.
- (2) Upon issuance of the Permanent License and satisfaction of all other legal requirements, the applicant or provider may:
- (a) Open the Continuing Care facility; and
 - (b) Provide Continuing Care.
- (f) For a Restricted or Conditional License:
- (1) If all other licensing requirements are met, the Commissioner shall, in lieu of denying the issuance of a Permanent License, issue a Restricted or Conditional License to an applicant when one or more of the following conditions exist:
 - (a) A hazardous financial condition.
 - (b) Occupancy at the facility, or the number of executed agreements for new units at the facility, is below the level at which the facility would break-even.
 - (2) Upon issuance of the Restricted or Conditional License, the provider may operate the facility under the conditions or restrictions established by the Commissioner until such time as the Commissioner alters the conditions for continued operations or issues a Permanent License.
 - (3) Upon issuance of the Restricted or Conditional License, the provider shall file with the Commissioner quarterly financial statements and an occupancy report. These shall be due no later than 45 days following the end of each fiscal quarter.

8200.2

Any person seeking to operate a Continuing Care Retirement Facility in the District of Columbia shall file an application for licensure following the process described in section 8200.1 with a filing fee in the amount of \$500.00 attached to the Application for Continuing Care Retirement Community License—Start-up Certificate.

- 8200.3 (a) All continuing care retirement facilities operating as such in the District of Columbia shall submit an application for permanent license with a filing fee in the amount of \$500.00 attached within 120 days after the effective date of the final regulations. The permanent licensure application shall be accompanied by the following:
- (1) Disclosure statement,
 - (2) Financial statements,
 - (3) Escrow agreement,
 - (4) Narrative describing the facility, its mode of operation and its location,
 - (5) Advertising materials that are used or to be used;
 - (6) Confirmation of signed agreements for units in the Continuing Care facility to break-even, reserved by a deposit equal to at least 10% of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two months for facilities that have no entrance fee.
- (b) Each applicant may continue to operate until the Commissioner acts upon the application for permanent licensure. In event the application is denied pursuant to section 102 (d) or (e) of the Continuing Care Retirement Communities Act of 2004, the applicant shall thereafter be treated as a continuing care retirement facility whose certificate of authority has been revoked.

8200.4 All forms referred to in this section and following sections may be found on the Department of Insurance, Securities and Banking website at disb.dc.gov

8201 REVOCATION OF LICENSE

8201.1 The revocation process shall apply to the Start-Up Certificate, Preliminary Certificate, Permanent License, and Restricted or Conditional License.

8201.2 Suspension or revocation of a certificate of authority, the denial of an application, or imposition of an administrative penalty shall be by written order and shall be sent to the continuing care retirement facility or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, or denial of administrative penalty is based. A continuing care retirement facility or applicant may in writing request a hearing within 30 days from the date of the mailing of the order. If no written request is made, such order shall be final upon expiration of the 30 days.

- 8201.3 If a continuing care retirement facility or applicant requests a hearing, the Commissioner shall issue a written notice of hearing and send it to the continuing care retirement facility or applicant by certified or registered mail. The notice shall include a specific date, time and place for the hearing.
- 8201.4 If a hearing is requested, the Commissioner or his designee shall be in attendance and shall participate in the proceedings. The provisions of the District of Columbia Administrative Procedure Act, approved October 21, 1968, (82 Stat. 1204; D.C. Official Code § 1-1501 *et seq.*) ("DCAPA") shall apply to the proceedings under this section.
- 8201.5 After a hearing, or upon failure of the continuing care retirement facility or applicant to appear at a hearing, the Commissioner shall issue a decision and order that includes findings of fact and conclusions of law. The Commissioner's decision and order shall be sent to the continuing care facility or applicant by certified mail. The Commissioner's decision and order shall be subject to appeal to the Court of Appeals.
- 8201.6 When the certificate authority of a continuing care retirement facility or applicant is revoked, such organization shall proceed, immediately following the effective date of the order or revocation, to wind up its affairs within the District, and shall conduct no further business within the District except as may be essential to the orderly conclusion of the affairs of such organization within the District. It shall engage in no further advertising or solicitation whatsoever within the District. The provisions under section 111, Rehabilitation or Liquidation of the Continuing Care Retirement Community Act shall be implemented unless the Commissioner, by written order, permits further operation of the organization as the Commissioner may find to be in the best interest of residents of a continuing care retirement facility, to the end that residents will be afforded the greatest practical opportunity to obtain continuing care services.

8202 SALE OR TRANSFER OF OWNERSHIP

The sale or transfer of ownership process in section 104 of the Continuing Care Retirement Community Act shall apply to the Start-Up Certificate, Preliminary Certificate, Permanent License and Restricted or Conditional License.

8203 STANDARDIZED DISCLOSURE STATEMENT FORMAT

The format of the standardized disclosure statement shall be maintained by the Commissioner, and may be updated as necessary.

8204 HEALTH AND FINANCIAL CONDITIONS FOR ACCEPTANCE

The health and financial conditions for acceptance as a resident shall appear within the Disclosure Statement. The Disclosure Statement shall also include any

conditions related to the acceptance conditions required by the provider or facility, such as age, ability to move or communicate, minimum assistance levels necessary to perform daily activities, prepare wills, and ability to pay under specified conditions.

8205 FINANCIAL STATEMENTS AND COMPILED FIVE -YEAR FORECASTS

8205.1 Certified financial statements and compiled five year forecasts prepared by an independent CPA shall be a required filing of the provider's corporation or other legal entity that owns the Continuing Care facility. The Commissioner may also require the provider to supply supplementary financial data or other appropriate disclosure on individual Continuing Care facilities, where a corporation or other legal entity owns various Continuing Care facilities or is engaged in various enterprises.

8205.2 The Commissioner may accept all or part of the report and supporting documentation of an approved accrediting organization acceptable to the Commissioner to satisfy the review requirements under the Continuing Care Retirement Communities Act of 2004; provided, that such acceptance shall not preclude the Commissioner from performing the examination function.

8206 COMPILED FIVE-YEAR FORECAST

(a) The compiled five-year forecast shall consist of the following:

- (1) A balance sheet;
- (2) A statement of operations;
- (3) A statement of cash flows; and
- (4) A narrative detailing all significant assumptions.

(b) The balance sheet shall include individual categories or line items that sum into the following sub-totals, at a minimum:

- (1) Current assets;
- (2) Restricted assets, including a line item for operating reserve assets;
- (3) Fixed assets, including property, plant, and equipment;
- (4) Total assets;
- (5) Current liabilities;

- (6) Long-term debt;
 - (7) Total liabilities;
 - (8) Overdue revenue-refundable;
 - (9) Deferred revenue-nonrefundable;
 - (10) Equity or fund balance-unrestricted; and
 - (11) Equity or fund balance-restricted.
- (c) The statement of operations shall include the following individual categories or line items, at a minimum:
- (1) Monthly fee revenues;
 - (2) Amortization of entrance fees;
 - (3) Health care revenues;
 - (4) Investment/interest income;
 - (5) Contributions/gifts;
 - (6) Health care expenses;
 - (7) Operation expenses, consisting of at least maintenance, laundry, and housekeeping;
 - (8) Dietary expenses;
 - (9) Administrative expenses;
 - (10) Interest expenses; and
 - (11) Depreciation.

8207

PROPOSED OR DEVELOPMENT STAGE FACILITIES

The Commissioner may apply all or part of Section 105 (a) (14) of the Continuing Care Retirement Communities Act of 2004 to existing Continuing Care facilities that are expanding.

8208

INSOLVENCY OR HAZARDOUS FINANCIAL CONDITION

(a) A negative fund balance is a financial position of a provider or facility in which the assets of a provider or facility do not exceed its liabilities, as required under generally accepted accounting principles. The Commissioner may deem a provider or facility that has a negative fund balance to be insolvent or in imminent danger of becoming insolvent if any of the following hazardous financial condition standards or factors are applicable or present:

- (1) There are findings or conditions reported in the provider's or facility's financial statements that the Commissioner determines to be adverse to the financial stability of the provider or facility.
- (2) The current or projected ratios of total assets, including required reserve levels, to total liabilities indicate an impairment or a deterioration of the provider's or facility's operations or equity; or demonstrate a trend that could lead to an impairment or a deterioration of the provider's or facility's operations, working capital, or equity.
- (3) The current or projected ratios of current assets to current liabilities indicate an impairment or a deterioration of the provider's or facility's operations, working capital, or equity; or demonstrate a trend that could lead to an impairment or a deterioration of the provider's or facility's operations, working capital, or equity.
- (4) The provider or facility is unable to perform normal daily activities and meet its obligations as they become due, considering the provider's or facility's current or projected cash flow and liquidity position.
- (5) The provider's or facility's operating losses for the past year or projected operating losses are of such magnitude as to jeopardize normal daily activities or continued provider or facility operations.
- (6) The insolvency of an affiliated provider or facility or other affiliated person results in legal liability of the provider or facility for payments and expenses of such magnitude as to jeopardize the provider's or facility's ability to meet its obligations as they become due, without substantial disposition of assets outside the ordinary course of business, any restructuring of debt, or externally forced revisions of its operations.
- (7) The provider or facility has receivables that are more than 90 days old.
- (8) The insolvency is not temporary and the provider or facility cannot demonstrate that the insolvency is materially reduced or eliminated.
- (9) There is an adverse effect on the provider or facility of reporting entrance fees as deferred revenues, with consideration given to all reporting

requirements required under generally accepted accounting principles and the ultimate net income component of those revenues.

- (10) A start-up provider or facility or any operational provider or facility undergoing plant expansion or refinancing of its debt has a financial condition as a result of such action that could otherwise seriously jeopardize present or future operations.

(b) The provider or facility shall prepare a plan to address and correct any condition that has led to a determination of insolvency or imminent danger of insolvency by the Commissioner. The plan must be presented to the Commissioner within 90 days after the date of the insolvency determination. If the plan to correct the condition is disapproved by the Commissioner, the plan does not correct the condition leading to the Commissioner's determination of insolvency, or the provider's or facility's hazardous condition is such that it cannot be significantly corrected or eliminated, the Commissioner may take action pursuant to Section 103 or Section 111 of the Continuing Care Retirement Communities Act of 2004.

8209 BOOKS AND RECORDS

(a) Each provider shall maintain its books and records in the District of Columbia and shall not remove from the District of Columbia its books and records without the permission of the Commissioner.

(b) Each provider shall maintain its books and records for 10 years.

8299 DEFINITIONS

8299.1 "Break-even" means confirmation of sufficient executed resident's agreements to assure the facility's financial stability and which further indicate that projected revenues will at least be equal to projected expenses.

8299.2 "Continuing care facility" means a building, or complex of buildings under one management at one or more sites, if continuing care services are provided.

8299.3 "Entrance fee" means a payment that assures a resident a place in a facility for a term of at least a year or life.

8299.4 "Health related services" means domiciliary (rest home) care or Homes for the Aged, skilled or intermediate nursing, nursing home or rest home admission, or priority admission into a facility, unit, or bed providing any of the above-named services.