

## **Table of Contents**

**State Name:** District of Columbia

**State Plan Amendment (SPA)#:** 17-0008

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Seven (7) SPA Pages



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**Financial Management Group**

**NOV 06 2017**

Claudia Schlosberg, J.D.  
Medicaid Director  
Department of Health Care Finance  
441 4<sup>th</sup> St. N.W., Suite 900 South  
Washington, DC 2000

RE: State Plan Amendment 17-0008

Dear Ms. Schlosberg:

We have reviewed the proposed amendment to Attachment 4.19-D of the District of Columbia State plan submitted under transmittal number (TN) 17-0008. This amendment modifies the State's methods and standards for setting intermediate care facility (ICFID) payment rates. Specifically, this amendment combines therapeutic leave and hospitalization for reserved bed days, decreases the frequency of low-acuity assessments, and changes the spending requirements on certain cost center revenues.

We conducted our review of your submittal according to the statutory requirements at Sections 1902(a)(2), 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 District of Columbia State plan amendment 17-0008 with an effective date of November 1, 2017. The approved HCFA-179 and the amended state plan pages are enclosed.

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

Sincerely,

/S/

Kristin Fan  
Director

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: <b>17-008</b>	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
<b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	4. PROPOSED EFFECTIVE DATE November 1, 2017	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services		

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 Section 1902(a)(31) of the Social Security Act (42 U.S.C. § 1396a(31)); 42 CFR Part 483, Subpart I	7. FEDERAL BUDGET IMPACT a. FFY 18 \$ 182,453.50 b. FFY 19 \$ 188,656.92
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19C: p 2 Attachment 4.19D, Part II: p 4; p 9A; p 11A; p 18; pp 20 – 20A(new)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19C: p 2 Attachment 4.19D, Part II: p 4; p 9A; p 11A; p 18; p 20

10. SUBJECT OF AMENDMENT:

**Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities**

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Resolution Number: 22-0104  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL <i>/S/</i>	16. RETURN TO Claudia Schlosberg, J.D. Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 <sup>th</sup> Street, NW, 9 <sup>th</sup> Floor, South Washington, DC 20001
13. TYPED NAME Claudia Schlosberg J.D.	
14. TITLE Senior Deputy Director/Medicaid Director	
15. DATE SUBMITTED August 23, 2016	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED	18. DATE APPROVED <b>NOV 06 2017</b>
<b>PLAN APPROVED – ONE COPY ATTACHED</b>	
19. EFFECTIVE DATE OF APPROVED MATERIAL <b>NOV 01 2017</b>	20. SIGNATURE OF REGIONAL OFFICIAL <i>/S/</i>
21. TYPED NAME <i>Kristin Fan</i>	22. TITLE <i>Director, FMC</i>

23: REMARKS

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POLICY ON PAYMENT FOR RESERVED BEDS IN INTERMEDIATE CARE FACILITIES  
FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Payment for reserved bed days for hospitalization and therapeutic leaves of absence will be authorized for up to sixty (60) days total during a District fiscal year if there is a reasonable expectation that the beneficiary will return to the facility. Therapeutic leaves of absence must be provided for in a beneficiary's plan of care in order to be authorized.

Payment for reserved bed days shall equal the facility's per diem rate for the beneficiary, based on the beneficiary's approved acuity level assignment.

A District fiscal year is a twelve (12) month period beginning on October 1 and ending on September 30.

Hospitalization includes any inpatient admission.

Therapeutic leaves of absence include visits with relatives and friends as well as leaves to participate in District-approved therapeutic and rehabilitative programs.

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 above 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 every three (3) years for beneficiaries assigned Acuity Level 1 through 4, and annually for beneficiaries assigned Acuity Level 5 or 6.
- 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 (ADLs);
  2. Is non-ambulatory;
  3. Is unable to evacuate without assistance in the event of a fire or other emergency situation;
  4. Is assessed to lack life safety skills to ensure self-preservation; or

- e. All adjustments described in section III.E shall be limited to fiscal years when rebasing does not occur.
- f. For purposes of section III.E, the following definitions shall apply:
  - i. "Operational Adjustment" shall refer to an adjustment made to any cost center based on information reflected in an ICF/IID's cost report (i.e., actual reported costs). These reported costs will be compared to the actual reported aggregate costs for all ICFs/IID. An operational adjustment provides a mechanism for DHCF to address under- or over-payments that are identified after comparing the projections used to determine the rate with the provider's actual costs.
  - ii. "Outlier Adjustment" shall refer to an adjustment made after the ICF/IID submits a cost report and the actual reported costs reflect uncharacteristically low or high costs. In order to qualify for an outlier adjustment, the unexpected expense must impact all of the District's ICFs/IID.

2. Effective January 1, 2014, the rate for Non-Emergency Transportation shall be twelve dollars and sixteen cents (\$12.16).

F. Reimbursement rates shall be rebased in FY 2018, and every three (3) years thereafter.

G. Direct Service cost center reimbursement rates shall be calculated based on staffing ratios, facility size, and beneficiaries' 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).

- H. All Other Health Care and Program Related Expenses cost center reimbursement rates shall be calculated based on the facility size and the Direct Service 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.



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).

- O. Supplemental payments to individual ICF/IID provider 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 ICF/IID providers' actual costs or the calculable payment per licensed Medicaid bed.
- P. 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.
- Q. In order to receive supplemental payment reimbursements an ICF/IID provider shall incur costs and provide DHCF with evidence of training requirements as outlined in Sections II (A) and IV (A-G). 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 ninety (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.

#### IV. REBASING

Effective October 1, 2017 (FY 2018), 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, as determined by DHCF.

#### V. 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. A 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.

**VI. FISCAL ACCOUNTABILITY AND AUDITING**

- A. From October 1, 2013 through September 30, 2017, except for the Administration, Capital, and Active Treatment cost centers, 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. From October 1, 2013 through September 30, 2017, each ICF/IID shall spend one hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid beneficiaries. Facilities expending less than one hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements.
- C. From January 1, 2014 through September 30, 2017, each ICF/IID shall spend one hundred percent (100%) of the rate associated with the Capital cost center. A facility that fails to expend one hundred percent (100%) on Capital shall be subject to repayment requirements.
- D. Effective October 1, 2017, each ICF/IID shall spend at least ninety-five percent (95%) of the rate for Direct Service and one-hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid beneficiaries. Facilities expending less than ninety-five percent (95%) of the rate for Direct Service or one-hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements.
- E. Effective October 1, 2017, each ICF/IID shall spend at least ninety-five percent (95%) of the aggregate rate for the All Other Health Care and Program Related, Non Personnel Operations, Non-Emergency Transportation, and Capital cost centers. Facilities expending less than ninety-five percent (95%) of the aggregate rate for these four (4) cost centers shall be subject to repayment requirements.
- F. The repayment amounts shall be the differences between ninety-five percent (95%) or one hundred percent (100%) of the applicable rate component, as set forth in the D.C. Municipal Regulations, and the facility's reported expenses.
- G. In accordance with D.C. Official Code §§ 47-1270(5) and 47-1272(c), DHCF, or its designee, reserves the right to inspect payroll and personnel records to support the Department's obligations pursuant to the Living Wage Act of 2006, effective March 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.*), and implementing regulations.
- H. DHCF shall evaluate expenditures subject to the requirements in this Section through annual review of cost reports. DHCF, or its designee, shall review each cost report for completeness, accuracy, compliance, and reasonableness through a desk audit.

- I. 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.

**VII. NOTICE OF RATES AND RIGHT TO APPEAL**

- A. Rules published in the DC. Register set forth procedures and timeframes for requesting an informal review and appeals 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.