DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF SECOND EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), 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 (2012 Repl. & 2013 Supp.)) and Section 6 (6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6)) (2012 Repl.)), hereby gives notice of the adoption, on an emergency basis, of an amendment to Chapter 41 (Medicaid Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These rules amend the methodology used to calculate Medicaid reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and update the current reimbursement rates. The current rate methodology, as approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for implementation in Fiscal Year (FY) 2013, authorizes adjustments for inflation beginning in FY2014 and annually thereafter. This emergency and proposed rulemaking reflects inflation-adjusted rates for FY2014. This rulemaking also supports a proposed amendment to the District of Columbia State Plan for Medical Assistance (State Plan) intended to clarify the methodology with respect to: 1) calculating holiday pay for direct service personnel and active treatment providers; 2) aligning the non-emergency transportation rate with providers' actual costs; 3) implementing the previously approved option for annual rate adjustments – independent of rebasing years; 4) incorporating Capital rates that account for fully depreciated premises and assets; 5) ensuring the ICFs/IID understand DHCF's right to review records and confirm compliance with the District's living wage standards; 6) clarifying the relationship between this reimbursement methodology and the fee-for-service Durable Medical Equipment, Prosthetics, Orthotics, and Supplies benefit; and 7) implementing a uniform Administrative rate. This rulemaking also updates the title of a Qualified Intellectual Disabilities Professional to comport with Rosa's Law (Pub. L. 111-256, 42 U.S.C. § 1400 note) and 42 C.F.R. § 483.430. Finally, by clarifying the annual renewal process for acuity level assignments, this rulemaking offers providers the flexibility to produce evidence of the interdisciplinary team's consensus around the appropriate acuity level assignment for a beneficiary, without having to delay recertification submissions while awaiting the Individual Service Plan. In providing this enhanced flexibility, this rulemaking also clarifies that DHCF will not retroactively adjust payments made at the Base level, if the provider failed to submit the documentation necessary for recertification within the prescribed timeframe.

The increase in total expenditures related to these updates is approximately $6.5 million for FY2014. The corresponding State Plan amendment must be approved by the Council of the District of Columbia (Council) and CMS. While awaiting approval from the Council and CMS a second emergency rulemaking is necessary for the immediate preservation of the health, safety, and welfare of the persons who are in need of services provided in an ICF/IID.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on December 20, 2013 at 60 DCR 017052. No comments were received and no substantive changes have been made. This emergency rulemaking was adopted on March 11, 2014 and became effective on that date. The emergency rules will remain in effect for one hundred and twenty (120) days or until July 8, 2014, 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 this emergency and proposed rule not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Chapter 41 of Title 29 (Public Welfare) DCMR is amended to read as follows:

CHAPTER 41 MEDICAID REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

4100 GENERAL PROVISIONS

4100.1 This chapter shall 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.

4100.2 For an ICF/IID to be eligible to receive reimbursement under this chapter, it shall be certified as an Intermediate Care Facility by the Health Regulation and Licensing Administration (HRLA) in the Department of Health (DOH), pursuant to 22 DCMR §§ 3100 *et seq.* for a period up to fifteen (15) months.

4100.3 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.

4100.4 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 are 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 used the following financial principles in developing the reimbursement methodology described in this chapter:

(a) Basing payment rates on the acuity of each individual;

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

(c) Establishing consistent payment rates for the same classes of facilities serving individuals with comparable levels of need; and

(d) Establishing one (1) day, inclusive of residential care and active treatment, as the unit of service.

4100.5 The reimbursement rates paid to ICFs/IID for Medicaid individuals residing in the facility shall be equal to one hundred percent (100%) of the following components:

(a) Residential component base rate determined by acuity level, as defined in § 4101 of this chapter, and inclusive of the following:

(1) Direct service;

(2) All other health care and program related expenses;

(3) Non-personnel operations;

(4) Administration;

(5) Non-Emergency Transportation;

(6) Capital; and

(7) Allowable share of the Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment.

(b) Services constituting an active treatment program, described in § 4103, as set forth in the individual's Individual Service Plan (ISP); and

(c) Payments associated with participation in quality improvement initiatives, as set forth in § 4104.

4100.6 The reimbursement rates paid to ICFs/IID. shall exclude all of the following services that are provided outside of the ICF/IID:

(a) Inpatient and outpatient hospital visits;

(b) Physician and specialty services;

(c) Clinic services;

(d) Emergency department services;

(e) Services delivered by any other long-term care facility;

(f) Durable medical equipment, prosthetic, orthotic, and supply items that either require prior authorization or are solely for the use of one (1) individual (such as a wheelchair); and

(g) Prescription drug costs, excluding copays for individuals who are also subject to the *Evans* court order.

4100.7 Medicaid reimbursement to each ICF/IID shall comply with the "Policy on Reserved Beds," as set forth on page 2 of Attachment 4.19C of the State Plan for Medical Assistance.

4100.8 An organization related to an enrolled ICF/IID ("related organization") may 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 shall apply to the sale, transfer, leaseback, or rental of property, plant, or equipment or purchase of services of any facility or organization.

4100.9 In accordance with 42 C.F.R. § 456.360, the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986, as amended (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*), and implementing rules, a qualified physician shall certify that an individual needs 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/IID, before any payment is made to the facility.

4100.10 Recertification of an individual'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).

4100.11 A Medicaid individual 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.

4101 ACUITY LEVEL ASSIGNMENTS

4101.1 Reimbursement rates shall be differentiated based on the individual's acuity level, as recommended by 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).

4101.2 Acuity levels higher than Acuity Level 1 (Base), specific to the medical and health needs of each qualified individual, shall be requested by the ICF/IID, recommended by DDS, and approved by DHCF.

4101.3 Reimbursement under this chapter shall be governed according to the following acuity levels:

(a) 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.

(b) Acuity Level 2 (Moderate) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires moderate levels of services in order to effectively support functional impairments, as described in § 4101.7.

(c) Acuity Level 3 (Extensive – Behavioral) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires services and interventions that can address conditions associated with an extensive intellectual and developmental disability and significant behavioral challenges as described in § 4101.8.

(d) Acuity Level 4 (Extensive – Medical) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires services and interventions that can address conditions associated with a significant intellectual and developmental disability and significant medical and support challenges as described in § 4101.9.

(e) Acuity Level 5 (Pervasive) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3;

(2) Requires services and interventions that can address conditions associated with a significant intellectual and developmental disability; and

(3) Exhibits dangerous behaviors or conditions that require one-to-one (1:1) supervision for twenty-four (24) hours per day or less, as described in § 4101.10.

(f) Acuity Level 6 (Pervasive Plus Skilled Nursing) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a);

(2) Requires services and interventions that can address conditions associated with a pervasive level of care to accommodate individuals with dangerous behaviors or conditions that require one to one (1:1) supervision twenty-four (24) hours per day; and

(3) Requires extensive skilled nursing services as described in § 4101.11.

4101.4 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 through, and with supporting documentation by, DDS that DHCF assign a beneficiary to an enhanced level, above Acuity Level 1. This request must be accompanied by documentation submitted by the ICF/IID that justifies the enhanced acuity level.

4101.5 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.

4101.6 A beneficiary shall qualify for Acuity Level 2 (Moderate) when assessed to have at least one (1) of the following characteristics:

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

(b) Is non-ambulatory;

(c) Is unable to evacuate self without assistance in the event of a fire or other emergency situation;

(d) Is assessed to lack life safety skills to ensure self-preservation; or

(e) Has a diagnosis of one (1) of the following conditions:

(1) Blindness;

(2) Deafness;

(3) Autism Spectrum Disorder; or

(4) Epilepsy.

4101.7 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 (1) or more behavioral disorders that:

(a) Are assaultive, self-abusive, including pica, or aggressive;

(b) Require a Behavior Support Plan (BSP) which shall be based on current data and targets the identified behaviors; and

(c) Require intensive staff intervention and additional staff resources to manage the behaviors set forth in § 4101.8(a).

4101.8 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 (APRN).

4101.9 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:

(a) Has a history of, or is at high risk for, elopement resulting in risk to the beneficiary or others;

(b) Exhibits behavior that is life-threatening to the beneficiary or others;

(c) Exhibits destructive behavior that poses serious property damage, including fire-setting;

(d) Is a sexual predator; or

(e) Has 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.

4101.10 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 a minimum, on an hourly basis.

4101.11 For a beneficiary who requires services at or above Acuity Level 4, the prescription of the physician or advanced practice registered nurse, shall specify the type, frequency, scope, and duration of the skilled nursing and health and habilitation support services required.

4101.12 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 staff member(s) assigned to the beneficiary who have no other duties while assigned to the beneficiary.

4101.13 Each ICF/IID shall have responsible direct care staff on duty and awake on a twenty-four (24) hour basis when residents are present in the facility to ensure prompt, appropriate action in the event of injury, illness, fire, or other emergency.

4101.14 Acuity level assignments shall be renewed annually. Each ICF/IID shall be responsible for requesting renewal of the beneficiary's acuity level assignment by compiling and submitting the beneficiary's information in the required format(s) at least twenty (20) days before the ISP effective date. Each ICF/IID shall ensure that the individual has an approved acuity level assignment by the ISP effective date. At minimum, the ICF/IID shall provide DHCF with the following:

(a) Level of Need Assessment and Risk Screening Tool (LON); and

(b) Current ISP document including medical, psychological, occupational or physical therapy assessment, or in the absence of a current ISP document, evidence of consensus by a majority of the members of the beneficiary's interdisciplinary team for the proposed acuity level assignment.

4101.15 Late submission of the documentation required for renewals as set forth in § 4101.14 shall result in payment at the rates that correspond to Acuity Level 1 (Base) beginning on the first day following the expiration of the assignment. DHCF shall not make retroactive adjustments to the reimbursement rates for late submissions of renewal documentation.

4101.16 Additional documentation shall be required to support the acuity level assignment for a beneficiary. Depending on acuity level, additional documentation shall be required as follows:

(a) For Acuity Level 3 (Extensive – Behavioral) the following additional documentation is required:

(1) A BSP addressing the targeted behaviors;

(2) A written behavior plan that shall be based on current data and which targets the identified behaviors; and

(3) A concise statement that summarizes thirty (30) days of behavioral data prior to the date of the request and justification of the need for intensive staff intervention and additional staff resources to manage targeted behaviors.

(b) For Acuity Level 4 (Extensive – Medical) documentation that includes an order for daily skilled nursing and extensive health supports prepared by the beneficiary's primary care physician or an advance practice registered nurse is required.

(c) For Acuity Level 5 (Pervasive) the following additional documentation is required:

(1) A concise statement setting forth the presenting problem that necessitates one to one (1:1) supervision and the number of requested one to one (1:1) hours;

(2) Evidence of a history or risk of elopement that results in risk to the beneficiary and/or others;

(3) Evidence of behavior that is life threatening to self and/or others;

(4) Evidence of destructive behavior causing serious property damage, including fire starting;

(5) Evidence of sexually predatory behavior;

(6) Evidence of a history of, or risk of, falls with injury, and an order from the beneficiary's primary care physician or APRN;

(7) A BSP that shall be based on current data and targets the behaviors identified;

(8) A job description for one to one (1:1) staff based on the beneficiary's individual needs; and

(9) Thirty (30) days of behavioral data prior to the date of the request in support of the targeted behaviors.

(d) For Acuity Level 6 (Pervasive plus Skilled Nursing) the following additional documentation is required:

(1) An order for skilled nursing services prepared by the beneficiary's primary care physician or APRN;

(2) A concise statement setting forth the presenting problem that necessitates one to one (1:1) supervision and skilled nursing and the number of requested one to one (1:1) hours; and

(3) A job description for one to one (1:1) staff based on the beneficiary's individual needs.

4101.17 Documentation required to review a beneficiary's acuity level shall be submitted to DHCF within sixty (60) days of the event that necessitates assignment to a higher acuity level.

4101.18 On a case-by-case basis, DHCF shall consider requests for retroactive adjustment to a beneficiary's acuity level that may result in a change to the reimbursement rate. DHCF decisions shall be based on the facility's submission of required documentation as set forth below:

(a) A concise statement setting forth the situation that necessitates retroactive adjustment;

(b) Evidence of the higher acuity level for the specified period of time for which the change in acuity level is requested. This evidence shall include the LON and other clinical and professional documentation such as discharge planning notes, physician's notes, other clinician's notes, interdisciplinary team meeting notes, and healthcare reports for the same defined period of time; and

(c) Evidence that a higher level of service was delivered for the defined period and that the higher level of service delivered is that required for the higher acuity level. This evidence shall include documentation of staffing levels detailing hours and types of services delivered for each day in the defined period of time. Evidence shall also include the identity of the specific staff delivering the higher acuity services and an attestation from the staff of the higher acuity service they delivered.

4101.19 Any retroactive adjustment based on § 4101.18 shall be limited to the time that has lapsed since the date of the beneficiary's last continuous stay review, as set forth in § 4109.

4101.20 DHCF, or its designee, shall have access to all approved ISP documents.

4101.21 Each ICF/IID shall notify DHCF of the transfer or death of a beneficiary at least seven (7) business days after the date of the event.

4102 REIMBURSEMENT METHODOLOGY

4102.1 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.

4102.2 For the purposes of rate-setting, and independent of the classification used by the Department of Health for licensing, DHCF shall classify ICFs/IID as follows:

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

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

4102.3 The residential component of the rate, as described in § 4100.5(a), shall be based on a model that includes the following seven (7) cost centers:

(a) The "Direct Service" cost center, which shall include expenditures as follows:

(1) Nurses, including registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs);

(2) Qualified Intellectual Disabilities Professionals (QIDPs);

(3) House managers;

(4) Direct Support Personnel;

(5) Allocated time of staff with administrative duties and who 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

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

(b) The "All Other Health Care and Program Related" cost center, which shall include expenditures for:

(1) Pharmacy co-pays and over-the-counter medications;

(2) Medical supplies;

(3) Therapy costs, including physical therapy, occupational therapy, and speech therapy;

(4) Physician services;

(5) Behavioral health services provided by psychologists or psychiatrists;

(6) Nutrition and food;

(7) Medical record maintenance and review;

(8) Insurance for non-direct care health staff;

(9) Program materials excluding active treatment;

(10) Training for direct care staff;

(11) Program development and management, including recreation;

(12) Incident management;

(13) Clothing for beneficiaries; and

(14) Quality Assurance.

(c) The "Non-Personnel Operations" cost center, which shall include expenditures for:

(1) Food service and supplies related to food service;

(2) Laundry;

(3) Housekeeping and linen; and

(4) Non-capital repair and maintenance.

(d) The "Administration" cost center which shall include expenditures for:

(1) Payroll taxes;

(2) Salaries and consulting fees to non-direct care staff;

(3) Insurance for administrators and executives;

(4) Travel and entertainment;

(5) Training costs;

(6) Office expenses;

(7) Office space rent or depreciation;

(8) Clerical staff;

(9) Interest on working capital;

(10) Staff transportation; and

(11) Licenses.

(e) The "Non-Emergency Transportation" cost center, which shall include expenditures for:

(1) Vehicle license, lease, and fees;

(2) Vehicle maintenance;

(3) Depreciation of vehicle;

(4) Staffing costs for drivers and aides not otherwise covered by, or in excess of costs for, direct support personnel;

(5) Fuel; and

(6) Vehicle insurance.

(f) The "Capital" cost center, which shall include expenditures for leased, owned, or fully depreciated properties, less all amounts received for days reimbursed pursuant to the "Policy on Reserved Beds," as set forth on page 2 of Attachment 4.19C of the State Plan for Medical Assistance, for the following:

(1) Depreciation and amortization;

(2) Interest on capital debt;

(3) Rent;

(4) Minor equipment;

(5) Real estate taxes;

(6) Property insurance;

(7) Other capital; and

(8) Utilities, including electricity, gas, telephone, cable, and water.

(g) 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.

4102.4 Fiscal Year (FY) 2013 rates shall be based on Fiscal Year (FY) 2010 cost data reported by providers, legal requirements, and industry standards, 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 set forth in this Chapter. FY 2013 rates were developed based upon the following assumptions:

(a) FY 2013 Non-Personnel Operations per diem rates shall be based on FY 2010 costs, inflated twelve percent (12%);

(b) FY 2013 Capital per diem rates shall be based on FY 2010 costs, inflated fifteen percent (15%);

(c) FY 2013 rates for the cost centers described in § 4102.4(a) and (b) shall be calculated as the quotient of total industry expenditures divided by the total number of industry licensed bed days as reported for FY 2010;

(d) The FY 2013 rate for Non-Emergency Transportation shall be eighteen dollars ($18) per person, per day; and

(e) Capital expenditures for Class I and Class II facilities shall be calculated separately.

4102.5 FY 2014 rates shall be based on the reported FY 2013 cost reports, adjusted for inflation, in accordance with the index described in § 4102.13. In establishing the rates for FY 2014, DHCF shall use FY 2013 rates as a baseline to compare to the FY 2013 cost reports. After inflationary adjustments, DHCF may make operational adjustments as described in this section to each cost center based on the provider's actual reported costs. These adjustments may increase or decrease the per diem rates for each cost center. For services rendered on or after January 1, 2014, DHCF shall also incorporate the following rate setting principles:

(a) Effective January 1, 2014, and beginning October 1, 2014 and annually thereafter, DHCF may make appropriate outlier adjustments. Outlier adjustments refer to uncharacteristically low or high costs (e.g., wage increases) experienced by the entire ICF/IID provider community. With respect to the Capital cost center, market induced fluctuations in the cost of items comprising that rate (*e.g.*, property appreciation/depreciation,

significant increase in the cost of utilities, etc.) shall be documented and confirmed using national indices, reports, and metrics;

(1) All adjustments shall be limited to one (1) time in any given fiscal year. Except for the Capital cost center, operational and outlier adjustments shall be subject to a five percent (5%) maximum. Operational and outlier adjustments to the Capital cost center shall be subject to a maximum of ten percent (10%);

(2) Except for inflationary adjustments, all other adjustments under this section shall be supported through provider documentation and data reflecting the economic landscape of the Washington, D.C. Metropolitan area; and

(3) All adjustments described in § 4102.5 shall be limited to fiscal years when rebasing does not occur.

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

4102.6 For dates of service on or after October 1, 2016, final reimbursement rates for the residential component will be based on providers' FY 2014 cost reports subject to audit and adjustment by DHCF.

4102.7 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:

(a) 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:

(1) Class I Facilities: One (1) DSP to every two (2) individuals (1:2); and

(2) Class II Facilities: One (1) DSP to every three (3) individuals (1:3).

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

(c) 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;

(d) One (1) RN, one (1) QIDP, and one (1) house manager, each at one (1) shift per day for two hundred sixty (260) days per year, at a ratio of one (1) staff person to every twelve (12) individuals (1:12) for all ICFs/IID;

(e) 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:

(1) 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;

(2) 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;

(3) 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;

(4) 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); and

(5) 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).

(f) The base salaries used in the development of FY 2013 rates for direct care staff wages and salaries, subject to annual inflationary adjustment, shall be as follows:

(1) DSP: Twelve dollars and fifty cents ($12.50) per hour;

(2) LPN: Twenty one dolllars ($21.00) per hour;

(3) CNA: Sixteen dollars and eighty-three cents ($16.83) per hour;

(4) House Manager: Forty-five thoushand dollars ($45,000) per year;

(5) RN: Seventy thousand dollars ($70,000) per year; and

(6) QIDP: Sixty thousand dollars ($60,000) per year.

(g) Salaries set forth in Section 4102.7(f) shall be treated as follows:

(1) "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 that the rate includes the rate of pay plus one-half (1/2) the rate of pay (time and one-half) for holidays worked;

(2) Salaries shall be inflated by twenty percent (20%) and paid leave and holiday pay shall be inflated by twelve percent (12%), to accommodate fringe benefits; and

(3) All rates shall include paid time off and holiday pay for all hourly full-time equivalents (FTEs).

(h) Beginning in FY 2014 and each fiscal year thereafter, 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.

4102.8 The "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 shall be 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.

4102.9 The "Non-Personnel Operations" cost center reimbursement rates shall be calculated based on industry average reported costs. The Non-Personnel

Operations reimbursement 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.

4102.10 During FY 2013, the "Administration" cost center reimbursement rates shall be calculated based on the staffing ratios, facility size, and individuals' acuity levels. The Administration reimbursement 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. Beginning January 1, 2014, and on October 1, 2014 and annually thereafter, reimbursement rates for the Administration cost center shall be uniform for Class I and Class II facilities. The Administration rate shall be a uniform percentage of the sum of the Acuity Level I (Base) rates comprising the Residential cost center for leased, Class I facilities, as set forth in this Chapter

4102.11 The "Non-Emergency Transportation" cost center reimbursement rates shall be based on the industry average expenses divided by the total number of licensed bed days. Beginning January 1, 2014, and on October 1, 2014 and annually thereafter, Non-Emergency Transportation cost center reimbursement rates shall be based on actual, reported costs.

4102.12 The "Capital" cost center reimbursement rates shall be determined 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 in Section § 4102.3. 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 for fully depreciated premises shall be equal to fifty percent (50%) of the rate for provider owned premises. The Capital rate shall also be subject to the following principles:

(a) 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 seller/lessor would have recorded had the seller/lessor retained legal title;

(b) Depreciation shall incorporate the following principles:

(1) When depreciated buildings and building improvements are acquired, the cost basis of the depreciable asset shall be the lesser of the cost or acquisition value of the previous owner(s) less all reimbursement attributable to the asset as determined by DHCF or the fair market value of the asset at time of acquisition.

Notwithstanding, if the seller makes the full payback in accordance with paragraph (e) below, the cost basis to the new owner shall be the lesser of the fair market value or the purchase price;

(2) Facilities shall employ the straight-line method for calculating depreciation subject to the limits set forth in paragraphs (d) and (e) below. Accelerated methods for calculating depreciation shall not be allowed. Subject to the limits set forth in paragraphs (d) and (e), the annual depreciation expense of an asset shall be determined by dividing the basis of the asset reduced by any estimated salvage or resale value by the estimated years of useful life of the asset at the time it is placed in service;

(3) Depreciation expense of buildings and building improvements shall be limited to the basis of each asset and shall not exceed the basis of such assets less the aggregate amount received in reimbursement for such assets in the current and prior years;

(4) Fully depreciated buildings and building improvements subsequently sold or disposed of shall be subject to payback by the owner to the program of all depreciation expense paid to the owner and all previous owners when such assets are no longer used to provide ICF/IID services or have been transferred to new owners in an arm's length transaction, provided that such payback shall be reduced by all amounts previously paid back, if any, by prior owners;

(5) ICFs/IID shall estimate assets' years of useful life in accordance with the most recent edition of "Estimated Useful Lives of Depreciable Hospital Assets" published by the American Hospital Association, or if not applicable, relevant guidance issued by the U.S. Internal Revenue Service. Subject to the limits set forth in paragraphs (d) and (e), depreciation expense for the year of disposal can be computed by using either the half-year method or the actual time method;

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

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

(8) Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years shall 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. Fully depreciated assets shall not be included in the Capital cost center, except for the costs associated with utilities and relevant leasehold improvements. 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;

(9) Leasehold improvements made to rental property by the lessor shall be depreciated over the lesser of the asset's useful life or the remaining life of the lease;

(c) On a case by case basis, DHCF may reimburse an ICF/IID by providing an offset to capital costs that shall be equal to the daily amount computed under this subsection in situations when DDS has not filled 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;

(d) The daily cost described in paragraph (k) shall be computed as the capital component of the daily per-diem rate, multiplied by the number of vacant bed space(s); and

(e) ICFs/IID shall incur costs and provide DHCF with proof of the vacant bed space, in order to be eligible.

4102.13 Effective October 1, 2013, and annually thereafter, the per diem rates for "Non-Personnel Operations", "Non-Emergency Transportation", "Capital", and "Active Treatment" cost centers 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.

4102.14 The Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment shall be a broad based assessment on all ICF/IID 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 shall be calculated consistently with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70, and 433.72.

4102.15 Beginning January 1, 2014, ICF/IID reimbursement rates, shall be as follows:

Acuity	Beds	Facility	Direct care staffing	Other health care & program Total	Non-Pers Oper	Transp.	Capital	Admin	Active Tx	Total Rate	Tax	Total rate paid
Base	4 - 5	Leased	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 609.15	$ 33.50	$ 642.66
		Owned	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 579.52	$ 31.87	$ 611.39
		Depreciated	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 564.70	$ 31.06	$ 595.76
	6	Leased	$ 246.77	$ 44.42	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 523.80	$ 28.81	$ 552.61
		Owned	$ 246.77	$ 44.42	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 496.73	$ 27.32	$ 524.05
		Depreciated	$ 246.77	$ 44.42	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 483.20	$ 26.58	$ 509.77
Moderate	4 - 5	Leased	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 609.15	$ 33.50	$ 642.66
		Owned	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 579.52	$ 31.87	$ 611.39
		Depreciated	$ 328.68	$ 42.73	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 564.70	$ 31.06	$ 595.76
	6	Leased	$ 321.79	$ 57.92	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 612.33	$ 33.68	$ 646.01
		Owned	$ 321.79	$ 57.92	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 585.26	$ 32.19	$ 617.45
		Depreciated	$ 321.79	$ 57.92	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 571.72	$ 31.44	$ 603.17
Extensive behavioral	4 - 5	Leased	$ 398.96	$ 51.86	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 688.57	$ 37.87	$ 726.44
		Owned	$ 398.96	$ 51.86	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 658.93	$ 36.24	$ 695.17
		Depreciated	$ 398.96	$ 51.86	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 644.11	$ 35.43	$ 679.54
	6	Leased	$ 368.64	$ 66.36	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 667.61	$ 36.72	$ 704.33
		Owned	$ 368.64	$ 66.36	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 640.54	$ 35.23	$ 675.77
		Depreciated	$ 368.64	$ 66.36	$ 19.12	$ 12.16	$13.53	$60.05	$87.15	$627.01	$34.49	$ 661.49

Acuity	Beds	Facility	Direct care staffing	Other health care & program Total	Non-Pers Oper	Transp.	Capital	Admin	Active Tx	Total Rate	Tax	Total rate paid
Extensive medical	4 - 5	Leased	$ 446.74	$ 58.08	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 742.57	$ 40.84	$ 783.41
		Owned	$ 446.74	$ 58.08	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 712.93	$ 39.21	$ 752.14
		Depreciated	$ 446.74	$ 58.08	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 698.11	$ 38.40	$ 736.51
	6	Leased	$ 388.55	$ 69.94	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 691.10	$ 38.01	$ 729.11
		Owned	$ 388.55	$ 69.94	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 664.03	$ 36.52	$ 700.55
		Depreciated	$ 388.55	$ 69.94	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 650.49	$ 35.78	$ 686.27
Pervasive 8 h / 7 d	4 - 5	Leased	$ 459.74	$ 59.77	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 757.25	$ 41.65	$ 798.90
		Owned	$ 459.74	$ 59.77	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 727.61	$ 40.02	$ 767.63
		Depreciated	$ 459.74	$ 59.77	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 712.79	$ 39.20	$ 752.00
	6	Leased	$ 377.83	$ 68.01	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 678.45	$ 37.31	$ 715.76
		Owned	$ 377.83	$ 68.01	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 651.38	$ 35.83	$ 687.20
		Depreciated	$ 377.83	$ 68.01	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 637.84	$ 35.08	$ 672.92
Pervasive 8 h / 5 d	4 - 5	Leased	$ 416.03	$ 54.08	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 707.86	$ 38.93	$ 746.79
		Owned	$ 416.03	$ 54.08	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 678.22	$ 37.30	$ 715.52
		Depreciated	$ 416.03	$ 54.08	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 663.40	$ 36.49	$ 699.89
	6	Leased	$ 334.12	$ 60.14	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 626.87	$ 34.48	$ 661.35
		Owned	$ 334.12	$ 60.14	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 599.80	$ 32.99	$ 632.79
		Depreciated	$ 334.12	$ 60.14	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 586.27	$ 32.24	$ 618.51
Pervasive 16 h	4 - 5	Leased	$ 609.78	$ 79.27	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 926.80	$ 50.97	$ 977.77
		Owned	$ 609.78	$ 79.27	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 897.16	$ 49.34	$ 946.51
		Depreciated	$ 609.78	$ 79.27	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 882.34	$ 48.53	$ 930.87
	6	Leased	$ 527.87	$ 95.02	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 855.50	$ 47.05	$ 902.55
		Owned	$ 527.87	$ 95.02	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 828.43	$ 45.56	$ 873.99
		Depreciated	$ 527.87	$ 95.02	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 814.90	$ 44.82	$ 859.72

Acuity	Beds	Facility	Direct care staffing	Other health care & program Total	Non-Pers Oper	Transp.	Capital	Admin	Active Tx	Total Rate	Tax	Total rate paid
Pervasive 24 h	4 - 5	Leased	$ 778.82	$ 101.25	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 1,117.81	$ 61.48	$ 1,179.29
		Owned	$ 778.82	$ 101.25	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 1,088.17	$ 59.85	$ 1,148.02
		Depreciated	$ 778.82	$ 101.25	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 1,073.35	$ 59.03	$ 1,132.39
	6	Leased	$ 696.91	$ 125.44	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 1,054.96	$ 58.02	$ 1,112.98
		Owned	$ 696.91	$ 125.44	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 1,027.89	$ 56.53	$ 1,084.43
		Depreciated	$ 696.91	$ 125.44	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 1,014.36	$ 55.79	$ 1,070.15
Nursing 1:1 8 h / 7 d	4 - 5	Leased	$ 548.85	$ 71.35	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 857.95	$ 47.19	$ 905.14
		Owned	$ 548.85	$ 71.35	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 828.31	$ 45.56	$ 873.87
		Depreciated	$ 548.85	$ 71.35	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 726.35	$ 39.95	$ 766.30
	6	Leased	$ 466.94	$ 84.05	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 783.60	$ 43.10	$ 826.70
		Owned	$ 466.94	$ 84.05	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 756.54	$ 41.61	$ 798.14
		Depreciated	$ 466.94	$ 84.05	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 655.85	$ 36.07	$ 691.92
Nursing 1:1 8 h / 5 d	4 - 5	Leased	$ 475.42	$ 61.80	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 774.97	$ 42.62	$ 817.60
		Owned	$ 475.42	$ 61.80	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 745.34	$ 40.99	$ 786.33
		Depreciated	$ 475.42	$ 61.80	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 643.37	$ 35.39	$ 678.76
	6	Leased	$ 393.51	$ 70.83	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 696.96	$ 38.33	$ 735.29
		Owned	$ 393.51	$ 70.83	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 669.89	$ 36.84	$ 706.73
		Depreciated	$ 393.51	$ 70.83	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 569.20	$ 31.31	$ 600.51
Nursing 1:1 16 hours	4 - 5	Leased	$ 800.93	$ 104.12	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 1,142.80	$ 62.85	$ 1,205.65
		Owned	$ 800.93	$ 104.12	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 1,113.16	$ 61.22	$ 1,174.38
		Depreciated	$ 800.93	$ 104.12	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 1,099.47	$ 60.47	$ 1,159.95
	6	Leased	$ 719.02	$ 129.42	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 1,081.05	$ 59.46	$ 1,140.51
		Owned	$ 719.02	$ 129.42	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 1,053.99	$ 57.97	$ 1,111.96
		Depreciated	$ 719.02	$ 129.42	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 1,041.58	$ 57.29	$ 1,098.87

Acuity	Beds	Facility	Direct care staffing	Other health care & program Total	Non-Pers Oper	Transp.	Capital	Admin	Active Tx	Total Rate	Tax	Total rate paid
Nursing 1:1 24 hours	4 - 5	Leased	$1,084.91	$ 141.04	$ 19.12	$ 12.16	$ 59.27	$ 60.05	$ 87.15	$ 1,463.69	$ 80.50	$ 1,544.20
		Owned	$1,084.91	$ 141.04	$ 19.12	$ 12.16	$ 29.64	$ 60.05	$ 87.15	$ 1,434.06	$ 78.87	$ 1,512.93
		Depreciated	$1,084.91	$ 141.04	$ 19.12	$ 12.16	$ 14.82	$ 60.05	$ 87.15	$ 1,420.37	$ 78.12	$ 1,498.49
	6	Leased	$1,003.00	$ 180.54	$ 19.12	$ 12.16	$ 54.14	$ 60.05	$ 87.15	$ 1,416.15	$ 77.89	$ 1,494.04
		Owned	$1,003.00	$ 180.54	$ 19.12	$ 12.16	$ 27.07	$ 60.05	$ 87.15	$ 1,389.08	$ 76.40	$ 1,465.48
		Depreciated	$1,003.00	$ 180.54	$ 19.12	$ 12.16	$ 13.53	$ 60.05	$ 87.15	$ 1,376.68	$ 75.72	$ 1,452.40

4103 ACTIVE TREATMENT SERVICES

4103.1 An individual 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.

4103.2 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.

4103.3 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:

(a) The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

(b) The prevention or deceleration of regression or loss of current optimal functional status.

4103.4 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.

4103.5 For dates of service on or after January 1, 2014, the per diem reimbursement rate for active treatment shall equal the average of FY13 active treatment rates multiplied by two hundred sixty (260) days of service, to account for the maximum days of service provided, inclusive of holidays, and divided by three hundred sixty-five (365).

4104 SUPPLEMENTAL PAYMENT FOR QUALITY OF CARE IMPROVEMENTS

4104.1 Consistent with the requirements set forth in the Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Act of 2005, effective March 8, 2006 (D.C. Law 16-68; D.C. Official Code §§ 47-1270 *et seq.*), implementing rules, and subsequent amendments, beginning in FY 2014 an ICF/IID that meets the criteria in this section shall be eligible to receive a supplemental payment based on the cost of training provided to employees other than managers, administrators, and contract employees.

4104.2 In addition to the aggregate per diem described in § 4102, an ICF/IID may receive an additional payment for participation in quality improvement initiatives that are intended to increase the qualifications of employees by making available educational opportunities.

4104.3 To qualify for a supplemental payment for quality improvements under this Section for a fiscal year, an ICF/IID shall, by June 30 of the preceding fiscal year, provide DHCF with documentation verifying that it:

(a) Has a legally binding written agreement with its employees to fund quality of care improvements through measurable efforts to develop and improve staff skills by increasing staff training and educational opportunities;

(b) Has written procedures outlining the process, such as arbitration, for employees to follow to enforce this agreement. The process shall:

(1) Be expeditious;

(2) Be economical for the employees; and

(3) Provide for a neutral decision maker to resolve disputes; and

(c) Has provided copies of the agreement and the written procedures to its employees and their representatives.

4104.4 To establish the cost amount for purposes of determining the facility's supplemental payment amount, an ICF/IID shall provide DHCF with documentation verifying the amount of training costs no later than June 30 of the preceding fiscal year.

4104.5 The training cost amount shall include the cost of providing training for employees other than managers, administrators, and contractors, and shall be the actual costs incurred by the facility in providing training to these employees. For training costs to be included, the training shall be:

(a) Related to patient care;

(b) Related to improving the skills, competency, and qualifications of employees in providing care; and

(c) Approved by DHCF.

4104.6 In order to be eligible for the supplemental payment, an ICF/IID shall incur costs and provide DHCF with evidence that payment has been made in full. 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).

4104.7 All supplemental payments shall be subject to a uniform percentage of thirteen percent (13%) for administrative costs for FY 2013. The administrative cost percentage may be adjusted in subsequent fiscal years. Adjusted rates will be set forth in the *D.C. Register*.

4104.8 Supplemental payments associated with the costs of implementing quality improvement initiatives shall be recorded as an offset to the costs incurred, and shall be included in the cost report submitted annually.

4104.9 The supplemental payments described in this § shall not be used to enhance training or educational opportunities for management, administration, and contractual staff.

4104.10 The amount and availability of the supplemental payment shall be contingent upon the availability of funding from DHCF. If the total amount of payments to be made to all eligible providers exceeds the amount of available funds, then payments made to all eligible facilities shall be proportionately reduced.

4104.11 DHCF shall issue a Notice of Eligibility and Proposed Reimbursement to each provider within sixty (60) days of receipt of all required information. The written notice shall contain at a minimum all of the following information:

(a) A determination indicating whether the provider is eligible or ineligible to receive the supplemental payment;

(b) If a provider is determined to be ineligible to receive the supplemental payment, a written statement explaining why the facility is ineligible; and

(c) Language describing the procedures and timeframes for requesting an administrative review with DHCF.

4104.12 A provider who disagrees with the Notice of Eligibility and Proposed Reimbursement may request an administrative review by submitting a written request for an administrative review to DHCF within thirty (30) days after the date of the Notice of Eligibility and Proposed Reimbursement.

4104.13 The written request for an administrative review shall include:

(a) The reason(s) for the request, including an identification of the specific item(s) to be reviewed; and

(b) Supporting documentation.

4104.14 No later than ninety (90) days after receipt of all requests for administrative review DHCF shall issue a Final Notice of Eligibility and Reimbursement to each

provider that has applied for the supplemental payment. The notice shall contain at a minimum the following information:

(a) A final determination indicating whether the provider is eligible to receive the supplemental payment. If ineligible, the notice shall contain a written statement explaining why the provider is ineligible;

(b) The total amount of the supplemental payment, including the annual salary, benefit, and training cost amounts;

(c) The annul number of employee hours excluding managers, administrators, and contract employees;

(d) The timeframe for payment of the supplemental payment; and

(e) Language describing the procedures and timeframes for requesting an appeal with the Office of Administrative Hearings (OAH).

4104.15 A provider who disagrees with the Final Notice of Eligibility and Reimbursement may file an appeal with the OAH within forty-five (45) days of the date of the Final Notice of Eligibility and Reimbursement.

4104.16 Any adjustments to the supplemental payment as a result of a decision rendered by the OAH shall be offset against payments the following fiscal year.

4105 REBASING

4105.1 Effective October 1, 2016, final reimbursement rates for the residential component will be based on providers' FY 2014 cost reports subject to audit and adjustment by DHCF. Subsequent rebasing to adjust the residential component will occur every three (3) years thereafter.

4106 COST REPORTING AND RECORD MAINTENANCE

4106.1 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 unless the facility obtains advance permission from DHCF to allow an alternative reporting period, for good cause.

4106.2 In accordance with instructions from DHCF, providers shall file an initial interim cost report.

4106.3 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.

4106.4 DHCF shall issue a delinquency notice if the ICF/IID does not submit the cost report as specified in § 4106.1 and has not previously received an extension of the deadline for good cause.

4106.5 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.

4106.6 The costs described in § 4102 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.

4106.7 If the ICF/IID utilizes outside resources pursuant to § 4103.2, the ICF/IID shall submit the cost reports or invoices provided by the outside resources as an attachment to the submitted cost report required under § 4106.6. 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.

4106.8 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.

4106.9 A facility reporting expenditures associated with holiday pay within the Direct Service cost center, as described under §§ 4102.7 and 4103.5, shall submit supporting documentation, along with the cost report, to DHCF, or its designee. Supporting documentation required under this section shall include employee timesheets or comparable document(s)

4106.10 Any allocated time claimed under § 4102.3(a)(5) shall 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.

4106.11 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.

4106.12 If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is complete.

4106.13 In accordance with § 4100.9, 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.

4106.14 Costs incurred during a period when an ICF/IID is subject to denial of payment for new admissions, described in § 4112, shall be included on the cost report for the period during which payment was denied, in order to accurately determine rates in subsequent periods.

4107 FISCAL ACCOUNTABILITY

4107.1 Beginning in FY 2014, 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.

4107.2 Beginning in FY 2014, each ICF/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. Effective January 1, 2014, 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.

4107.3 The repayment amount described in § 4107.1 shall be the difference between ninety-five percent (95%) of the rate component and the facility's reported expenses. The repayment amount for Active Treatment described in § 4107.2 shall be the difference between one hundred percent (100%) of the payments made for active treatment services and reported expenses for active treatment services. The repayment amount for Capital costs shall be the difference between 100 hundred percent (100%) of the payments made for Capital costs and reported Capital expenses.

4107.4 In accordance with D.C. Official Code § 47-1272(c), DHCF, or its designee, has 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 §§ 47-1270 *et seq.*), and implementing regulations

4107.5 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.

4107.6 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.

4107.7 DHCF shall issue a notice to each ICF/IID that is required to repay as set forth in this section. The notice shall set forth the repayment amount and include language describing the procedure and timeframes for requesting an appeal before OAH. Filing an appeal with OAH shall not stay any action to recover the amounts prescribed in this section.

4108 RIGHT TO APPEAL

4108.1 DHCF shall issue a notice to each beneficiary when DHCF disapproves the acuity level assignment submitted by the provider. The notice shall comply with District and federal law and rules. A copy of the notice shall also be sent to the provider. If the beneficiary consents, a provider may appeal the determination described in this section on behalf of the beneficiary.

4108.2 For Fiscal Years 2013 and after, DHCF shall send a transmittal to all providers notifying them of the rates.

4108.3 Provider appeals shall be limited to challenges based on acuity level assignments and audit adjustments.

4108.4 At the conclusion of each rebasing year audit or any other required audit, an ICF/IID facility shall receive an audited cost report including a description of each audit adjustment and the reason for each adjustment. An ICF/IID 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 DHCF within thirty (30) days of the date of receipt of the audited cost report.

4108.5 For annual cost reports submitted by the ICF/IID facility, any determinations made following reviews conducted by DHCF shall be communicated to the ICF/IID Facility within thirty (30) days. Within thirty (30) days of the date of receipt of the DHCF communication on the submitted annual cost report, an ICF/IID facility that disagrees with the determination may request an administrative review by sending a written request for administrative review to DHCF.

4108.6 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.

4108.7 DHCF shall mail a formal response to the ICF/IID facility no later than forty-five (45) days from the date of receipt of the written request for administrative review.

4108.8 Decisions made by DHCF and communicated in the formal response may be appealed, within thirty (30) days of the date of DHCF's letter notifying the facility of the decision, to OAH.

4108.9 Filing an appeal with OAH pursuant to this section 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.

4109 UTILIZATION REVIEW REQUIREMENTS

4109.1 In accordance with 42 C.F.R. § 456.401, each ICF/IID shall develop, implement, and maintain a written Utilization Review Plan (URP) for each Medicaid beneficiary receiving services furnished by the ICF/IID. The URP shall provide for a review of each beneficiary's need for the services that the ICF furnished him or her.

4109.2 Utilization review for ICFs/IID enrolled in D.C. Medicaid may be conducted by any of the following:

(a) The ICF/IID;

(b) DHCF or its designee; or

(c) Any other approved method.

4109.3 The URP shall, at minimum, include the following:

(a) A description of how utilization review shall be performed;

(b) The frequency of utilization review;

(c) Assurances and documentation establishing that the personnel who shall perform utilization review meet the requirements of 42 C.F.R. § 456.406;

(d) Administrative staff responsibilities related to utilization review;

(e) The types of records maintained by the utilization review team;

(f) The types and frequency of any reports developed by the utilization review team, and related plan for dissemination; and

(g) The procedures that shall be used when corrective action is necessary.

4109.4 In accordance with 42 C.F.R. §§ 456.431 - 456.438, each URP shall establish a process whereby each individual residing in the ICF/IID receives continued stay reviews, at minimum, every six (6) months.

4109.5 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 individual's circumstances reflect any of the following associations:

(a) High costs;

(b) Frequent and excessive services; or

(c) Attended by a physician or other practitioner whose practices reflect questionable billing patterns or misrepresentation of facts needed in order to secure claims reimbursement, including but not limited to ordering and/or providing services that are not medically necessary or that fail to meet professionally recognized standards of care.

4110 TERMINATION AND ALTERNATIVE SANCTIONS FOR ICF/IID NONCOMPLIANCE

4110.1 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:

(a) Governing body and management;

(b) Client protections;

(c) Facility staffing;

(d) Active treatment services;

(e) Client behavior and facility practices;

(f) Health care services;

(g) Physical environment; and

(h) Dietetic services.

4110.2 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.

4111 ALTERNATIVE SANCTIONS FOR ICFs/IID – NON-IMMEDIATE JEOPARDY

4111.1 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.

4111.2 In lieu of terminating the provider agreement, DHCF may impose one (1) or more alternative sanctions against an ICF/IID as set forth below:

(a) Denial of payment, as described in § 4112;

(b) Directed Plan of Correction (DPoC), as described in § 4113;

(c) Directed In-Service Training (DIST), as described in § 4114; or

(d) State Monitoring, as described in § 4115.

4111.3 DHCF shall determine the appropriateness of alternative sanctions against an ICF/IID upon notification by the Department of Health that an ICF/IID is not in compliance with any of the federal CoPs. A determination to terminate a provider from the Medicaid program, or to impose an alternative sanction shall be made based on the following factors:

(a) Seriousness of the violation(s);

(b) Number and nature of the violation(s);

(c) Potential for immediate and serious threat(s) to ICF/IID residents;

(d) Potential for serious harm to ICF/IID residents;

(e) Any history of prior violation(s) and/or sanction(s);

(f) Actions or recommendations of DDS, developmental disability advocacy groups, or health care entities;

(g) Mitigating circumstances; and

(h) Other relevant factors.

4111.4 DHCF shall issue a written notice to each ICF/IID notifying the facility of termination of the Medicaid provider agreement or the imposition of an alternative sanction. The written notice shall comply with District and federal law and rules.

4111.5 All costs associated with the imposition of an alternative sanction against an ICF/IID pursuant to these rules shall be borne by the facility.

4112 DENIAL OF PAYMENT

4112.1 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 (1) or more of the CoPs for Medicaid enrollment.

4112.2 The denial of payment term shall be eleven (11) months in duration, beginning on the first day of the month after DHCF imposes the denial of payments.

4112.3 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.

4112.4 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:

(a) The ICF/IID has up to sixty (60) days to correct the cited deficiencies; and

(b) The procedures that shall commence once the sixty (60) days have lapsed, pursuant to § 4112.5.

4112.5 If the ICF/IID does not correct the violations within the sixty (60) day timeframe, DHCF shall notify the facility of its intention to deny payment. This written notification shall include:

(a) Reasons for denial of payment;

(b) Information on the right to request a hearing though OAH, pursuant to 29 DCMR §§ 1300 *et seq.*;

(c) Details of public notice; and

(d) The effective date for denial of payments.

4112.6 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 § 4112.2, shall be suspended until the appeal is resolved.

4112.7 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.

4112.8 DHCF, in coordination with other District agencies, shall monitor the facility's progress in improving cited violation(s) throughout the eleven (11) month period.

4112.9 The Director of DHCF shall consider modifying or rescinding denial of payment upon the occurrence of one of the following:

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

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

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

4112.10 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.

4112.11 An ICF/IID provider agreement that is subject to denial of payment shall be 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.

4112.12 ICF/IID provider agreements that are subject to denial of payment may only be renewed when the denial period expires or is rescinded.

4113 DIRECTED PLAN OF CORRECTION (DPoC)

4113.1 In lieu of termination in situations where the ICF/IID is not in compliance with the federal CoPs, and residents are not in immediate jeopardy, DHCF may require an ICF/IID to take prompt, timely action specified by DHCF to achieve and maintain compliance with CoPs and other District of Columbia Medicaid requirements. These actions specified by DHCF shall constitute a Directed Plan of Correction (DPoC).

4113.2 The DPoC shall be developed in coordination with and approved by DOH, DHCF, and DDS, incorporating findings from DDS' Continuous Quality Improvement Plan.

4113.3 The DPoC shall specify:

(a) How corrective action shall be accomplished for beneficiaries found to have been affected by the deficient practice and include remedies that shall be implemented;

(b) How the facility shall identify other individuals who may have been affected by the same deficient practice but not previously identified, and how the facility shall act to remedy the effect of the deficient practices for these individuals;

(c) What measures and actions shall be put into place to ensure that the deficient practice(s) is/are being corrected and future noncompliance prevented;

(d) Timelines, including major milestones for completion of all corrective action in the DCoP;

(e) How compliance shall be determined; and

(f) How the DPoC relates to other alternative sanctions.

4113.4 A state monitor shall oversee implementation of the DPoC and evaluate compliance with the plan.

4113.5 DHCF may terminate the Medicaid provider agreement of an ICF/IID that is unable to meet the timeline for completion of all corrective actions in the DCoP.

4114 DIRECTED IN-SERVICE TRAINING (DIST)

4114.1 In lieu of termination in situations where the ICF/IID is not in compliance with federal CoPs, but residents are not in immediate jeopardy, DHCF may require an ICF/IID to implement Directed In-Service Training (DIST) for deficiencies determined by the District to be correctable through education. This alternative sanction shall require the staff and relevant contractors of the ICF/IID to attend in-service trainings and demonstrate competency in the knowledge and skills presented during the trainings.

4114.2 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.

4114.3 Facilities shall use training programs developed by well-established organizations with prior experience and expertise in training, services for individuals with intellectual disabilities, and the operation of ICF/IID to meet training requirements described in this section. All programs and personnel used to deliver the training shall be approved by DHCF prior to their use.

4114.4 The ICF/IID shall bear the expense of the DIST.

4114.5 A state monitor shall oversee implementation of DIST, and shall ensure compliance with the requirements.

4114.6 DHCF may terminate the provider agreement of an ICF/IID that is unable to meet the timeline for full and successful completion of the DIST.

4115 STATE MONITORING

4115.1 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.

4115.2 The following entities may serve as the State Monitor:

(a) DOH;

(b) DHCF;

(c) DDS; or

(d) A District of Columbia contractor that meets the following requirements:

(1) Is not a designee or current contractor of the monitored facility;

(2) Does not have an immediate family member who is a resident of the facility;

(3) Is not a person who has been terminated for cause by the facility; and

(4) Is not a former contractor who has had a contract canceled, for cause, by the facility.

4115.3 State monitoring shall be discontinued under the following circumstances:

(a) The facility's provider agreement is terminated;

(b) The facility has demonstrated to the satisfaction of the District of Columbia that it substantially complies with the CoPs as described in § 4113; or

(c) The facility has demonstrated to the satisfaction of the District of Columbia that it has substantially implemented the DIST as described in § 4114.

4116 ACCESS TO RECORDS

4116.1 Each ICF/IID shall grant full access to all records during announced and unannounced audits and reviews by DHCF personnel, representatives of the U.S. Department of Health and Human Services, and any authorized agent(s) or official(s) of the federal or District of Columbia government.

4199 DEFINITIONS

4199.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

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 individual 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.

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

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.

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.

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

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

Behavior Support Plan - A written document requested by the Individual Support Team that is developed by a psychologist or psychology associate and incorporated into the Individual Support Plan. If developed by a psychology associate, the plan shall be approved by the psychologist.

Current Individual Support Plan (ISP) - An Individual Support Plan with a range of effective dates that includes the date on which the plan is being reviewed.

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

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

Elopement - To run away; abscond.

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.

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

Habilitation – The process by which an individual 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 D.C. Official Code § 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.

Holiday pay – The term used in a labor agreement, provider policy, or in the absence of either, by the U.S. Department of Labor.

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.

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

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.

Level of Care Determination (LOC) - The assessment used by DDS to determine a beneficiary's eligibility for ICF/IID services.

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

Licensed bed days - Three hundred and sixty-five (365) days or the number of days of that calendar year.

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.

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

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

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.

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

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

Professional services - Services provided pursuant to any legal arrangement, which include occupational and speech therapies and nursing care services provided by an individual or a corporation.

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

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.

Comments on the proposed rule shall be submitted in writing to Linda Elam, Ph.D., M.P.H., Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, One Judiciary Square, 441 4th Street, NW, Suite 900-S, Washington, DC 20001, via email at DHCFPubliccomments@dc.gov, online at www.dcregs.dc.gov, or by telephone at (202) 442-9115, within thirty (30) days after the date of publication of this notice in the *D.C. Register*. Additional copies of these proposed rules may be obtained from the above address.