

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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 (2017 Supp.)) and 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) (2013 Repl.)), hereby gives final notice of the intent to adopt amendments to Chapter 9 (Medicaid Program) and 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), respectively entitled “Medicaid Program” and “Medicaid Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities.”

These final rules update the reimbursement methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Each ICF/IID may be reimbursed when the Medicaid beneficiary is hospitalized or on a therapeutic leave of absence. The rules governing reserved bed days for nursing facilities and ICFs/IID are set forth in § 950 (Payment for Reserved Beds) of Chapter 9. These proposed rules repeal the reserve bed day sections governing ICFs/IID in section 950. These sections are now included as a new § 4117 to ensure that all the rules governing reimbursement for ICFs/IID are included in one chapter. In addition, the “hospitalization” and “therapeutic leave of absence” categories of reserved bed days have been combined to afford increased flexibility in the utilization of reserved bed days.

The reimbursement methodology is amended as follows: (1) in § 4101.14 the frequency of acuity level assessments has been extended for low-acuity beneficiaries from once every twelve (12) months to once every three (3) years to lessen the administrative burden on providers and beneficiaries; (2) in § 4107 the requirements to spend a certain percentage of Medicaid reimbursement funds on direct service delivery have been modified to require providers to expend ninety-five percent (95%) of funds in the Direct Service cost center and one-hundred percent (100%) of funds in the Active Treatment cost center, allowing providers to shift unspent reimbursement funds among certain other cost centers to cover over-expenditure in those cost centers; and (3) in § 4105 the rebasing timeline has been changed from FY17 to FY18 due to the length of time to complete the audit process for provider cost reports and ongoing provider appeals associated with the cost report audit process. The aggregate impact of these changes is \$ 260,647.85 in FY18 and \$ 269,509.88 in FY19.

A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on October 27, 2017 at 64 DCR 011222. DHCF received no comments. DHCF is making technical corrections in §§ 4105 and 4107 to clarify that certain changes to ICFs/IID provider reimbursement methodology are effective November 1, 2017, the effective date of the corresponding State Plan Amendment (SPA). Finally, DHCF is proposing a technical change to § 4105.2, to clarify that updated rates for ICF/IID services, effective January 1, 2018, are included in the Medicaid Fee Schedule located on the DHCF website at <https://www.dc->

medicaid.com/dcwebportal/nonsecure/feeScheduleDownload. A public notice of the Medicaid Fee Schedule update was published in the *D.C. Register* on at 64 DCR 012357 on December 1, 2017.

The corresponding amendment to the District of Columbia State Plan for Medical Assistance (State Plan) was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and the Council of the District of Columbia (Council). The Council approved the corresponding SPAs through the Fiscal Year 2018 Budget Support Emergency Act of 2017, on July 20, 2017 (D.C. Act 22-104). CMS approved the corresponding SPA on November 6, 2017 with an effective date of November 1, 2017.

This final rule was adopted on February 26, 2018, and shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Section 950, PAYMENT FOR RESERVED BEDS, is amended to read as follows:

950 PAYMENT FOR RESERVED BEDS

950.1 Vendor payment for reserved bed days for hospitalization or therapeutic leaves of absence, for a resident of a nursing facility, when provided in the resident's plan of care, shall not exceed eighteen (18) days during any fiscal year, if there is a reasonable expectation that the resident will return to the nursing facility.

950.2 **[REPEALED]**

950.3 **[REPEALED]**

950.4 Payment for reserved bed days authorized in accordance with section 950.1 shall equal one hundred (100) percent of the facility's per diem rate.

950.5 **[REPEALED]**

950.6 Each resident shall reside in the nursing facility for at least one (1) day as a condition of vendor payment for reserved bed days.

950.7 Each provider shall require the family member or caregiver to sign a leave and request form upon exit and return to the facility. The provider shall ensure that each family member or caregiver provide contact information.

950.8 Each provider shall discuss the resident's medical regimen with the family member or caregiver. The provider shall ensure that each family member or

caregiver is provided a sufficient quantity of the resident's medication for the leave period.

- 950.9 Each provider shall report to DHCF any unusual incident that occurred during any therapeutic leave of absence.

Chapter 41, MEDICAID REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, of Title 29 DCMR, PUBLIC WELFARE, is amended to read as follows:

Section 4101, ACUITY LEVEL ASSIGNMENTS, is amended as follows:

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 § 4101.6.
 - (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 § 4101.7.

- (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 § 4101.8.
- (e) Acuity Level 5 (Pervasive) 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 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 § 4101.9.
- (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 § 4101.10.

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 a higher acuity level. This request must be accompanied by documentation submitted by the ICF/IID that justifies the higher acuity level.

- 4101.5 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.
- 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 recertified every three (3) years for beneficiaries assigned Acuity Level 1 through 4, and annually for beneficiaries assigned Acuity Level 5 or 6. Each ICF/IID shall be responsible for requesting recertification 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 recertifications 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 recertification 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.

Section 4102, REIMBURSEMENT METHODOLOGY, is amended as follows:

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) Behavioral health services provided by psychologists or psychiatrists;
 - (5) Nutrition and food;
 - (6) Medical record maintenance and review;
 - (7) Insurance for non-direct care health staff;
 - (8) Quality Assurance;
 - (9) Training for direct care staff;
 - (10) Program development and management, including recreation;
 - (11) Incident management; and
 - (12) Clothing for beneficiaries.
- (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) Licenses;
 - (8) Office space rent or depreciation;
 - (9) Clerical staff;
 - (10) Interest on working capital; and
 - (11) Staff transportation.
- (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 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 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;
 - (1) All adjustments shall be limited to one (1) time in any given fiscal year.
 - (2) 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%);
 - (3) An outlier adjustment shall not exceed the amount of the rebased cost center, subject to the upper payment limit;
 - (4) 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;
 - (5) All adjustments described in § 4102.5 shall be limited to fiscal years when rebasing does not occur;

(6) “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 ICF/IIDs. 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; and

(7) “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 ICF/IIDs.

(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 through September 30, 2017, 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 adjustment for inflation using the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index, shall be as follows:
- (1) DSP: Twelve dollars and fifty cents (\$12.50) per hour;

- (2) LPN: Twenty one dollars (\$21.00) per hour;
 - (3) CNA: Sixteen dollars and eighty-three cents (\$16.83) per hour;
 - (4) House Manager: Forty-five thousand 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) 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.
- (i) Effective October 1, 2016, Direct Care Staff Compensation shall be inflated only by any adjustment to the living wage.

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 § 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 § 4102.12(b)(6), 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 §§ 4102.12(b)(3)-(6) below. Accelerated methods for calculating depreciation shall not be allowed. Subject to the limits set forth in §§ 4102.12(b)(3)-(6), 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 § 4102.12(c) 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 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.

4102.14 Effective October 1, 2016, the annual inflation adjustment in the per diem rates for “Non-Personnel Operations,” “Non-Emergency Transportation,” “Capital,” and “Active Treatment” cost centers shall be eliminated.

4102.15 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.

4102.16 Beginning October 1, 2016, ICF/IID reimbursement rates, shall be as follows:

| | Beds | Facility | Direct care staffing FY 17 | Other health care & program FY 17 | Non-Pers Oper FY 17 | Transp. FY 17 | Capital FY 17 | Admin FY 17 | Active Tx FY 17 | Tax FY 17 | Total Rate FY 17 |
|-------------------------|-------|-------------|-------------------------------|---|------------------------|------------------|------------------|----------------|--------------------|--------------|---------------------|
| Base | 4 - 5 | Leased | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$33.25 | \$637.85 |
| | | Owned | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$31.57 | \$605.51 |
| | 6 | Depreciated | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$27.47 | \$589.34 |
| | | Leased | \$240.73 | \$43.33 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$28.69 | \$550.41 |
| | | Owned | \$240.73 | \$43.33 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$27.15 | \$520.88 |
| | | Depreciated | \$240.73 | \$43.33 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$26.38 | \$506.11 |
| Moderate | 4 - 5 | Leased | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$33.25 | \$637.85 |
| | | Owned | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$31.57 | \$605.51 |
| | 6 | Depreciated | \$320.02 | \$41.60 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$30.72 | \$589.34 |
| | | Leased | \$312.05 | \$56.17 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$33.32 | \$639.20 |
| | | Owned | \$312.05 | \$56.17 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$31.78 | \$609.67 |
| | | Depreciated | \$312.05 | \$56.17 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$31.01 | \$594.90 |
| Extensive behavioral | 4 - 5 | Leased | \$391.35 | \$50.87 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$37.69 | \$732.87 |
| | | Owned | \$391.35 | \$50.87 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$36.00 | \$690.54 |
| | 6 | Depreciated | \$391.35 | \$50.87 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$35.16 | \$674.37 |
| | | Leased | \$359.60 | \$64.73 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$36.41 | \$698.40 |
| | | Owned | \$359.60 | \$64.73 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$34.87 | \$668.86 |
| | | Depreciated | \$359.60 | \$64.73 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$34.10 | \$654.09 |
| Extensive medical | 4 - 5 | Leased | \$431.59 | \$56.11 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$40.19 | \$770.85 |
| | | Owned | \$431.59 | \$56.11 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$38.50 | \$738.51 |
| | 6 | Depreciated | \$431.59 | \$56.11 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$37.66 | \$722.34 |
| | | Leased | \$374.71 | \$67.45 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$37.39 | \$717.21 |
| | | Owned | \$374.71 | \$67.45 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$35.85 | \$687.67 |
| | | Depreciated | \$374.71 | \$67.45 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$35.08 | \$672.90 |

| | | | | | | | | | | | |
|--------------------------|-------|-------------|----------|----------|---------|---------|---------|---------|---------|---------|------------|
| Pervasive 8 h / 7 d | 4 - 5 | Leased | \$462.67 | \$60.15 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$42.12 | \$807.90 |
| | | Owned | \$462.67 | \$60.15 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$40.43 | \$775.56 |
| | | Depreciated | \$462.67 | \$60.15 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$39.59 | \$759.40 |
| Pervasive 8 h / 5 d | 6 | Leased | \$383.38 | \$69.01 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$37.95 | \$727.99 |
| | | Owned | \$383.38 | \$69.01 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$36.41 | \$698.46 |
| | | Depreciated | \$383.38 | \$69.01 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$35.64 | \$683.69 |
| Pervasive 8 h / 5 d | 4 - 5 | Leased | \$417.33 | \$54.25 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$39.30 | \$753.86 |
| | | Owned | \$417.33 | \$54.25 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$37.61 | \$721.52 |
| | | Depreciated | \$417.33 | \$54.25 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$36.77 | \$705.35 |
| Pervasive 16 h | 6 | Leased | \$338.04 | \$60.85 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$35.01 | \$671.56 |
| | | Owned | \$338.04 | \$60.85 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$33.47 | \$642.02 |
| | | Depreciated | \$338.04 | \$60.85 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$32.70 | \$627.25 |
| Pervasive 24 h | 4 - 5 | Leased | \$605.32 | \$78.69 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$50.98 | \$977.96 |
| | | Owned | \$605.32 | \$78.69 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$49.30 | \$945.62 |
| | | Depreciated | \$605.32 | \$78.69 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$48.45 | \$929.45 |
| Nursing 1:1 8 h / 7 d | 6 | Leased | \$526.02 | \$94.68 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$47.21 | \$905.58 |
| | | Owned | \$526.02 | \$94.68 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$45.67 | \$876.04 |
| | | Depreciated | \$526.02 | \$94.68 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$44.90 | \$861.27 |
| Pervasive 8 h / 7 d | 4 - 5 | Leased | \$747.96 | \$97.24 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$59.85 | \$1,148.02 |
| | | Owned | \$747.96 | \$97.24 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$58.16 | \$1,115.68 |
| | | Depreciated | \$747.96 | \$97.24 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$57.32 | \$1,099.51 |
| Nursing 1:1 8 h / 7 d | 6 | Leased | \$668.67 | \$120.36 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$56.47 | \$1,083.16 |
| | | Owned | \$668.67 | \$120.36 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$54.93 | \$1,053.62 |
| | | Depreciated | \$668.67 | \$120.36 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$54.16 | \$1,038.85 |
| Nursing 1:1 8 h / 7 d | 4 - 5 | Leased | \$543.15 | \$70.61 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$47.12 | \$903.85 |
| | | Owned | \$543.15 | \$70.61 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$45.43 | \$871.51 |
| | | Depreciated | \$543.15 | \$70.61 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$44.59 | \$855.34 |
| Nursing 1:1 8 h / 7 d | 6 | Leased | \$463.86 | \$83.49 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$43.18 | \$828.18 |
| | | Owned | \$463.86 | \$83.49 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$41.64 | \$798.65 |
| | | Depreciated | \$463.86 | \$83.49 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$40.87 | \$783.88 |

| | | | | | | | | | | | |
|--------------------------|-------|-------------|----------|----------|---------|---------|---------|---------|---------|---------|------------|
| Nursing 1:1 8 h / 5 d | 4 - 5 | Leased | \$472.24 | \$61.39 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$42.71 | \$819.31 |
| | | Owned | \$472.24 | \$61.39 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$41.03 | \$786.97 |
| | | Depreciated | \$472.24 | \$61.39 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$40.18 | \$770.80 |
| 6 | | Leased | \$392.94 | \$70.73 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$38.57 | \$739.91 |
| | | Owned | \$392.94 | \$70.73 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$37.03 | \$710.37 |
| | | Depreciated | \$392.94 | \$70.73 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$36.26 | \$695.60 |
| 4 - 5 | | Leased | \$766.28 | \$99.62 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$60.99 | \$1,169.85 |
| | | Owned | \$766.28 | \$99.62 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$59.30 | \$1,137.51 |
| | | Depreciated | \$766.28 | \$99.62 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$58.46 | \$1,121.34 |
| Nursing 1:1 16 hours | 6 | Leased | \$686.98 | \$123.66 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$57.66 | \$1,105.96 |
| | | Owned | \$686.98 | \$123.66 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$56.12 | \$1,076.42 |
| | | Depreciated | \$686.98 | \$123.66 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$55.35 | \$1,061.65 |
| 4 - 5 | | Leased | \$989.41 | \$128.62 | \$19.77 | \$12.57 | \$61.30 | \$59.19 | \$90.14 | \$74.85 | \$1,435.85 |
| | | Owned | \$989.41 | \$128.62 | \$19.77 | \$12.57 | \$30.65 | \$59.19 | \$90.14 | \$73.17 | \$1,403.51 |
| | | Depreciated | \$989.41 | \$128.62 | \$19.77 | \$12.57 | \$15.33 | \$59.19 | \$90.14 | \$72.33 | \$1,387.34 |
| Nursing 1:1 24 hours | 6 | Leased | \$910.11 | \$163.82 | \$19.77 | \$12.57 | \$55.99 | \$59.19 | \$90.14 | \$72.14 | \$1,383.73 |
| | | Owned | \$910.11 | \$163.82 | \$19.77 | \$12.57 | \$28.00 | \$59.19 | \$90.14 | \$70.60 | \$1,354.19 |
| | | Depreciated | \$910.11 | \$163.82 | \$19.77 | \$12.57 | \$14.00 | \$59.19 | \$90.14 | \$69.83 | \$1,339.42 |

Section 4103, ACTIVE TREATMENT SERVICES, is amended as follows:**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 C.F.R. § 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).

Section 4105, REBASING, is amended as follows:**4105 REBASING**

- 4105.1 Effective November 1, 2017 (FY 2018), and every three (3) years thereafter, reimbursement rates for the residential component shall be updated based on cost reports from the most recently audited year, as determined by DHCF.

4105.2 The rate schedule set forth in § 4102.16 shall be updated after completion of the FY 2018 rebasing. The updated rates for ICF/IID services, effective January 1, 2018, are included in the Medicaid Fee Schedule located on the DHCF website at <https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload>.

Section 4107, FISCAL ACCOUNTABILITY, is amended as follows:

4107 FISCAL ACCOUNTABILITY

- 4107.1 Effective 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 set forth in Subsection 4107.6.
- 4107.2 Effective 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 individuals. Facilities expending less than one hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements set forth in Subsection 4107.6.
- 4107.3 Effective 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 set forth in Subsection 4107.6.
- 4107.4 Effective November 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 set forth in Subsection 4107.6.
- 4107.5 Effective November 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 set forth in Subsection 4107.6.
- 4107.6 Repayment amounts shall be as follows:
- (a) The repayment amount described in § 4107.1 shall be the difference between ninety-five percent (95%) of the rate for the applicable cost

center(s) and the facility's reported expenses for the applicable cost center(s);

- (b) 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 and the facility's reported expenses for Active Treatment;
- (c) The repayment amount for Capital described in § 4107.3 shall be the difference between one hundred percent (100%) of the payments made for Capital and the facility's reported Capital expenses;
- (d) The repayment amounts described in § 4107.4 shall be as follows:
 - (1) The difference between ninety-five percent (95%) of the Direct Service rate and the facility's reported Direct Service expenses; and
 - (2) The difference between one-hundred percent (100%) of the Active Treatment rate and the facility's reported Active Treatment expenses; and
- (e) The repayment amount described in § 4107.5 shall be the difference between 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 and the facility's reported aggregate expenses for these four (4) cost centers.

4107.7 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.

4107.8 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.

4107.9 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.

4107.10 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.

A new Section 4117, PAYMENT FOR RESERVED BEDS, is added to read as follows:

4117 PAYMENT FOR RESERVED BEDS

- 4117.1 Payment for reserved bed days for hospitalization or therapeutic leaves of absence for a beneficiary who is a resident of an ICF/IID may be authorized for up to sixty (60) days during a District fiscal year, if there is a reasonable expectation that the beneficiary will return to the facility.
- 4117.2 Payment for therapeutic leaves of absence shall only be authorized if provided for in a beneficiary's plan of care.
- 4117.3 Payment for reserved bed days authorized in accordance with §§ 4117.1 and 4117.2 shall equal the facility's per diem rate for the beneficiary, based on the beneficiary's approved acuity level assignment.
- 4117.4 A reserved bed day for purposes of this section is a day in which a beneficiary who is a resident of an ICF/IID receives fewer than eight (8) hours of supports in an ICF/IID beginning at midnight (12:00 am) and ending at 11:59 p.m.
- 4117.5 Payment for reserved beds is conditioned on each beneficiary residing in an ICF/IID for at least one (1) day.
- 4117.6 Each provider shall require the family member or caregiver to sign a leave and request form upon exit and return to the facility. The provider shall ensure that each family member or caregiver provide contact information.
- 4117.7 Each provider shall discuss the resident's medical regimen with the family member or caregiver. The provider shall ensure that each family member or caregiver is provided a sufficient quantity of the resident's medication for the leave period.
- 4117.8 Each provider shall report to DHCF any unusual incident that occurred during any therapeutic leave of absence.
- 4117.9 Each provider shall comply with all reporting requirements for reserved bed days set forth in 29 DCMR § 951.

Section 4199, DEFINITIONS, is amended as follows:

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.

District Fiscal Year - A twelve (12) month period beginning on October 1 and ending on September 30.

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.

Therapeutic leave of absence – When a beneficiary leaves the ICF/IID to visit with relatives and friends or to participate in a District-approved therapeutic and rehabilitative program.