

**THE OFFICE OF CONTRACTING AND PROCUREMENT**

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**NOTICE OF EMERGENCY RULEMAKING**

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The Chief Procurement Officer of the District of Columbia, pursuant to authority granted by section 204 of the District of Columbia Procurement Practices Act of 1985 ("PPA"), effective February 21, 1986 (D.C. Law 6-85; D.C. Official Code § 2-302.04 (2001)), and Mayor's Order 2002-207 (dated December 18, 2002), hereby gives notice of the adoption of the following emergency rules to amend Chapter 13 of Title 27 of the District of Columbia Municipal Regulations (Contracts and Procurements). The rules amend section 1301.1 of Chapter 13 concerning notices of contract awards so as to be consistent with the small purchase limitations, thereby only requiring publication of notices of awards of contracts above the small purchase limit of \$500,000 for the Metropolitan Police Department (MPD) and the Office of the Chief Technology Officer (OCTO), and above \$100,000 for all other agencies.

The rules were approved as emergency and proposed rules on August 2, 2005, and published in a Notice of Emergency and Proposed Rulemaking in the *D. C. Register* on September 16, 2005, at 52 DCR 8538. A Proposed Resolution to approve the rules has been submitted to the District of Columbia Council, and the Notice of Final Rulemaking has been certified by the Office of the Attorney General for publication after either Council approval of the rules or expiration of a 60-day Council layover period. No changes were made to the rules as proposed.

Since the emergency rules expired on November 30, 2005, action was taken on November 30, 2005 to adopt the following rules on an emergency basis effective on that date, pending Council approval of the final rules. Without these emergency rules, the Office of Contracting and Procurement (OCP) will be required to publish notices of all awards of contracts for \$25,000 and above on the OCP Internet site established in accordance with section 303(c-1) of the PPA (D. C. Official Code § 2-303.03(c-1) (2001)) and section 1300.7 of Title 27, even though the small purchase rules are applicable to procurements up to \$500,000 for MPD and OCTO, and \$100,000 for other agencies. This rule conforms the publication requirement for contract awards to the small purchase limitations.

Adoption of these emergency rules to amend Chapter 13 is thus necessary for the immediate preservation of the public health, safety and welfare, by not requiring OCP to publish notices of awards of every procurement \$25,000 and above for supplies and services. These emergency rules will remain in effect up to one hundred twenty (120) days from date of adoption, unless earlier superseded by another rulemaking notice or by publication of a Notice of Final Rulemaking in the *D.C. Register*.

**CHAPTER 13**

**PUBLICIZING CONTRACT ACTIONS**

*Section 1301 is amended to read as follows:*

**1301 NOTICE OF CONTRACT AWARDS**

1301.1 Notice of awards of contracts exceeding five hundred thousand dollars (\$500,000) for the Metropolitan Police Department and the Office of the Chief Technology Officer, and exceeding one hundred thousand dollars (\$100,000) for all other agencies, shall be published on the Internet site maintained in accordance with § 1300.7, within a reasonable period of time after the contracts are awarded.

**THE OFFICE OF CONTRACTING AND PROCUREMENT**

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**NOTICE OF EMERGENCY AND PROPOSED RULEMAKING**

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The Chief Procurement Officer of the District of Columbia, pursuant to authority granted by section 204 of the District of Columbia Procurement Practices Act of 1985 (PPA), effective February 21, 1986 (D.C. Law 6-85; D.C. Official Code § 2-302.04 (2001)), and Mayor's Order 2002-207 (dated December 18, 2002), hereby gives notice of the adoption of the following emergency rules and of the intent to adopt final rulemaking to amend Chapter 20 of Title 27 of the District of Columbia Municipal Regulations (Contracts and Procurements). The proposed rules are intended to amend a section of Chapter 20 concerning special contracting methods which would allow the District to extend an existing contract for more than five (5) years on recurring and continuing services requirements.

These rules will supersede a Notice of Emergency Rulemaking adopted on August 22, 2005, published in the *D. C. Register* on September 30, 2005 at 52 DCR 8847, and a Notice of Final Rulemaking and Resolution submitted to the Council of the District of Columbia on August 18, 2005, to be deemed approved on December 11, 2005 (P.R. 16-437). The attached rules add one category of contract to be extended and clarify that multiyear contracts are excepted from the operation of the rule.

Action was taken on November 21, 2005 to adopt the following rules on an emergency basis effective on that date. Without these emergency rules, the Office of Contracting and Procurement (OCP) will not be able to extend options on several city-wide contracts that are critical to the needs of District residents. These contracts include services for evidenced traffic violations enforcement; motor vehicle ticket processing; janitorial maintenance; trash and recyclable materials collection services; and food, medical and mental health services for inmates at the Department of Corrections. OCP also needs to extend the current contract for the Medicaid Management Information System (MMIS) that expires on February 27, 2006, in order to continue operation of the MMIS to process Medicaid claims for health care services for District residents. Future MMIS contracts will also be extended to seven years, owing to the need for a two-year period for an assessment of future information technology needs, planning, and procuring a contract to transition to and implement a new MMIS system. All these contracts provide services that impact the environment, health and safety of District residents.

Adoption of these emergency rules to amend Chapter 20 is thus necessary for the immediate preservation of the public peace, health, safety, or welfare, in accordance with the District law as codified at D.C. Official Code §2-505(c)(2001). These emergency rules will remain in effect up to

one hundred twenty (120) days from date of adoption, unless earlier superseded by another rulemaking notice or by publication of a Notice of Final Rulemaking in the *D.C. Register*.

The Chief Procurement Officer also gives notice of intent to take final rulemaking action in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. The Chief Procurement Officer will submit the rules to the Council of the District of Columbia for a sixty (60) day period of review pursuant to subsection 205(a) of the PPA (D.C. Official Code §2-302.05(a)), and will not take final rulemaking action until completion of the 60-day review period or Council approval of the rules by resolution before the end of the review period.

## CHAPTER 20

### SPECIAL CONTRACTING METHODS

*Section 2005.6 is amended to read as follows:*

#### 2005 USE OF OPTIONS

2005.6 The basic period in a contract for services or supplies shall not exceed one (1) year, unless the contract is funded from an appropriation that is available for more than one (1) year or is a multiyear contract for which funds would otherwise be available for obligation only within the fiscal year for which appropriated pursuant to D. C. Official Code § 1-204.51(c). The total of the basic and option periods in a contract for services or supplies shall not exceed five (5) years except as follows:

- (a) a contract for city-wide telecommunications systems may exceed five years but shall not exceed ten years;
- (b) a contract for evidenced traffic violations systems provided to the Metropolitan Police Department may exceed five years but shall not exceed seven years and two months;
- (c) a contract for ticket processing provided to the Department of Motor Vehicles may exceed five years but shall not exceed seven years;
- (d) a contract for medical and mental health services provided to the Department of Corrections may exceed five years but shall not exceed six years;
- (e) a contract for any supplies or services may exceed five years where awards for recurring or continuing supply or service requirements may be delayed but shall not exceed five years and six months; and
- (f) a contract for a Medicaid Management Information System (MMIS) provided for the Department of Health may exceed five years but shall not exceed seven years.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, no later than thirty (30) days after the date of publication of this notice in the *D. C. Register*. Hand-delivered comments should be delivered, and mailed comments should be postmarked, no later than thirty (30) days after publication of this notice in the *D. C. Register*. Comments should be delivered or mailed to Herbert R. Tillery, Deputy Mayor for Operations and Interim Chief Procurement Officer, Office of Contracting and Procurement, 441 Fourth Street, N.W., Suite 700 South, Washington, D.C. 20001. Copies of the proposed rules may be obtained from the above address.

**THE OFFICE OF CONTRACTING AND PROCUREMENT**

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**NOTICE OF EMERGENCY RULEMAKING**

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The Chief Procurement Officer of the District of Columbia, pursuant to authority granted by sections 202 and 204 of the District of Columbia Procurement Practices Act of 1985, as amended, effective February 21, 1986 (D.C. Law 6-85; D.C. Official Code §§2-302.02 and 2-302.04)(PPA), and Mayor's Order 2002-207, dated December 18, 2002, hereby gives notice of the adoption of the following emergency rules, amending Chapter 22 of Title 27 of the *District of Columbia Municipal Regulations (Contracts and Procurements)*. The rules will amend Chapter 22 of Title 27 D.C. Municipal Regulations to reflect changes necessary to implement the *Debarment Procedures Amendment Act of 2004*, effective April 12, 2005 (D.C. Law 15-327; D.C. Official Code § 2-308.04) (Act).

A Notice of Emergency and Proposed Rulemaking to amend Chapter 22 was published in the *D.C. Register* on July 29, 2005 (52 DCR 7043), and the current emergency rules will expire on November 9, 2005. No substantive changes have been made to the text of the proposed rules as published. The final rules to amend Chapter 22 have been submitted to the Council of the District of Columbia for its review pursuant to section 205(b) of the PPA (D.C. Official Code §2-302.05(b)), and may not become effective until the expiration of the 60-day period for Council review or upon approval by Council resolution, whichever occurs first, and publication of a notice of final rulemaking in the *D.C. Register*. The rules are necessary to provide continuing authority to use the provisions in the amended Chapter 22 until the final rules are effective.

Emergency rulemaking action is necessary to allow the Debarment and Suspension Panel (Panel) created by the Act to conduct hearings on certain companies and their principals due to convictions and other improprieties in connection with the award of District contracts. Without these emergency rules, the Panel will not be able to conduct debarment proceedings on companies and their principals that have been convicted and have violated District contracting laws. The debarment or suspension actions pertain to serious questions about the appropriateness of the District contracting with certain companies because of convictions or other improprieties in connection with the award or

performance of District contracts, and the length of time for which a contractor should be debarred from District contracting. Adoption of emergency rules to establish these procedures to allow the Panel to convene is necessary for the immediate preservation of the public peace, health, safety, or welfare, in accordance with D.C. Official Code §2-505(c).

To ensure that amended chapter 22 will continue in effect, action was taken on November 9, 2005, to adopt the following rules on an emergency basis effective on that date. These rules will remain in effect for up to one hundred twenty (120) days from the date of adoption, unless superseded by another rulemaking notice or by publication of a Notice of Final Rulemaking in the *D.C. Register*.

## CHAPTER 22

### CONTRACTORS

*Chapter 22 is amended by adding a new section 2218 to read as follows:*

#### **2218 Debarment and Suspension Panel**

- 2218.1 This section shall apply to any debarment or suspension that is required to be heard by the Debarment and Suspension Panel ("Panel") in accordance with the *Debarment Procedures Amendment Act of 2004*, D.C. Law 15-327, effective April 12, 2005 ("Act").
- 2218.2 For any debarment or suspension that the Panel hears, the Chief Procurement Officer ("CPO") shall transmit to the Panel his debarment or suspension recommendation and any supporting documentation.
- 2218.3 Upon receipt of the documentation specified in section 2218.2 from the CPO, the Chair of the Panel shall convene the Panel to conduct a hearing of the debarment or suspension in accordance with Title 27 *D.C. Municipal Regulations*, sections 2213 through 2217, except as provided in section 2218.4. The term "Director," as it appears in sections 2213 through 2217, shall mean the "Panel."
- 2218.4 For any debarment or suspension that the Panel hears, the period of time provided in section 2214.1(c) shall be shortened to fifteen (15) days after receipt of the notice.
- 2218.5 The Panel shall hear and decide, *de novo*, all debarments and suspensions required to be heard in accordance with this section and the Act.
- 2218.6 The attendance of at least five (5) members of the Panel shall constitute a quorum to hear a debarment or suspension.

- 2218.7 A majority vote of those present and voting shall be necessary and sufficient for any action taken by the Panel. Each Panel member in favor of the debarment or suspension decision of the Panel shall indicate his or her agreement with the decision by signing the decision.
- 2218.8 *Ex parte* communications, as defined in section 2299.1, shall be prohibited. Excluded from *ex parte* communications are those that:
- (a) are specifically authorized by law to be made on an *ex parte* basis;
  - (b) relate to the Panel's administrative functions or procedures; or
  - (c) are matters of public record.
- A Panel member or staff member for the Panel who receives an *ex parte* communication prohibited by this section, shall immediately report its receipt to the Chair of the Panel and prepare a memorandum describing in detail the substance of the communication. The memorandum shall be placed in the debarment or suspension file, along with the actual communication if it is in written form. The Panel shall provide a copy of the memorandum to all parties.
- 2218.9 Panel members shall promptly advise the Chair of the Panel of any conflict of interest, or appearance thereof, relating to any debarment or suspension action under consideration by the Panel. Each member of the Panel shall disqualify himself or herself from acting on matters in which he or she has a conflict of interest, or the appearance thereof, in accordance with Chapter 18 of the District of Columbia Personnel Regulations.
- 2218.10 The Panel shall keep and maintain a case docket of current debarments or suspensions under the Panel's jurisdiction; copies of decisions and final orders of the Panel; and copies of the Panel's rules. The case docket, updated monthly, shall provide the names of the companies or individuals proposed for debarment or suspension, the case number, the date the Panel received the debarment or suspension, and the date of any scheduled hearing on the merits of the debarment or suspension. The case docket, copies of decisions, final orders, and rules shall be available for inspection by the public at the office of the Chair of the Panel.

*Section 2299.1 is amended by adding the following definitions:*

**Debarment and Suspension Panel** – the panel established by the *Debarment Procedures Amendment Act of 2004*, D.C. Law 15-327, effective April 12, 2005 (“Act”), consisting of the Chief Procurement Officer and a representative from the Office of the Chief Financial Officer, the Office of the Deputy Mayor for Planning and Economic

Development, the Deputy Mayor for Operations, the Director of the Office of Labor Relations and Collective Bargaining, and from each agency which, in the judgment of the Mayor, would be directly and significantly affected by the proposed debarment.

*Ex parte communications* – any oral or written communication with the Panel, which excludes one or more parties to the case, concerning the merits of the case pending before the Panel, made by any persons directly or indirectly involved in the outcome of the case.

## DISTRICT OF COLUMBIA BOARD OF EDUCATION

## NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Board of Education ("Board"), pursuant to the authority set forth in D.C. Code, 2001 Edition, §§38-101 & 38-102 et seq., hereby gives notice of emergency and proposed rulemaking action taken by the Board at its meeting held on December 14, 2005 to amend Chapter 21 of the Board Rules (Title 5 of the D.C. Municipal Regulations).

This amendment, if enacted, will effect the following actions: 1) Eliminate the expiration date of July 1, 2005, because the assessment requirement for the pilot program was completed; 2) Establish annual reporting requirements and 3) Remove the May 15, 2004 requirement to assess the out of boundary pilot because the assessment has been completed and a report has been submitted to the Board of Education.

The emergency is necessitated by the need to preserve the public welfare: In order to accurately provide necessary and timely notice to parents regarding application requirements for out of boundary transfers, Chapter 21 of D.C. Municipal Regulations must be amended to accurately reflect the current requirements. The Superintendent will report annually on the number of children seeking out boundary of transfers.

The emergency rulemaking took effect following approval by the Board at its meeting of December 14, 2005. It shall expire within 120 days of December 14, 2005 or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first. The Board also gives notice of its intent to take final rulemaking action to adopt this emergency and proposed rulemaking in not less than thirty (30) days from the publication of this notice in the D.C. Register.

**Amend Section 2106.12:**

~~2106.12 The policy set forth in sections 2106.1 through 2106.5 shall expire on July 1, 2005. While the policy is in effect, the~~ The Superintendent shall assess report **annually** on the impact of the implementation of sections 2106.1 through 2106.5 by collecting data including, but not limited to:

- (a) The number of children seeking out of boundary transfers from each school **and zip code**; the school(s) **and zip code** to which they sought to transfer; and the priority category under which each applied;
- (b) The number of out of boundary applicants admitted and in attendance in each school **and zip code** the category under which each was admitted (~~this shall include the numbers of out of boundary students grandfathered into attendance at a school under the old policy~~);

(c) The number of students enrolled at each school pursuant to the No Child Left Behind Act who reside outside of the school's attendance zone; and

(d) For students admitted pursuant to Section 2106.3(d) above, a survey of parents to determine their reasons for seeking out of boundary transfer.

### Delete Section 2106. 13

~~2106.13 The Superintendent shall provide a report of the assessment performed pursuant to Section 2106.12 to the Board for review no later than May 15, 2004.~~

Written comments on the proposed rulemaking are invited from interested citizens. Such comments should be addressed to Mr. Russell Smith, Executive Director, D.C. Board of Education, 825 North Capitol Street, N.E., Washington, D.C. 20002. This rulemaking is available on the District of Columbia Public Schools website at [http://www.k12.dc.us/dcps/boe/boe\\_frame.html](http://www.k12.dc.us/dcps/boe/boe_frame.html). Copies of this rulemaking are available from the Office of the Board of Education by calling (202) 442-4289.

## DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, 1987 hereby gives notice of the adoption, on an emergency basis, of an amendment to sections 921 ("Standards for Determining D.C. Medicaid Reimbursement Costs for Prescribed Multiple Source Drugs and Other Drugs and Methodology for Determining Prescription Reimbursement") through 925 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR).

These amendments are required to enable the Medicaid program to change the existing nursing facility pharmacy reimbursement methodology to a nursing facility pharmacy point-of sale methodology that is designed to improve the quality of pharmacy care for recipients. Currently, District nursing facilities are paid an all-inclusive per diem rate that covers the cost of care for all resident services including pharmaceuticals. Upon implementation of the Point of Sale (POS) system and case mix reimbursement methodology, prescription costs will be carved out and reimbursed directly by the Medicaid program. These rules: (1) establish pharmacy dispensing fees for nursing home pharmacy providers and other reimbursement requirements; (2) establish a reimbursement methodology for nursing home pharmacy providers who are also federally approved 340-B (Public Health Service) providers; and (3) updates the rules to reflect the name change of the Centers for Medicare and Medicaid Services, formerly the Health Care financing Administration. The Medicaid Program projects an increase in total pharmacy expenditures of \$12 million in FY 2004 to \$21 million in FY 2010.

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. The pharmacy point of sale allows the Medicaid program to implement the mandates required for the Part D benefit. Emergency action is necessary for the immediate preservation of the health, safety and welfare of persons who are in need of prescription drugs.

To ensure compliance with federal law, the Medicaid Program is also amending the District of Columbia State Plan for Medical Assistance (State Plan) to reflect these changes. The corresponding State Plan amendment 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 has indicated approval of the corresponding State Plan amendment with an effective date of January 1, 2006.

On May 12, 2005 (52 DCR 4613), a notice of proposed rulemaking governing standards for prescription reimbursement was published. These rules amend the previously published rules by delaying the implementation date from October 1, 2005 until January 1, 2006; changing the dispensing fee for total parenteral nutrition or container drugs; adding barbiturates and

benzodiazepines to the class of prescribed drugs; clarifying the prescribed drugs for purposes of nursing home reimbursement; and other technical changes.

The emergency rulemaking was adopted on December 16, 2005 and will become effective on January 1, 2006. The emergency rules will remain in effect for one hundred and twenty days or until April 15, 2006, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Amend sections 921 through 925 of Chapter 9 of Title 29 DCMR to read as follows:

- 921        STANDARDS FOR DETERMINING D.C. MEDICAID REIMBURSEMENT COSTS FOR PRESCRIBED MULTIPLE SOURCE DRUGS AND OTHER DRUGS AND METHODOLOGY FOR DETERMINING PRESCRIPTION REIMURSEMENT
- 921.1      The provisions of this rule shall govern the determination of reimbursement costs to pharmacies, including nursing home pharmacy providers, by the D.C. Medicaid Program and the methodology for determining prescription reimbursement for prescribed multiple source drugs and other drugs provided to eligible Medicaid recipients. The Medicaid Program restricts payment to only those drugs supplied from manufacturers that have signed a national agreement, as specified in section 1927(a) of the Social Security Act or have an approved existing agreement.
- 922        METHODS FOR DETERMINING COSTS OF PRESCRIBED MULTIPLE SOURCE DRUGS
- 922.1      The allowable cost for multiple source drugs designated by the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services and included in its listings issued pursuant to 42 CFR 447.322, shall be the lower of the following:
- (a)      The upper limit established by CMS, which is determined by multiplying the cost of the lowest cost drug by one hundred and fifty percent (150%);  
                  or
- (b)      The estimated acquisition cost, as determined by the Medical Assistance Administration based upon information from drug manufacturers and local wholesale price data.
- 922.2      If a drug is unavailable in the local market at a cost at or below the CMS limit described in subsection 922.1 (a), the allowable cost shall be the lowest price, determined by the CMS, at which the drug is available in the local market.

- 922.3 The CMS upper limit for a drug price shall not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular patient.
- 922.4 The handwritten phrase "Medically Necessary" or "Brand Necessary" shall appear on the face of the prescription form. If the prescription is for a nursing facility resident a handwritten phrase "Medically Necessary" or "Brand Necessary" shall be documented in the resident's medical record accompanied by a copy of the physician's order and plan of care.
- 922.5 Neither a dual line prescription form, check-off box on the a prescription form or check off-box on the physician's orders and plan of care shall satisfy the certification requirement.
- 922.6 The Department shall supplement the CMS listing by adding drugs and their prices which, in the judgment of CMS, meet the following requirements:
- (a) The formulation of the drug approved by the U.S. Food and Drug Administration (FDA) has been evaluated as therapeutically equivalent in the most current edition of its publication, Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or in successor publications); and
  - (b) At least two (2) suppliers list the drug (which has been classified by the FDA as category "A" in its publication, Approved Drug Products with Therapeutic Equivalence Evaluations, including supplements or in successor publications) based on listing of drugs which are locally available.
- 922.7 Each pharmacy that participates in the Medicaid program shall be notified in writing by the Department of Health, Medical Assistance Administration (MAA), of the established maximum allowable cost for the selected multiple source drugs listed pursuant to this section.
- 923 METHODS FOR DETERMINING COSTS OF OTHER PRESCRIBED DRUGS
- 923.1 Costs for prescribed drugs not listed by CMS shall be the average wholesale price, minus ten percent (10%).
- 923.2 The average wholesale price shall be the price, at the time of service, set forth in the most recent listing supplied to MAA by the First Data Bank National Drug Data File Services.
- 924 METHOD ESTABLISHED FOR DETERMINING PRESCRIPTION REIMBURSEMENT

- 924.1 Pharmacy claims for a community or retail pharmacy provider shall be reimbursed at the lower of the following:
- (a) The allowable cost, established pursuant to section 922 or 923, as appropriate, plus a dispensing fee of four dollars and fifty cents (\$4.50) per prescription; or
  - (b) The pharmacy's usual and customary charge to the general public.
- 924.2 Effective January 1, 2006, pharmacy claims for a nursing home pharmacy provider shall be reimbursed at the lower of the following:
- (a) The allowable cost, established pursuant to section 922, 923 or 924.3, as appropriate, plus a dispensing fee of four dollars and fifty cents (\$4.50) per non-IV (intravenous) prescription; or seven dollars and twenty-five cents (\$7.25) per IV prescription; or seventeen dollars and twenty-five cents (\$17.25) for cassette, TPN (total parenteral nutrition) or container-related prescriptions; or
  - (b) The pharmacy's usual and customary charge for non-Medicaid residents.
- 924.3 The allowable cost for drugs purchased by a nursing home pharmacy provider who is also a federally approved 340-B (Public Health Service) provider for Medicaid shall not exceed the actual acquisition cost for all 340-B purchased drugs. Pharmacy claims for 340-B providers shall be excluded from any manufacturer's rebate.
- 924.4 Drugs covered by Medicare for persons who are dually eligible for Medicare and Medicaid shall be billed to Medicare under the Medicare Prescription Drug Benefit Part D, effective January 1, 2006.
- 924.5 An additional supply of medications may be dispensed for use by a nursing facility resident during a short-term medically approved trip away from the facility during holidays or family trips.
- 924.6 Prescribed drugs for purposes of nursing homes pharmacy reimbursement shall not include over-the-counter medications, syringes for diabetic preparations, geriatric vitamin formulations, or senna extract single dose preparations except when required for diagnostic radiological procedures performed under the supervision of a physician.
- 925 DEFINITIONS

925.1 For the purposes of this Chapter, the following terms and phrases shall have the meanings ascribed:

**Brand** – any registered trade name commonly used to identify a drug.

**Container**- a light resistant receptacle designed to hold a specific dosage form which is or maybe in direct contact with the item and does not interact physically or chemically with the item or adversely affect the strength, quality or purity of the item.

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

**Multiple source drug** – a drug marketed or sold by three (3) or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer, or labeler under two (2) or more different proprietary names or both under a proprietary name and without such a name.

**Prescribed drugs** – legend drugs approved as safe and effective by the U.S. Food and Drug Administration and those over-the-counter medications which fall into the following categories:

- (a) Oral analgesics with a single active ingredient (i.e. aspirin, acetaminophen, ibuprofen, etc);
- (b) Ferrous salts (sulfate, gluconate, etc.);
- (c) Antacids with up to three active ingredients, (i.e.- Aluminum, magnesium, bismuth, etc.);
- (d) Diabetic preparations (i.e.- Insulin, syringes, etc.);
- (e) Pediatric, prenatal and geriatric vitamin formulations;
- (f) Family planning drugs and supplies;
- (g) Senna extract, single dose preparations when required for diagnostic radiological procedures performed under the supervision of a physician;
- (h) The class of barbiturates approved as safe and effective by the Federal Food and Drug Administration; and
- (i) The class of benzodiazepines approved as safe and effective by the Federal Food and Drug Administration.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5<sup>th</sup> Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the D.C. Register. Copies of the proposed rules may be obtained from the same address.

## DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, 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. Emergency action is necessary for the immediate preservation of the health, safety and welfare of persons who are in need of services provided in nursing facilities.

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.

On May 20, 2005 (52 DCR 4751), a notice of proposed rulemaking governing Medicaid reimbursement to nursing facilities was published. These rules amend the previously published rules by delaying the implementation date from October 1, 2005 until January 1, 2006 and by clarifying that provider tax costs are excluded from allowable costs.

The emergency rulemaking was adopted on December 12, 2005 and will become effective on January 1, 2006. The emergency rules will remain in effect for one hundred and twenty days or until April 11, 2006, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director also gives notice of the intent to take final rulemaking action to adopt these rules not less than thirty (30) days from 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 1<sup>st</sup> shall be the average of the preceding year fourth calendar quarter and first calendar quarter picture dates.
  - (b) April 1<sup>st</sup> 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 F102 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**

- 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.

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- 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

**DISTRICT OF COLUMBIA REGISTER**

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 1<sup>st</sup> and ends on September 30<sup>th</sup>. 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.

All persons wishing to comment on these proposed rules shall submit written comments no later than thirty (30) days after the date of publication of this notice in the *D.C. Register* to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5<sup>th</sup> Floor, Washington, D.C. 20002. Copies of the proposed rules may be obtained from the same address between the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays.

DISTRICT OF COLUMBIA  
DEPARTMENT OF MOTOR VEHICLESNOTICE OF EMERGENCY RULEMAKING

The Director of the Department of Motor Vehicles, pursuant to the authority set forth in Section 1825 of the Department of Motor Vehicles Establishment Act of 1998, effective March 26, 1999 (D.C. Law 12-175; D.C. Official Code § 50-904); Section 6(c) of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1206; D.C. Official Code § 2-505(c)); § 105 of the District of Columbia Traffic Adjudication Act of 1978 (D.C. Law. 2-104; D.C. Official Code § 50-2301.05); § 9 of the International Registration Plan Agreement Act of 1997, effective September 5, 1997 (D.C. Law 12-14; D.C. Official Code § 50-1507.01); and Mayor's Order 03-58, effective April 21, 2003, hereby gives notice of the adoption, on an emergency basis, of amendments to Chapter 26 of Title 18 of the District of Columbia Municipal Regulations (DCMR) (Vehicles and Traffic). This amendment extends the authority to issue civil fines for a violation of the International Registration Plan ("IRP).

This emergency rule will expire on April 12, 2005, one hundred and twenty (120) days after its adoption, or upon publication of a notice of final rulemaking covering these provisions, whichever occurs first.

The emergency circumstances are as follows:

This is a continuation of a previous emergency rulemaking, published on May 27, 2005 (52 DCR 7831), which expired on November 27, 2005. That rulemaking was forwarded to the Council for review, for approval of the permanent version of the rules. It was submitted together with another resolution that would have approved the Commercial Driver's License ("CDL") rules and a host of proposed customer service improvement provisions. During the scheduled hearing on this rulemaking, the Committee on Public Works and the Environment voiced support for the CDL and IRP provisions, but had objections to one or more of the customer service provisions, which led to disapproval resolutions for both sets of proposed rules. Therefore, the proposed CDL and IRP provisions were again forwarded to the Council in November, 2005, absent the customer service provisions. The previous emergency must be extended to allow the regulations to continue to be in effect as the permanent rules undergo a Council-review period.

Immediate action is necessary to ensure the continued enforcement of the IRP rules and the safety of the District's roads.

Title 18, DCMR is amended as follows:

B. Chapter 26, CIVIL FINES FOR MOTOR VEHICLE MOVING AND NON-MOVING INFRACTIONS, Section 2600, CIVIL FINES FOR MOTOR VEHICLE MOVING

INFRACTIONS, Subsection 2600.1, is amended by adding a new heading and offenses to read as follows:

International Registration Plan [D.C. Official Code § 50-1507.03]

Failure to register	\$ 500
Failure to obtain trip permit	\$ 500
Exceeding registered gross weight	\$ 500