DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

Ms. Linda Elam
Deputy Director/Medicaid Director
Department of Health Care Finance
899 N. Capitol St., NE
Washington, DC 20002

JAN 25 2013

RE: State Plan Amendment 12-05

Dear Mrs. Elam:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-05. This amendment modifies the methods and standards for making Medical Assistance payments to intermediate care facilities for individuals with intellectual disabilities. Specifically, this SPA makes active treatment reimbursement part of the per diem rate and adds supplemental payments to facilities for training costs in an effort to develop and retain highly qualified staff.

We reviewed this amendment pursuant to sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Medicaid State plan amendment 12-05 effective October 1, 2012. We are enclosing the Form-179 and the amended plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,
/s/

Cindy Mann
Director
Centers for Medicaid and CHIP Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **12-05**

2. STATE: District of Columbia

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act

TO: Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

4. PROPOSED EFFECTIVE DATE
October 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.252

7. FEDERAL BUDGET IMPACT
FFY 13 $60,058,189.75
FFY 14 $62,280,342.77

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D II pp1-28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D II pp 1-29

10. SUBJECT OF AMENDMENT:
Medicaid Reimbursement for Intermediate Facilities for Persons with Intellectual and/or Developmental Disabilities

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: PR 19-796

12. SIGNATURE OF STATE AGENCY OFFICIAL
/ s /

13. TYPED NAME
Linda Elam, Ph.D.

14. TITLE
Deputy Director/Medicaid Director

15. DATE SUBMITTED
June 22, 2012

16. RETURN TO
Linda Elam
Deputy Director/Medicaid Director
Department of Health Care Finance
899 N. Capitol St., NE
Washington, DC 20002

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED JAN 25 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME

22. TITLE

23. REMARKS

FORM CMS-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH CARE FINANCE

STATE PLAN AMENDMENT ESTABLISHING
REIMBURSEMENT PRINCIPLES AND METHODS FOR
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES
(ICFs/IID)

I. GENERAL PROVISIONS

A. The purpose of this Chapter is to establish principles of reimbursement that shall apply to each intermediate care facility for individuals with intellectual disabilities (ICF/IID) participating in the District of Columbia Medicaid program.

B. An ICF/IID that is eligible to receive reimbursement under this chapter shall be certified as a Level 2 group home for mentally retarded persons (GHMRP), by the Department of Health (DOH), pursuant to 22 DCMR §§ 3100 *et seq.* for a period up to fifteen (15) months.

C. Medicaid reimbursement to ICFs/IID for services provided beginning on or after October 1, 2012, shall be on a prospective payment system consistent with the requirements set forth in this Chapter.

D. The Department of Health Care Finance (DHCF) shall pay for ICF/IID services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently, economically operated facilities in order to provide services in conformity with applicable District and Federal laws, regulations, and quality and safety standards. DHCF applied consistent financial principles in developing the reimbursement methodology described in this chapter, including the following:

1. Basing payment rates on the acuity of each beneficiary, as determined by DHCF, or its designee;

2. Establishing uniform reimbursement of services constituting the active treatment program for individuals who meet the requirements of 42 C.F.R. § 483.440(a);

3. Establishing consistent payment rates across the District of Columbia for the same classes of facilities serving individuals with comparable levels of need; and

4. One (1) day, inclusive of residential care and active treatment services, shall constitute the unit of service.

E. DHCF assures that the reimbursement methodology and policies set forth in this State Plan Amendment meet the requirements of 42 C.F.R. §§ 447.250 *et seq.* and 42 C.F.R. § 430.10.

F. The reimbursement rates paid to ICFs/IID for Medicaid individuals residing in the facility shall be equal one hundred percent (100%) of the following components:

1. Residential component base rate, determined by acuity level, as defined in Section II, and inclusive of costs for the following:

   a. Direct service;
   b. All other health care and program related expenses;
   c. Non-personnel operations;
   d. Administration;
   e. Non-Emergency Transportation;
   f. Capital; and
   g. Allowable share of the Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment.

2. Services constituting an active treatment program, described in Section IV., as set forth in the Individual Service Plan (ISP); and

3. Payments associated with participation in quality improvement initiatives, as set forth in Section V.

G. The reimbursement rates paid to ICFs/IID shall exclude the following:

1. Inpatient and outpatient hospital visits;
2. Clinic services;
3. Emergency department services;
4. Any other long-term care facility services;
5. Durable medical equipment that is solely for the use of one beneficiary (such as a specialized wheelchair); and
6. Prescription drug costs, excluding copays for individuals who are also subject to the *Evans* court order.

H. ICF/IID reimbursement under this Attachment shall adhere to the "Policy on Reserved Beds," as set forth on page 2 of Attachment 4.19C of the State Plan for Medical Assistance.

I. An organization related to an enrolled ICF/IID ("related organization") can furnish services and supplies under the prudent buyer concept, provided the costs of such services and supplies are consistent with costs of such items furnished by independent third party providers in the same geographic area. These requirements apply to the sale, transfer, leaseback or rental of the property, plant or equipment or purchase of services of any facility or organization.

J. In accordance with 42 C.F.R. § 456.360(a), the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-

1201.01 *et seq.*), as amended, and implementing rules, a qualified physician shall certify that an individual requires ICF/IID services. The certification shall be made at the time of admission for current Medicaid individuals, or for individuals who apply for Medicaid while residing in an ICF, before any payment is made to the ICF/IID.

K. Recertification of a beneficiary's need for continued ICF/IID services is required, at minimum, twelve (12) months following the date of the previous certification, pursuant to 42 C.F.R. § 456.360(b).

L. A Medicaid beneficiary shall be assessed by an interdisciplinary team within thirty (30) days of admission to an ICF/IID. This determination shall provide the foundation for requests to elevate an acuity level assignment beyond Acuity Level 1.

II. ACUITY LEVEL ASSIGNMENTS

A. Reimbursement rates shall be differentiated based on the beneficiary's acuity level, as recommended by the Department on Disability Services (DDS), through the Level of Need Assessment and Risk Screening Tool (LON), and interdisciplinary teams of health and habilitation professionals, pursuant to the Individual Service Plan (ISP).

B. Acuity levels higher than Acuity Level 1 (Base) shall be approved by DHCF and shall be specific to the medical and health care needs of each qualified beneficiary.

C. Reimbursement under this chapter shall be governed according to the following acuity levels:

1. Acuity Level 1 (Base) shall represent the health, habilitation, and support needs of a beneficiary whose level of care determination (LOC) reflects a need for ICF/IID services. Acuity Level 1 shall be the base acuity level;

2. Acuity Level 2 (Moderate) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1. and requires moderate levels of services in order to effectively support functional impairments, as described in Section II.G.;

3. Acuity Level 3 (Extensive – Behavioral) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1. and requires services and interventions than can address conditions associated with an extensive intellectual and developmental disability and significant behavioral challenges as described in Section II.H.;

4. Acuity Level 4 (Extensive – Medical) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1. and requires services and interventions that can address conditions associated with an

extensive intellectual and developmental disability and significant medical and support challenges as described in Section II.I.;

5. Acuity Level 5 (Pervasive) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1. and requires services and interventions that can address conditions associated with a pervasive intellectual and developmental disability and who exhibits dangerous behaviors and/or conditions that require one-to-one (1:1) supervision for twenty-four (24) hours per day or less, as described in Section II.J.; and

6. Acuity Level 6 (Pervasive Plus Skilled Nursing) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1. and requires services and interventions that can address conditions associated with a pervasive level of care to accommodate individuals with dangerous behaviors and/or conditions that require one-to-one (1:1) supervision twenty-four (24) hours per day and those individuals who are in need of extensive skilled nursing service as described in Section II.K.

D. For purposes of reimbursement, a beneficiary admitted on or after October 1, 2012, shall be assumed to be at Acuity Level 1 (Base). An ICF/IID may request that DHCF assign a beneficiary to an enhanced level, above Acuity Level 1, if the facility provides the required documentation.

E. In order for a beneficiary to qualify at an acuity level beyond Acuity Level 1 (Base), the ICF/IID shall ensure that qualified health and habilitation practitioners assess each beneficiary using the LON.

F. Acuity level assignments shall be recertified annually.

G. A beneficiary shall qualify for Acuity Level 2 (Moderate) when exhibiting at least one (1) of the following characteristics:

1. Is unable to perform two (2) or more activities of daily living (ADL);

2. Is non-ambulatory;

3. Is unable to evacuate self without assistance in the event of a fire and other emergency situation;

4. Is assessed to lack life safety skills to ensure self-preservation; or

5. A diagnosis of one of the following:

    a. Blindness;
    b. Deafness;
    c. Autism Spectrum Disorder; or
    d. Epilepsy.

H. A beneficiary shall qualify for Acuity Level 3 (Extensive – Behavioral) when he or she is dually diagnosed with an intellectual and developmental disability and with one or more behavioral disorders that:

    1. Are assaultive, self-abusive, including pica, or aggressive;

    2. Require a written behavior plan which is based on current data and targets the identified behaviors; and

    3. Require intensive staff intervention and additional staff resources to manage the behaviors as set forth in Section II.H.1.

I. A beneficiary shall qualify for Acuity Level 4 (Extensive – Medical) when he or she requires skilled nursing and extensive health and habilitation supports on a daily basis. Skilled nursing and extensive health and habilitation supports shall be prescribed by the individual's primary care physician or advanced practice registered nurse.

J. A beneficiary shall qualify for Acuity Level 5 (Pervasive) when he or she requires one-to-one (1:1) staffing and exhibits one (1) or more of the following characteristics:

    1. A history of, or is at high risk for, elopement resulting in risk to beneficiary or others;

    2. Exhibits behavior that is life-threatening to the beneficiary or others;

    3. Exhibits destructive behavior that poses serious property damage, including fire-setting;

    4. Is a sexual predator; and

    5. A history of, or is at high risk for, falls with injury, and a primary care physician or advanced practice registered nurse order for one-to-one (1:1) supervision.

K. A beneficiary shall qualify for Level 6 (Pervasive Plus Skilled Nursing) if the beneficiary requires at least one (1) type of skilled nursing that shall be ordered by a primary care physician or advanced practice registered nurse and provided, at minimum, on an hourly basis.

L. The number of one-to-one (1:1) staffing hours shall be approved by DHCF using results from assessments conducted by ICFs/IID. Under Levels 5 and 6 (Pervasive and Pervasive Plus Skilled Nursing), DHCF's approval shall be based on having the staff member(s) assigned to the beneficiary having no other duties while assigned to the beneficiary.

M. Each ICF/IID shall have responsible direct care staff on duty and awake on a twenty-four (24) hour basis when individuals are present to ensure prompt, appropriate action in the event of injury, illness, fire, or other emergency.

N. Prior to the expiration of the current ISP, each ICF/IID shall be responsible for requesting renewal of the beneficiary's acuity level assignment by compiling the beneficiary's information in the required format(s) and ensuring the submission of supporting documentation to DDS.

O. DHCF may refuse requests for retroactive adjustments to reimbursement rates based on late renewal submissions.

III. REIMBURSEMENT METHODOLOGY

A. The rates for ICF/IID services were developed based on Fiscal Year (FY) 2010 cost data reported by providers of different sizes serving individuals at varying acuity levels. The rates shall vary based on staffing ratios, facility size, and beneficiary acuity level.

B. For the purposes of rate-setting, and independent of the rubric used by the Department of Health for licensing, DHCF shall classify ICFs/IID as follows:

1. Class I - A facility with five (5) or fewer licensed beds; and

2. Class II - A facility with six (6) or more licensed beds.

C. The residential component of the rate shall be based on a model that includes the following seven (7) cost centers:

1. The "**Direct Service**" cost center shall include expenditures as follows:

a. Direct Care Staff Compensation, to include the following:

i. Nurses, including registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs);
ii. Qualified Mental Retardation Professionals (QMRPs);
iii. House managers;
iv. Direct support personnel; and

v. Allocated time of staff who have administrative duties and are also utilized in direct service support, subject to the results of a time study or time sheet process that has been approved by DHCF; and

b. Fringe benefits, including but not limited to required taxes, health insurance, retirement benefits, vacation days, paid holidays, and sick leave.

2. The "**All Other Health Care and Program Related**" cost center shall include expenditures for:

a. Pharmacy co-pays and over-the-counter medications;
b. Medical supplies;
c. Therapy costs, including physical therapy, occupational therapy, and speech therapy;
d. Physician services;
e. Behavioral health services provided by psychologists or psychiatrists;
f. Nutrition and food;
g. Medical record maintenance and review;
h. Insurance for non-direct care health staff;
i. Program materials related to providing active treatment;
j. Program materials excluding active treatment;
k. Quality assurance;
l. Training for direct care staff;
m. Program development and management, including recreation;
n. Incident management; and
o. Clothing for individuals.

3. The "**Non Personnel Operations**" cost center shall include expenditures for:

a. Food service and supplies related to food service;
b. Laundry;
c. Housekeeping and linens; and
d. Non-capital repair and maintenance.

4. The "**Administration**" cost center shall include expenditures for:

a. Payroll taxes;
b. Salaries and consulting fees to non-direct care staff;
c. Insurance for administrators and executives;
d. Travel and entertainment (related to training seminars and staff appreciation events);
e. Training costs;
f. Office expenses;
g. Licenses
h. Office space rent or depreciation;

i. Clerical staff;
j. Interest on working capital; and
k. Staff transportation.

5. The "**Non-Emergency Transportation**" cost center shall include expenditures for:

   a. Vehicle license, lease, and fees;
   b. Vehicle maintenance;
   c. Depreciation of vehicle;
   d. Staffing costs for drivers and aides, not otherwise covered by, or in excess of costs for direct support personnel;
   e. Fuel; and
   f. Vehicle insurance.

6. The "**Capital**" cost center shall include expenditures for leased or owned properties:

   a. Depreciation and amortization;
   b. Interest on capital debt;
   c. Rent;
   d. Minor equipment;
   e. Real estate taxes;
   f. Property insurance;
   g. Other capital; and
   h. Utilities, including electricity, gas, telephone, cable, and water.

7. Capital costs shall be offset by all amounts received for days reimbursed pursuant to the "Policy on Payment for Reserved Beds in Intermediate Care Facilities for the Intellectually Disabled," page 2 of Attachment 4.19C of the State Plan.

8. The "**Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment**" cost center shall include only the allowable share of the Assessment expenditure consistent with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70, and 433.72.

D. Fiscal Year (FY) 2013 rates shall be based on FY2010 provider reported expenses and shall be paid for services delivered beginning on October 1, 2012, through September 30, 2013. FY 2013 rates, and all rates thereafter, shall be published in the D. C. Register. FY 2013 rates incorporate the following principles:

   1. FY 2013 Non-Personnel Operations per diem rates were based on FY 2010 costs, inflated twelve percent (12%);

2. FY 2013 Capital per diem rates were based on FY 2010 costs, inflated fifteen percent (15%);

3. FY 2013 rates were calculated as the quotient of total industry expenditures divided by the total number of industry licensed beds per reported as FY 2010 costs;

4. The FY 2013 rate for Non-Emergency Transportation shall be eighteen dollars ($18); and

5. Calculations were performed separately for Class I and Class II facilities for capital expenditures.

E. FY 2014 rates shall be based on the reported FY 2013 cost reports. In establishing the rates for FY 2014, DHCF shall use FY 2013 rates as a baseline to compare to the FY 2013 cost reports and address the following:

1. DHCF shall make adjustments to each cost center rate based on the actual costs reported in order to ensure appropriate payment. These adjustments may increase or decrease the per diem rates for each cost center;

2. DHCF shall adjust cost centers by reviewing submitted cost reports, analyzing industry-wide changes (for example, changes affecting personnel costs or medical supplies), and any relevant changes in District statutes and/or regulations; and

3. The resulting rates shall be inflated annually, beginning in FY 2014, in accordance with the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

F. Reimbursement rates shall be rebased in FY 2017, and every three (3) years thereafter.

G. Direct Service cost center reimbursement rates shall be calculated based on staffing ratios, facility size, and individuals' acuity levels. All rates shall accommodate the following staffing patterns:

1. Two (2) Direct Support Personnel (DSP) at three (3) shifts per day for three hundred sixty-five (365) days per year, at the following staffing ratios:

a. Class I Facilities: One (1) staff member to every two (2) individuals (1:2) and

b. Class II Facilities: One (1) staff member for every three (3) individuals (1:3).

2. One (1) Licensed Practical Nurse (LPN) for each facility at one (1) shift per day for three hundred sixty-five (365) days per year, for all ICFs/IID;

3. One (1) additional LPN for each ICF/IID at one (1) shift per weekend day (Saturday and Sunday) for fifty-two (52) weeks per year. This staffing pattern shall apply only to Class II Facilities.

4. One (1) Registered Nurse (RN), one (1) Qualified Mental Retardation Professional (QMRP), and one (1) house manager, each at one (1) shift per day for two hundred forty-nine (249) days per year, at a ratio of one (1) staff person to every twelve (12) individuals (1:12) for all ICFs/IID.

5. For services provided to individuals assigned to acuity levels higher than Acuity Level I, an ICF/IID shall be paid rates that can accommodate additional staffing needs as follows:

    a. Acuity Level 2 (Moderate) rates shall also include one (1) additional DSP at three (3) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP for every two (2) individuals (1:2) for all ICFs/IID.

    b. Acuity Level 3 (Extensive – Behavioral) rates shall also include costs associated with two (2) additional DSPs. The rates for Acuity Level 3 shall include one (1) DSP at three (3) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP staff member for every two (2) individuals for all ICFs/IID. The rate shall also include one (1) DSP at two (2) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP staff member for every two (2) individuals for all ICFs/IID.

    c. Acuity Level 4 (Extensive – Medical) rates shall also include costs associated with one (1) additional LPN at two (2) shifts per day for three hundred sixty-five (365) days per year, for all ICFs/IID. Class II facilities shall also receive a rate that includes one (1) certified nurse aide (CNA) at two (2) shifts per day for three hundred sixty-five (365) days per year.

    d. Acuity Level 5 (Pervasive) rates shall vary based on the number of one-to-one services prescribed for a beneficiary. Acuity Level 5 rates shall also include one (1) DSP at two (2) or three (3) shifts per day, for five (5) or seven (7) days per week for fifty-two (52) weeks per year, at a staffing ratio of one (1) DSP to one (1) beneficiary (1:1).

    e. Acuity Level 6 (Pervasive Plus Skilled Nursing) rates shall vary based on the number of one-to-one services prescribed for a beneficiary. Acuity Level 6 rates shall also include one (1) LPN at one (1), two (2), or three

(3) shifts per day for seven (7) days per week for fifty-two (52) weeks per year, at a staffing ratio of one (1) LPN to one (1) beneficiary (1:1).

6. The base salaries used in the development of FY 2013 rates for direct care staff wages and salaries shall be as follows:

   a. Direct Support Personnel: $12.50 per hour
   b. Licensed Practical Nurse: $21.00 per hour
   c. Certified Nurse Aide: $16.83 per hour
   d. House Manager: $45,000 per year
   e. Registered Nurse: $70,000 per year
   f. Qualified Mental Retardation Professional: $60,000 per year

7. Salaries set forth in Section III.G.6. shall be treated as follows:

   a. "Paid time off" shall include the addition of eighty (80) hours of paid leave. Holiday pay shall include the addition of forty-four (44) hours to ensure the rate includes the rate of pay plus one-half (1/2) the rate of pay (time and one-half) for holidays worked;

   b. In order to accommodate fringe benefits the following principles shall apply:

      i. Salaries shall be inflated by twenty percent (20%); and

      ii. Paid leave and holiday pay shall be inflated by twelve percent (12%); and

   c. All rates include paid time off and holiday pay for all hourly full-time equivalents (FTE).

8. For FY 2014 and after, Direct Care Staff Compensation shall be inflated by the greater of any adjustment to the living wage or the associated costs of benefits and inflation based on the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

H. All Other Health Care and Program Related Expenses cost center reimbursement rates shall be calculated based on the facility size and the direct care cost center rate, which varies by staffing ratios and individuals' acuity levels. The rate for this cost center is calculated as a fixed percentage of the rate for direct services, at twelve percent (12%) for Class I facilities and at seventeen percent (17%) for Class II facilities.

I. Non-personnel Operations cost center reimbursement rates shall be calculated based on industry average reported costs. The Non-personnel Operations rate shall be equal to the

industry average reported expenses per licensed bed day for the line items included in the cost center, and shall be uniformly set for all providers.

J. Administration cost center reimbursement rates shall be calculated based on the staffing ratios, facility size, and individuals' acuity levels. The Administration rate shall vary based on the nature of ownership of the physical premises where the ICF/IID is housed. The Administration rate shall be a uniform percentage of the sum of the rates for all other cost centers and acuity levels, as set forth in the D.C. Municipal Regulations.

K. Non-Emergency Transportation cost center reimbursement rates shall be based on the industry average expenses divided by the total number of licensed bed days. The industry average expense is determined based on the rate charged by the District's Non-Emergency Transportation broker for services provided to beneficiaries with comparable medical need (i.e., enrolled in the 1915(c) ID/DD HCBS Waiver). This rate is then adjusted to account for group-based transportation of ICF/IID residents, using an average of two beneficiaries being present for each round-trip.

L. Capital cost center reimbursement rates shall be calculated in accordance with 42 C.F.R. § 413.130 and based on the industry average reported expenses per licensed bed day for the line items included in this cost center as described above and the rate shall vary based on the nature of ownership of the physical premises where the ICF/IID is housed. The Capital rate for leased premises shall be equal to the industry average reported expenses per licensed bed day for the line items included. The Capital rate for provider-owned premises shall be equal to fifty percent (50%) of the rate for leased premises. The Capital rate shall also be subject to the following principles:

1. When a sale/leaseback of an existing ICF/IID facility occurs, the ICF/IID's allowable capital related cost may not exceed the amount that the facility would have included had the facility retained legal title;

2. When a depreciable asset is acquired, the cost basis of the depreciable asset is the lesser of the net book value of the previous owner or the fair market value;

3. Facilities must employ the straight-line method for calculating depreciation; accelerated methods for calculating depreciation are not acceptable. The amount of an annual depreciation is determined by first reducing the cost of the assets by any salvage value and then dividing by the number of years of useful life of the asset. The useful life may be shorter than the physical life depending upon the usefulness of the particular asset to the provider;

4. ICFs/IID shall follow the guidelines on useful life published by the Internal Revenue Service or the booklet entitled "Estimated Useful Lives of the Depreciable Hospital Assets" published by the American Hospital Association. Depreciation expense for the year of disposal can be computed by using either the half-year method or the actual time method;

5. Assets shall be recorded using historical cost, except for donated assets which shall be recorded at fair market value at the time they were received, based on the lesser of at least two (2) bona fide appraisals. Costs during the construction of an asset, consulting and legal fees, interest, fund raising, etc., should be capitalized as a part of the cost of the asset;

6. When an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid;

7. Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years will be entitled to any straight-line depreciation of the remaining useful life of the asset. The depreciation shall be based on the cost of the asset or fair market value of a donated asset at the time of purchase, construction or donation over its normal useful life. No depreciation may be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition;

8. Leasehold improvements may be depreciated over the lesser of the asset's useful life or the remaining life of the lease;

9. On a case by case basis, DHCF may reimburse an ICF/IID by providing an offset to capital costs that is equal to the daily amount computed under Section III.L in situations when the Department on Disability Services is unable to fill vacant bed space(s). The ICF/IID shall receive the product of the capital cost multiplied by the administrative rate anytime this payment is made;

10. The add-on capital cost shall be the capital component of the daily per-diem rate, multiplied by the number of vacant bed space(s); and

11. In order to be eligible for capital add-on payments, ICFs/IID shall incur costs and provide DHCF with proof of the vacant bed space.

M. Effective October 1, 2013, and annually thereafter, the per diem rates for Non-Personnel Operations, Non-Emergency Transportation, Capital, and Active Treatment shall be adjusted for inflation in accordance with the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

N. The Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment is a broad based assessment on all ICF/ID providers in the District of Columbia at a uniform rate of five and one-half percent (5.5%) of each ICF/IID's gross revenue. The allowable cost of the Assessment is calculated consistent with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70, and 433.72.

IV. ACTIVE TREATMENT SERVICES

A. A beneficiary residing in an ICF/IID shall receive continuous active treatment services, consistent with the requirements set forth in 42 CFR § 483.440. Active treatment services shall vary depending on the needs of the beneficiary, as determined by the interdisciplinary team.

B. An ICF/IID shall ensure that a beneficiary receives active treatment services on a daily basis. The ICF/IID may affiliate with outside resources to assist with program planning and service delivery or the facility may provide active treatment services directly.

C. A program of active treatment services shall include aggressive, consistent implementation of a program of specialized training, treatment, health services and other related services that is directed towards:

1. The acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible; and

2. The prevention or deceleration of regression or loss of current optimal functional status.

D. In accordance with 42 C.F.R. §§ 483.440(c) - (d), an interdisciplinary team shall determine the type of active treatment services that a beneficiary needs based on preliminary evaluations, assessments, and re-assessments. Each beneficiary's active treatment requirements shall be described in his Individual Program Plan (IPP), pursuant to 42 C.F.R. § 483.440(c). The ICF/IID shall ensure that each beneficiary receives all of the services described in the IPP.

E. The per diem for active treatment shall equal the average of FY12 active treatment rates multiplied by two hundred forty-nine (249) days of service, to account for the maximum days of service provided, and divided by three hundred sixty-five (365).

V. Stevie Sellows' Quality Improvement (QI) Initiative – Supplemental Payment

A. The purpose of the **Stevie Sellows' Quality Improvement (QI) Initiative** is to provide supplemental payments, under the Stevie Sellows' Quality Improvement Fund to qualified District of Columbia, Medicaid-Certified, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) for participation in a training programs designed to improve the quality of care for beneficiaries with intellectual disabilities, by efforts to reduce employee turnover and increase the qualifications of employees.

B. For Fiscal Year (FY) 2015, and annually thereafter, DHCF, in collaboration with the Department on Disability Services (DDS) will approve a slate of training topics , for selection by ICFs/IID interested in participating in the QI Initiative. Topics may vary

each fiscal year, and DHCF will solicit suggestions from stakeholders, including but not limited to the provider community, beneficiaries, or District licensing agencies.

C. For each fiscal year, in order for an ICF/IID to be considered for payments under the Stevie Sellows' Quality Improvement Fund, an ICF/IID must submit an application packet no later than June 30th of the preceding fiscal year and meet the standards set forth in this section. The application packet must include the following:

1. A Letter of Intent

2. Copy of Training Plan which identifies:

   a. Projected training cost;
   b. Training curriculum which includes the selected training topic(s) chosen from the approved slate of topics, objectives, length of training (a minimum of 16 hours per employee), and methods/medium;
   c. Handouts that may be used to teach employees;
   d. Competency test(s) to be administered;
   e. Quality improvement tool(s) that will be used to assess employee performance, after training is administered;
   f. Tool(s) that will used to evaluate the effectiveness of the training; and
   g. Process for assessing and measuring the Plan annually.

D. For FY 2015 and thereafter, each employee must complete a minimum of sixteen (16) hours of classroom training annually by their anniversary date of hire.

E. Training must be competency based, with employees receiving a passing score of 80% or better.

F. Training must be provided by an industry - recognized organization.

G. Training must have a person-centered perspective that is focused on improving the quality of life or care for individuals residing in ICFs.

H. Training must be provided to employees excluding managers, administrators and contract employees.

I. ICF/IID facilities that do not submit completed application materials within the required timeframe to the address below will not be considered for payment:.

The D.C. Department of Health Care Finance
Project Manager, Long Term Care Division, Special Needs Branch
899 North Capitol Street, NE, Suite 6037
Washington, DC, 20002

J. ICFs shall be responsible for the following:

1. Completed training records shall be maintained in the ICFs/IID administrative offices and shall contain the following for former and current employees:

   a. Names, hire dates, and position titles for all employees;
   b. Training curriculum and handouts used to teach employees;
   c. Training completion date, and verification score or graded tests; and
   d. Training sign - in sheets.

2. ICF/IID shall submit information to DHCF regarding personnel changes (e.g., when an employee leaves the agency, changes his/her name or receives a promotion).

3. In order to receive payment, an ICF/IID must meet the requirements identified above in Section II and submit the items below:

   a. Quarter One - A copy of the written notification by DHCF for approval of items listed in section I. above, and a complete list of employee names, hire dates, and position titles for all employees, submitted within fourteen (14) days of the end of the fiscal quarter;
   b. Quarter Two - The ICF/IID will submit to DHCF completed records indicating that 50% of employees have completed required training and have passed a written competency test (Score of 80% or better), submitted within fourteen (14) days of the end of the fiscal quarter;
   c. Quarter Three - The ICF/IID will submit to DHCF completed records indicating that 100% of employees have completed required training and have passed a written competency test (Score of 80% or better), submitted within fourteen (14) days of the end of the fiscal quarter; and
   d. Quarter Four - Annually the ICF/IID will produce and submit a Comprehensive Training Report no later than August 1that includes the following:

      i. Documentation of incurred training expenses;
      ii. Documentation of training completion date, graded tests, and training sign in sheets;
      iii. Performance measures which indicate the total number of employees who received training vs. the total number of employees who received a passing score, and the total number of individuals served vs. the total number of individuals with documented evidence that quality of care was improved, as a result of the employee's implementation of training received; and
      iv. A brief summary of how training impacted employee turnover and improved the qualifications/skills of the employee, and how the performance measures demonstrate the agency's progress towards quality improvement and/or challenges. If challenges have been identified, the summary should also include interventions the ICF/IID will implement to improve quality of care for individuals.

4. Payment shall not be made to an ICF/IID to cover costs that the ICF/IID incurred for employees attending agency required/standard training or for training sponsored by a D.C. governmental agency.

5. Missed timelines and discrepancies in documents/records provided may result in the need for a Corrective Action Plan (CAP).

J. The responsibilities of DHCF shall include:

1. The responsibility for this initiative shall be is vested in the Deputy Director, Medicaid, Department of Health Care Finance (DHCF). Implementation of this initiative is the responsibility of the Health Care Delivery Management Administration, Long Term Care Division, Special Needs Branch.

2. Within 90 days of receipt of application materials, DHCF will notify ICFs/IID in writing whether the training plan submitted by the ICF/IID was approved. Approval of the training topic does not guarantee that the ICF/IID will meet all necessary requirements for payment under the Stevie Sellows' quality improvement fund.

3. For FY 15, and annually thereafter, to identify performance improvement opportunities DHCF, Division of Quality and Health Outcomes will perform trend and data analysis of information provided. Findings will be shared with individual provider agencies.

4. An ICF/IID will be subject to random audits conducted by DHCF, Special Needs Branch. Audits may include; but not be limited to the following:

a. Training record reviews;
b. Interviews with agency personnel; and/or
c. In-class monitoring.

K. The supplemental payment shall conform to the Medicaid Upper Payment Limits (UPL) which ensures that rates do not exceed usual and customary charges billed to the general public in 42 CFR § 447.271.

L. For each fiscal year, the aggregate annual supplemental payment to all ICFs/IID shall not exceed 2% of the total reimbursements paid under Section III of this State Plan Amendment.

M. The supplemental payment rate shall be the lesser of the amount specified in Section V divided by the number of licensed Medicaid beds as certified at the beginning of the fiscal year, or the sum of total industry training costs divided by the total number of licensed Medicaid beds as certified at the beginning of the fiscal year. The total industry training costs are determined from the training application packages submitted pursuant to Section II (A).

N. Supplemental payments to individual ICF/IID will be the lesser of the following: the supplemental rate multiplied by the number of licensed Medicaid beds operated by the provider as certified at the beginning of the fiscal year, or the actual training costs incurred by the provider. Supplemental payments shall not exceed providers' actual costs or the calculable payment per licensed Medicaid bed.

O. Supplemental payments made in accordance with this section shall be included in the cost report submitted annually and shall be recorded as an offset to the costs incurred.

P. In order to receive supplemental payment reimbursements an ICF/IID shall incur costs and provide DHCF with evidence of training requirements as outlined in sections II (A) and IV (A-G).

Q. Acceptable forms of evidence shall include a copy of any invoice(s) for training costs and cancelled check(s) reflecting the facility's payment of the invoice(s). Within 90 days of receipt of required documents, DHCF shall notify the ICF/IID and process payments.

R. Payments made in accordance with this section are not subject to assessment under the Stevie Sellows Quality Improvement Fund.

VI. REBASING

Effective October 1, 2016 (FY 2017), and every three (3) years thereafter, reimbursement rates for the residential component shall be updated based on cost reports from the most recently audited year.

VII. COST REPORTING AND RECORD MAINTENANCE

A. Each ICF/IID shall report costs annually to DHCF no later than ninety (90) days after the end of the provider's cost reporting period, which shall correspond to the fiscal year used by the provider for all other financial reporting purposes, unless DHCF has approved an exception. All cost reports shall cover a twelve (12) month cost reporting period.

B. cost report that is not completed in accordance with the requirements of this Section shall be considered an incomplete filing, and DHCF shall notify the ICF/IID within thirty (30) days of the date on which DHCF received the incomplete cost report.

C. DHCF shall issue a delinquency notice if the ICF/IID does not submit the cost report as specified in Section VII.A. and has not previously received an extension of the deadline for good cause.

D. Late submission of cost reports shall result in a refundable withholding of an amount equal to seventy-five percent (75%) of the facility's total payment for the month that the cost report was due, and the same amount shall be withheld each month until the cost report is received.

E. The costs described in Section III. shall be reported on a cost report template developed by DHCF. The cost report shall be completed in accordance with accompanying instructions. The cost report instructions shall include, at minimum, guidelines and standards for determining and reporting allowable costs.

F. If the ICF/IID utilizes outside resources pursuant to Section IV.B., the ICF/IID shall submit the cost reports or invoices provided by the outside resources as an attachment to the submitted cost report under Section VII.E. Where the active treatment program is provided in house, the provider shall provide its own cost report in the active treatment section of the cost report.

G. In the absence of specific instructions or definitions contained in the accompanying regulations, cost report forms and instructions, the treatment and allowability of costs shall be determined in accordance with the Medicare Principles of Reimbursement, 42 C.F.R. Part 413, and the interpretation found in the relevant Provider Reimbursement Manual.

H. Any allocated time claimed under Section III.C.1.a.v. must be supported by contemporaneous time sheets attested to by the persons concerned, or a random moment time study designed and reviewed by an independent firm. Such documentation shall be submitted with the cost report in support of all amounts claimed.

I. All of the facility's accounting and related records, including the general ledger and records of original entry, and all transaction documents and statistical data, shall be permanent records and be retained for a period of not less than five (5) years after the filing of a cost report.

J. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is complete.

K. In accordance with Section I.I., the ICF/IID shall disclose a list of related organizations, associated amounts, and the reason(s) for payment to each related organization in the cost report.

L. Costs incurred during a period when an ICF/IID is subject to denial of payment for new admissions, described in Section XIII, shall be included on the cost report for the period during which payment was denied, in order to accurately determine rates in subsequent periods.

VIII. FISCAL ACCOUNTABILITY AND AUDITING

A. Beginning in FY 2014, except for the Administration cost center, each facility shall spend at least ninety-five percent (95%) of the rate under each cost center on service delivery to Medicaid individuals. Facilities expending less than ninety-five percent (95%) of each cost center shall be subject to repayment requirements.

B. Beginning in FY 2014, each ICD/IID shall spend one hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid individuals. Facilities expending less than one hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements.

C. DHCF shall evaluate expenditures subject to the requirements in this Section through annual review of cost reports.

D. The repayment amount shall be the difference between ninety-five percent (95%) of the rate component and reported expenses plus the administrative percentage, as set forth in the D.C. Municipal Regulations.

E. DHCF, or its designee, shall review each cost report for completeness, accuracy, compliance, and reasonableness through a desk audit.

F. On-site audits shall be conducted not less than once every three (3) years. Each ICF/IID shall allow access, during on-site audits or review by DHCF or U.S. Department of Health and Human Services auditors, to relevant financial records and statistical data to verify costs previously reported to DHCF.

XIX. NOTICE OF RATES AND RIGHT TO APPEAL

A. DHCF shall publish in the D.C. Register all rates and all procedures and timeframes for requesting an informal review and appeals in the D.C. Register consistent with the requirements set forth in this Section.

B. For Fiscal Years 2013 and after, DHCF will send a transmittal to all providers notifying them of the rates.

C. Provider appeals under this State Plan Amendment shall be limited to challenges based on acuity level assignments and audit adjustments.

D. Filing an appeal with OAH shall not stay any action to recover any overpayment to the ICF/IID, and the provider shall be immediately liable to the program for overpayments set forth in the Department's decision.

X. UTILIZATION REVIEW REQUIREMENTS

A. In accordance with 42 C.F.R. § 456.401, DHCF shall maintain a written Utilization Review Plan (URP) for each ICF/IID enrolled in the District of Columbia's Medicaid

program. This plan shall describe the review process that shall be used for each beneficiary receiving services furnished by the ICF/IID.

B. Utilization review for ICFs/IID enrolled in D.C. Medicaid may be conducted by any of the following:

1. The ICF/IID;
2. DHCF or its designee; or
3. Any other approved method.

C. At least annually, DHCF shall ensure that each ICF/IID has a completed and approved URP on file. The URP shall, at minimum, include the following:

1. A description of how utilization review is performed;
2. The frequency of utilization review;
3. Assurances and documentation establishing that the personnel who shall perform utilization review meet the requirements of 42 C.F.R. § 456.406(b);
4. Administrative staff responsibilities related to utilization review;
5. The types of records maintained by the utilization review team;
6. The types and frequency of any reports developed by the utilization review team, and related plan for dissemination; and
7. The procedures that shall be used when corrective action is necessary.

D. In accordance with 42 C.F.R. §§ 456.431 - 456.438, each URP shall establish a process whereby each beneficiary residing in the ICF/IID receives continued stay reviews, at minimum, every six (6) months.

E. The URP shall establish written methods and criteria used to conduct continued stay reviews. The URP shall also set forth enhanced criteria used to assess a case if the beneficiary's circumstances reflect any of the following associations:

1. High costs;
2. Frequent and excessive services; or
3. Questionable patterns of care by treating clinicians.

XI. COMMENCING TERMINATION OR IMPOSING SANCTIONS AGAINST ICFs/IID

A. In order to qualify for Medicaid reimbursement, intermediate care facilities for persons with intellectual and developmental disabilities (ICFs/IID) shall comply with federal conditions of participation (CoPs), pursuant to 42 C.F.R. §§ 483.400-483.480. The CoPs include adherence to acceptable standards in the following areas:

1. Governing body and management;
2. Client protections;
3. Facility staffing;
4. Active treatment services;
5. Client behavior and facility practices;
6. Health care services;
7. Physical environment; and
8. Dietetic services.

B. An ICF/IID that fails to maintain compliance with the CoPs may be subject to alternative sanctions and/or termination of its participation in the Medicaid program.

XII. ALTERNATIVE SANCTIONS IN CASES OF NON-IMMEDIATE JEOPARDY

A. In accordance with Section 1902(i)(1)(B) of the Social Security Act, the District of Columbia may impose alternative sanctions against an ICF/IID when that facility fails to meet the CoPs, but the violation does not place beneficiary health or safety in immediate jeopardy.

B. In lieu of terminating the provider agreement, DHCF may impose one or more alternative sanctions against an ICF/IID that meets the criteria in 29 DCMR § 4150.1, as follows:

1. Denial of payment, as described in Section XIII;
2. Directed Plan of Correction (DPoC), as described in Section XIV;
3. Directed In-Service Training (DIST), as described in Section XV; or
4. State Monitoring, as described in Section XVI.

C. DHCF shall, in conjunction with DOH, determine the appropriateness of alternative sanctions against an ICF/IID that is in violation of the CoPs according to the following factors:

1. Seriousness of the violation(s);
2. Number and nature of the violation(s);
3. Potential for immediate and serious threat(s) to ICF/IID residents;
4. Potential for serious harm to ICF/IID residents;
5. Any history of prior violation(s) and/or sanction(s);
6. Actions or recommendations of DDS, developmental disability advocacy groups, or health care entities;
7. Mitigating circumstances; and
8. Other relevant factors.

XIII. DENIAL OF PAYMENT

A. Pursuant to Section 1902(i) of the Act and 42 C.F.R. § 442.118, and in lieu of termination in situations where residents are not in immediate jeopardy, DHCF may initiate a one-

time, denial of payment for claims associated with new admissions at ICFs/IID that fail to comply with one or more of the CoPs for Medicaid enrollment.

B. The denial of payment term shall be eleven (11) months, beginning on the first day of the month after DHCF imposes the denial of payments.

C. DHCF shall also deny payment to ICFs/IID if DOH previously initiated enforcement actions due to immediate jeopardy, and the facility has failed to mitigate the circumstances that caused immediate jeopardy.

D. DHCF, in coordination with DOH, shall notify the ICF/IID that it is subject to denial of payment. The written notification shall indicate the following:

1. That the ICF/IID has up to sixty (60) days to correct the cited deficiencies; and
2. The procedures that will commence once the sixty (60) days have lapsed, pursuant to Section XIII.E.

E. If the ICF/IID does not correct the violations within the sixty (60) day timeframe, then DHCF shall notify the facility of its intention to deny payment. This written notification shall include:

1. Reasons for denial of payment;
2. Information on the right to request a hearing though the Office of Administrative Hearings (OAH), pursuant to 29 DCMR §§ 1300 *et seq.*;
3. Details of public notice; and
4. The effective date for denial of payments.

F. If an ICF/IID appeals DHCF's decision to deny payment, DHCF shall notify the provider that the effective date of the sanction, established in Section XIII.B., is suspended until the appeal is resolved.

G. If denial of payment is upheld at the appeal, the DHCF shall notify the facility and the public at least thirty (30) days before the newly established effective date of the sanction.

H. DHCF, in coordination with DOH, shall monitor the facility's progress in improving cited violation(s) throughout the eleven (11) month period.

I. The Director of DHCF shall consider modifying or rescinding denial of payment upon the occurrence of one of the following:

1. Circumstances have changed and resulted in alterations of the CoPs violation(s) in such a manner as to immediately jeopardize beneficiary health and safety; or

2. The ICF/IID achieves full compliance with the CoPs in fewer than eleven (11) months; or

3. The ICF/IID makes significant progress in achieving compliance with the CoPs through good faith efforts.

J. DHCF shall terminate the provider agreement of an ICF/IID that has been unable to achieve compliance with the CoPs during the full eleven (11) month period of denial of payment. Termination shall be effective on the first day following the last day of the denial payment period.

K. An ICF/IID provider agreement that is subject to denial of payment is automatically extended for the eleven (11) month period if the provider agreement does not lapse on or before the effective date of denial of payments.

L. ICF/IID provider agreements that are subject to denial of payment can only be renewed when the denial period expires or is rescinded.

XIV. DIRECTED PLAN OF CORRECTION (DPoC)

A. The DPoC shall be a plan developed by the District of Columbia that requires ICFs/IID to take prompt, timely action to achieve correction and continued compliance with CoPs and other District of Columbia Medicaid requirements.

B. The DPoC shall be developed in coordination with and approved by DOH, DHCF and DDS, incorporating findings from DDS' Continuous Quality Improvement Plan.

C. The DPoC shall specify:

1. How corrective action will be accomplished for individuals found to have been affected by the deficient practice;

2. How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

4. How the facility will monitor its corrective actions and performance to ensure that the deficient practice(s) is/are being corrected and will not recur;

5. When the corrective action must be complete;

6. How substantial compliance will be measured; and

7. How the DPoC related to other alternative sanctions.

D. A state monitor shall oversee implementation of the DPoC, and shall ensure compliance with the plan.

XV. DIRECTED IN-SERVICE TRAINING (DIST)

A. A DIST shall be used to address deficiencies determined by the District to be correctable through education. The sanction shall require the staff and relevant contractors of the ICF/IID to attend in-service trainings and demonstrate competency in the information presented during the trainings.

B. DHCF, in consultation with DOH and DDS, shall develop the areas for ICF/IID staff and contractor training by incorporating the findings from the Continuous Quality Improvement Plan.

C. Facilities shall use training programs developed by well-established developmental disabilities organizations, such as universities and developmental advocacy organizations, to meet training requirements described in this Section.

D. The ICF/IID shall bear the expense of the DIST.

E. A state monitor shall oversee implementation of DIST, and shall ensure compliance with the requirements.

XVI. STATE MONITORING

A. State monitoring shall be the District's oversight of efforts made by the ICF/IID to correct cited deficiencies. State monitoring shall be a safeguard against the facility's further noncompliance.

B. The following entities may serve as the State Monitor:

1. DOH;
2. DHCF;
3. DDS; or
4. A District of Columbia contractor that meets the following requirements:

   i. Is not a designee or current contractor of the monitored facility;
   ii. Does not have an immediate family member who is a resident of the facility;
   iii. Is not a person who has been terminated for cause by the facility; and
   iv. Is not a former contractor who has had a contract canceled, for cause, by the facility.

C. State monitoring shall be discontinued under the following circumstances:

1. The facility's provider agreement is terminated; or
2. The facility has demonstrated to the satisfaction of the District of Columbia that it is in substantial compliance with the CoPs.

XVII. ACCESS TO RECORDS

Each ICF/IID shall allow appropriate DHCF personnel, 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.

XVIII. DEFINITIONS

For purposes of this Part of Attachment 4.19-D, the following terms shall have the meanings ascribed:

A. **Active Treatment** - A program of specialized and generic training, treatment, health services and related services designed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status. These services shall be provided consistent with Federal standards.

B. **Activities of Daily Living** - The ability to bathe, transfer, dress, eat and feed self, engage in toileting, and maintain bowel and bladder control (continence).

C. **Acuity Level** - The intensity of services required for a Medicaid beneficiary residing in an ICF/IID. Individuals with a high acuity level require more care; those with lower acuity levels require less care.

D. **Administrator** - An individual responsible for the administration or implementation of ICF/IID policies or procedures, and other roles other than delivering services directly related to resident treatment and care, food service, or maintenance of the facility.

E. **Allowable costs** - Actual costs, after appropriate adjustments, incurred by an ICF/IID, which are reimbursable under the Medicaid program.

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

G. **Depreciation** - The systematic distribution of the cost or other basis of depreciable assets, less salvage value, over the estimated useful life of the assets.

H. **Direct service costs** - Costs incurred by a provider that are attributable to the operation of providing services to individuals.

I. **Elopement** - To run away; abscond.

J. **Employee** - A worker in an ICF/IID that does not serve as a manager or administrator, and is not under contract to provide professional services.

K. **Facility** - An intermediate care facility for individuals with intellectual disabilities.

L. **Habilitation** – The process by which a person is assisted to acquire and maintain those life skills which enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment, including, in the case of a person committed under § 7-1304.06a, to refrain from committing crimes of violence or sex offenses, and to raise the level of his or her physical, intellectual, social, emotional and economic efficiency.

M. **Holiday pay** - Shall have the meaning ascribed within a labor agreement, provider policy, or in the absence of either, by the U.S. Department of Labor.

N. **Individual Support Plan (ISP)** - The document produced through coordinated efforts of ICFs/IID and DDS. The ISP is the successor to the Individual Habilitation Plan as defined in the court-approved *Joy Evans* Exit Plan. For purposes of Medicaid reimbursement, the individual program plan, as described in 42 C.F.R. § 483.440(c), shall be included within the ISP.

O. **Industry Average** - The sum of total industry expenditures divided by total industry licensed bed days per reported fiscal year costs.

P. **Interdisciplinary team** - A group of persons, with special training and experience in the diagnosis and habilitation of individuals with intellectual and developmental disabilities, with the responsibility to perform a comprehensive evaluation of each beneficiary and participating in the development, implementation, and monitoring of the beneficiary's individual habilitation plan. The "core team" shall include the individual, the individual's representative, the service coordinator, and relevant clinical staff.

Q. **Level of Care Determination (LOC)** - The assessment used by the Department on Disability Services to determine a beneficiary's eligibility for ICF/IID services.

R. **Level of Need Assessment and Risk Screening Tool (LON)** - The comprehensive and uniform assessment tool developed by the Department on Disability Services that determines the beneficiary's individual support needs and identifies potential risks to be addressed by the interdisciplinary team.

S. **Licensed bed days** – Bed day policy for beneficiaries residing in Intermediate Care Facilities for the Intellectually and Developmentally Disabled pursuant to Attachment 4.19C of the District of Columbia State Plan for Medical Assistance.

T. **Life safety skills** - An individual's ability to protect oneself from perceived and apparent risks and life-threatening situations such as fires, evacuation emergencies, traffic, and ingestion of toxic substances.

U. **Manager** - An individual who is responsible for the administration of an ICF/IID facility inclusive of human resources, maintenance, and policy management.

V. **Non-ambulatory** - A beneficiary who spends all time out of bed in a wheelchair or a chair.

W. **One-to-One** - An altered staffing pattern that allows one staff to provide services to an individual with intellectual disabilities exclusively for an authorized period of time.

X. **Owner** - A person who is a sole proprietor, partner, or corporate stockholder-employee owning any of the outstanding stock of the contracted provider.

Y. **Per diem rate** - The rate per day established by DHCF.

Z. **Professional services** – Services provided pursuant to any legal arrangement. Professional services shall include occupational and speech therapies and nursing care services provided by an individual or a corporation.

AA. **Quality of care improvements** - The same definition as set forth in D.C. Official Code § 47-1270, and any subsequent amendments thereto.

BB. **Related organization** - In accordance with 42 C.F.R. § 413.17(b)(1), an organization is related to an ICF/IID when the ICF/IID, to a significant extent, is associated or affiliated with, or has control over, or is controlled by the organization furnishing the services, facilities, or supplies.