DEPARTMENT OF HEALTH CARE FINANCE

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

I. GENERAL PROVISIONS

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

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

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

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

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

2. Establishing uniform reimbursement of services constituting the active treatment program in accordance with the requirements of 42 C.F.R. § 483.440(a);

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

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

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

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

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

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

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

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

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

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

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

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

J. In accordance with 42 C.F.R. § 456.360(a), the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*), as amended, and implementing rules, a qualified physician shall certify that an individual requires ICF/IID services. The certification shall be made at the time of admission for current Medicaid beneficiaries, or for individuals who apply for Medicaid while residing in an ICF, before any payment is made to the ICF/IID.

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

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

II. ACUITY LEVEL ASSIGNMENTS

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

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

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

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

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

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

4. Acuity Level 4 (Extensive – Medical) shall represent the health, habilitation, and support needs of a beneficiary who meets the requirements of Section II.C.1 and requires services and interventions that can address conditions associated with an extensive intellectual and developmental disability and significant medical and support challenges as described in Section II.I;

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

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

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

E. In order for a beneficiary to qualify at an acuity level 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

5. Has a diagnosis of one of the following:

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

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

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

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

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

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

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

    1. A history or high risk of elopement resulting in risk to the beneficiary or others;

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

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

    4. Is a sexual predator; or

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

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

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

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

N. Prior to the expiration of the current ISP, each ICF/IID shall be responsible for requesting renewal of the beneficiary's acuity level assignment by compiling the beneficiary's information in the required format(s) and ensuring the submission of supporting documentation to DDS at least twenty (20) days before the expiration date of the ISP.

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

III. REIMBURSEMENT METHODOLOGY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. FY 2014 rates shall be based on the reported FY 2013 cost reports, adjusted for inflation, in accordance with Sections III.G.8 and III.M. 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 to each cost center rate based on the providers' actual reported costs. These adjustments may increase or decrease the per diem rates for each cost center. Rates applying to services rendered on and after January 1, 2014 shall incorporate the following principles:

1. Effective January 1, 2014, and on October 1, annually thereafter, DHCF may make appropriate outlier adjustments when the entire ICF/IID provider community experiences uncharacteristically low or high costs (e.g., wage increases) experienced by the entire ICF/IID provider community and supported by legislative or other unanticipated changes. 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 information from the Bureau of Labor Statistics, the Consumer Price Index, the District of Columbia Office of Tax and Revenue, and other relevant indices or reports.

    a. Any adjustment shall be limited to one (1) time in any given fiscal year.

    b. Except for the Capital cost center, operational adjustments shall be subject to a five percent (5%) maximum. Operational adjustments to the Capital cost center shall be subject to a maximum of ten percent (10%).

    c. An outlier adjustment shall not exceed the amount of the rebased cost center, subject to the upper payment limit.

    d. 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.

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 accordance with Section IV.

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).

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

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

4. One (1) Registered Nurse (RN), one (1) Qualified Intellectual Disabilities Professional (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.

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

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

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

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

    d. Acuity Level 5 (Pervasive) rates shall vary based on the number of one-to-one (1:1) 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.

    e. Acuity Level 6 (Pervasive Plus Skilled Nursing) rates shall vary based on the number of one-to-one (1:1) 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.

6. The base salaries used in the development of FY 2013 rates for direct care staff wages and salaries, subject to adjustment for inflation using the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index, shall be as follows:

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

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

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

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

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

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

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

8. Effective October 1, 2013 through September 30, 2016,, 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 CMS Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

9. Effective October 1, 2016, Direct Care Staff Compensation shall be inflated only by any adjustment to the living wage.

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.

J. 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.

K. Effective January 1, 2014, and on October 1 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.

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

M. 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 above. 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 owned premises. The Capital rate shall also be subject to the following principles:

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

2. Depreciation shall incorporate the following principles:

   a. When buildings and building improvements are acquired, the cost basis of the depreciable asset is 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 the time of acquisition. Notwithstanding, if the seller makes the full payback in accordance with paragraph (f) below, the cost basis to the new owner is the lesser of the fair market value or the purchase price;

   b. Facilities must employ the straight-line method for calculating depreciation, subject to the limitations in paragraphs (e) and (f) below. Accelerated methods for calculating depreciation are not acceptable.

c. 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;

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;

d. 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;

e. ICFs/IID shall follow the guidelines on 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. Depreciation expense for the year of disposal can be computed by using either the half-year method or the actual time method;

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

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

h. 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; and

i. 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.

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

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

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

N. Effective October 1, 2013 through September 30, 2016, the per diem rates for Non-Personnel Operations, Non-Emergency Transportation, Capital, and Active Treatment cost centers shall be adjusted for inflation on an annual basis 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.

O. Effective October 1, 2016, the annual inflation adjustment shall be eliminated.

P. The Stevie Sellows Quality Improvement Fund is a broad based assessment on all ICF/IID providers in the District of Columbia at a uniform rate of six percent (6%) of gross revenue. The allowable cost of the assessment is calculated consistent with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70, and 433.72.

IV. ACTIVE TREATMENT SERVICES

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

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

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

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

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

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

E. In addition to the residential component of the rate, derived from the seven (7) cost centers detailed in Section III, the rate shall include a per diem for active treatment. For dates of service on or after January 1, 2014, the per diem for active treatment shall equal the average of FY13 active treatment rates multiplied by two hundred and sixty (260) days of service, to account for the maximum days of service provided, and divided by three hundred sixty-five (365).

V. STEVIE SELLOWS QUALITY IMPROVEMENT FUND – DIRECT SUPPORT PROFESSIONAL SUPPLEMENTAL PAYMENT

A. The purpose of the Direct Support Professional supplemental payment, made from the Stevie Sellows Quality Improvement Fund, is to provide supplemental payments to qualified District of Columbia, Medicaid-certified, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) to reduce turnover by ensuring a competitive wage and increase the competency of direct support professionals (DSPs), thereby ensuring the provision of quality care to individuals in ICFs/IID.

B. Assessments from the Stevie Sellows Quality Improvement Fund shall be used to:

1. Fund quality of care improvements for those facilities that meet the requirements of the District's State Plan for Medical Assistance and the accompanying rules governing the reimbursement of ICF/IID.

2. Cover administrative costs of the DHCF in administering the ICF/IID reimbursement program and the Stevie Sellows quality improvement funding support, which costs shall not be more than 10% of the Fund's total revenues; and

3. Cover administrative costs of DHCF in auditing the ICF/IID in a rebasing year or as necessary to ensure the integrity of the ICF/IID reimbursement methodology, which costs shall not be more than 15% of the Fund's total revenues.

C. Eligible ICF/IID providers may receive supplemental payments to pay direct support professional employees of ICFs/IID if the providers meet the following criteria:

1. Certified to participate in the Medicaid program as described in section I.A. above;

2. Uses the supplemental payments to reimburse for salary, wages, and fringe benefit expenses for DSP employees. A DSP employee is defined as follows:

   a. Direct support professional must be an employee of an ICF/IID provider who provides direct services to individuals with developmental disabilities for at least 50% of the employee's work hours;

   b. Direct services for which the individual is eligible to be paid must include working with an individual providing support with self-care activities, behavior management, and community integration pursuant to an Individual Service Plan (ISP); and

   c. An employee as used in this section excludes managers, administrators, and contract employees.

3. Ensures compliance with any annual training requirements established by DHCF in collaboration with DDS to ensure DSP workers have sufficient knowledge and training to provide ICF/IID beneficiaries with quality care. DHCF shall provide notice of any annual training requirements at least 60 days in advance of the due date of the requirements;

4. Not closed for business;

5. Complies with DHCF reporting requirements described in section V.D. of this subsection;

6. Complies with the Clean Hands certificate requirements of the District of Columbia Office of Tax and Revenue and is otherwise in good standing with DHCF; and

7. Submits proof of a legally binding written commitment to use supplemental payments to fund DSP salaries, wages and fringe benefits, proof of an enforcement mechanism of the written commitment, and proof of written notice to DSP employees on the funding and availability of enforcement to the DHCF by June 30 of each year. The commitment and proof of enforcement and notice shall meet the requirements of D.C. Official Code § 47-1272(a).

D. ICF/IID providers that receive DSP supplemental payments shall comply with the following reporting requirements:

1. ICF/IID providers shall submit to DHCF a separate report on the distribution of the DSP supplemental payments on an annual basis. The report shall include the following:

   a. Total wage and benefits paid to employees;

   b. The marginal increases in wages and benefits that are covered by the supplemental payment;

   c. Documentation of compliance with training requirements, including records of training for DSPs and the tests used to determine competency, as applicable; and

   d. Any unused supplemental payment funds not distributed to DSPs during the course of the year.

2. Separate supplemental payment reports and any unused funds shall be submitted to DHCF no later than sixty (60) days following the end of the District's fiscal year (FY) (e.g., November 29). An ICF/IID provider's failure to submit the supplemental payment report and unused funds by the deadline shall result in exclusion from participation in the DSP supplemental payment program in the following FY.

3. ICF/IID providers shall include all expenses related to the DSP supplemental payment in the annual cost report submitted to DHCF. All supplemental payment funds received from and returned to DHCF shall be reported as adjustments in the annual cost report.

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

F. The DSP supplemental payment distribution to eligible ICF/IID providers shall be calculated based on the following parameters:

1. The total aggregate ICF/IID DSP supplemental payment amount for ICF/IID providers shall be based on ICF/IID assessments in the current FY and federal matching funds. The amount of ICF/IID assessments available for DHCF to distribute shall be a percentage of the total assessments collected under the Stevie Sellows Quality Improvement Fund during the FY, and DHCF shall provide notice of the amount of funds available for distribution at least sixty (60) days ahead of the FY.

2. To compute the quarterly payment:

   a. The total aggregate ICF/IID DSP supplemental payment amount shall be divided by total annual DSP hours required to provide services to all District Medicaid beneficiaries residing in an ICF/IID during the prior FY to calculate a DSP supplemental payment per hour.

   b. The total annual DSP hours (e.g., the total aggregate DSP hours for all ICF/IID providers) and the total individual ICF/IID annual DSP hours (e.g., the total DSP hours associated with a specific ICF/IID) will be calculated based on each beneficiary's acuity level and the staffing ratios, as prescribed in the ICF/IID rate methodology in section III.G. above and the following criteria:

      i. The Medicaid beneficiary utilization and acuity levels in the above calculation will be based on the most recent complete claims data available from the prior fiscal year. No adjustments will be made due to utilization or acuity changes that may occur during the disbursement year.

      ii. DSP hours from ineligible ICF/IID providers shall be excluded from the calculations in this subsection.

   c. An eligible ICF/IID provider shall receive a DSP supplemental payment equal to the DSP supplemental payment per hour times the ICF/IID's total annual DSP hours and as a lump-sum disbursement each quarter of the fiscal year.

3. DHCF reserves the right to recalculate the quarterly ICF/IID DSP supplemental payment amounts described in this section if revenues are insufficient to support the payment amounts calculated at the start of a FY. If DHCF recalculates the quarterly ICF/IID DSP supplemental payment amounts, then DHCF shall issue notice at least 30 days in advance of the recalculation to all eligible ICF/IID providers.

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

IV. REBASING

Effective October 1, 2018, and every three (3) years thereafter, DHCF will utilize the most recently audited cost reports to review the reimbursement rates through the rebasing process and revise, if necessary. Any adjusted rates will become effective in the following fiscal year.

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.

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

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

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

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

H. A facility reporting expenditures associated with holiday pay within the Direct Service cost center, as described in Sections III.G.4 and IV.E, shall submit supporting documentation, along with the cost report, to DHCF. Supporting documentation required under this section includes employee timesheets or comparable document(s).

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

J. 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.

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

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

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

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.

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

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

X. UTILIZATION REVIEW REQUIREMENTS

A. In accordance with 42 C.F.R. § 456.401, DHCF shall maintain a written Utilization Review Plan (URP) for each ICF/IID enrolled in the District of Columbia's Medicaid program. This plan shall describe the review process that shall be used for each beneficiary receiving services furnished by the ICF/IID.

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

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

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

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

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

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

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

XI. COMMENCING TERMINATION OR IMPOSING SANCTIONS AGAINST ICFs/IID

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

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

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

XII. ALTERNATIVE SANCTIONS IN CASES OF NON-IMMEDIATE JEOPARDY

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

B. In lieu of terminating the provider agreement, DHCF may impose one or more alternative sanctions against an ICF/IID, as follows:

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

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

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

8. Other relevant factors.

XIII. DENIAL OF PAYMENT

A. Pursuant to Section 1902(i) of the Act and 42 C.F.R. § 442.118, and in lieu of termination in situations where residents are not in immediate jeopardy, DHCF may initiate a one-time, denial of payment for claims associated with new admissions at ICFs/IID that fail to comply with one or more of the CoPs for Medicaid enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XIV. DIRECTED PLAN OF CORRECTION (DPoC)

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

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

C. The DPoC shall specify:

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

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

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

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

5. When the corrective action must be complete;

6. How substantial compliance will be measured; and

7. How the DPoC related to other alternative sanctions.

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

XV. DIRECTED IN-SERVICE TRAINING (DIST)

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

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

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

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

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

XVI. STATE MONITORING

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

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

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

i. Is not a designee or current contractor of the monitored facility;

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

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

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

XVII. ACCESS TO RECORDS

Each ICF/IID shall allow appropriate DHCF personnel, representatives of the Department of Health and Human Services and other authorized agents or officials of the District of Columbia government and federal government full access to all records during announced and unannounced audits and reviews.

XVIII. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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