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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 14-03

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

JUN 26 2014

Ms. Linda Elam, PhD, MPH
Sr. Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street NW, Suite 900 South
Washington, DC 20001

RE: State Plan Amendment 14-03

Dear Mrs. Elam:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-03. This amendment modifies the methods and standards for making Medical Assistance payments to intermediate care facilities for individuals with intellectual disabilities. Specifically, this SPA clarifies guidance for personnel costs, adjustments in non-rebasing years, and NEMT reimbursement, while also establishing a Capital rate component for fully depreciated properties.

We reviewed this amendment pursuant to sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Medicaid State plan amendment 14-03 effective January 1, 2014. We are enclosing the Form-179 and the amended plan pages.

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

Sincerely,

[redacted]

Cindy Mann
Director

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **14-03**	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE January 1, 2014	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447.252	7. FEDERAL BUDGET IMPACT FFY 14 $65,000,000 FFY 15 $68,700,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-D, Par II pp. 7-9a, 11-20	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19-D II pp. 7-9, 11-20

10. SUBJECT OF AMENDMENT: **Fiscal Year 2014 Updates to Medicaid Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities**

11. GOVERNOR'S REVIEW *(Check One)*
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☒ OTHER, AS SPECIFIED: PR 20-0693

12. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	16. RETURN TO Linda Elam, PhD, MPH Sr. Deputy Director/Medicaid Director Department of Health Care Finance 441 4th Street NW, Suite 900 South Washington, DC 20001
13. TYPED NAME Linda Elam, PhD, MPH	
14. TITLE Sr. Deputy Director/Medicaid Director	
15. DATE SUBMITTED March 28, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED 6/26/14 JUN 26 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JAN 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME Penny Thompson	22. TITLE Deputy Director, Policy & Finance/Mgt. CMCS

23. REMARKS

FORM CMS-179 (07-92) ***Instructions on Back***

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

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

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

   a. Pharmacy co-pays and over-the-counter medications;
   b. Medical supplies;
   c. Therapy costs, including physical therapy, occupational therapy, and speech therapy;
   d. Physician services;
   e. Behavioral health services provided by psychologists or psychiatrists;
   f. Nutrition and food;
   g. Medical record maintenance and review;
   h. Insurance for non-direct care health staff;
   i. Quality assurance;
   j. Training for direct care staff;
   k. Program development and management, including recreation;
   l. Incident management; and
   m. 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," page 2 of Attachment 4.19C of the State Plan.

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

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

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

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

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

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

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

E. FY 2014 rates shall be based on the reported FY 2013 cost reports, adjusted for inflation, in accordance with sections III.G.8. and III.M. of this State Plan Amendment. 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/IIDs 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.

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 ICF/IIDs.

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

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

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

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

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

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

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

6. The base salaries used in the development of FY 2013 rates for direct care staff wages and salaries, 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 Mental Retardation Professional: $60,000 per year

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

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

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

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

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

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

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

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

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

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

J. 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. 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.

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

L. 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.

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;

c. 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.

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

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

IV. ACTIVE TREATMENT SERVICES

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

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

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

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

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

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

E. For dates of service on or after January 1, 2014, the per diem for active treatment shall equal the average of FY12 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 (QI) INITIATIVE – SUPPLEMENTAL PAYMENT

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

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

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

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

1. A letter of intent;

2. Copy of training plan that identifies::

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

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

E. Training must be competency-based, with employees receiving a passing score of eighty percent (80%) or better.

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

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

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

I. ICF/IID providers that do not submit completed application materials within the required time frame will not be considered for supplemental payment. The address for submission is as follows:

D.C. Department of Health Care Finance
Project Manager, Special Needs, Long Term Care Administration
441 4th Street NW, Suite 900 South
Washington, DC 20001

J. Providers shall be responsible for the following

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

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

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

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

   a. Quarter One - A copy of the written notification by DHCF for approval of items listed in section I. above, and a complete list of employee names, hire dates, and position titles for all employees, submitted within fourteen (14) days of the end of the fiscal quarter;
   b. Quarter Two - The ICF/IID will submit to DHCF completed records indicating that 50% of employees have completed required training and have passed a written competency test (Score of 80% or better), submitted within fourteen (14) days of the end of the fiscal quarter;
   c. Quarter Three - The ICF/IID will submit to DHCF completed records indicating that 100% of employees have completed required training and have passed a written competency test (Score of 80% or better), submitted within fourteen (14) days of the end of the fiscal quarter; and
   d. Quarter Four - Annually the ICF/IID will produce and submit a Comprehensive Training Report no later than August 1that includes the following:
      i. Documentation of incurred training expenses;
      ii. Documentation of training completion date, graded tests, and training sign in sheets;
      iii. Performance measures which indicate the total number of employees who received training vs. the total number of employees who received a passing score, and the total number of individuals served vs. the total number of individuals with documented evidence that quality of care was improved, as a result of the employee's implementation of training received; and
      iv. A brief summary of how training impacted employee turnover and improved the qualifications/skills of the employee, and how the performance measures demonstrate the agency's progress towards quality improvement and/or challenges. If challenges have been identified, the summary should also include interventions the ICF/IID will implement to improve quality of care for individuals.

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

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

K. The responsibilities of DHCF, under this section, are as follows:

1. The responsibility for this initiative shall be is vested in the State Medicaid Director. Implementation of this initiative is the responsibility of the Special Needs Branch, DHCF Long Term Care Administration.

2. Within ninety (90) days of receipt of application materials, DHCF will notify ICF/IID providers, in writing, as to whether the training plan was approved. Approval of the training topic does not guarantee that the ICF/IID will meet all necessary requirements for payment under the Stevie Sellows' Quality Improvement Fund.

3. For FY 2015, and annually thereafter, to identify performance improvement opportunities the Division of Quality and Health Outcomes, Health Care Delivery Management Administration, will perform trend and data analysis of information provided. Findings will be shared with individual provider agencies.

4. An ICF/IID provider will be subject to random audits conducted by DHCF, or its designee. Audits may include; but not be limited to the following:

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

L. 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.

M. For each fiscal year, the aggregate annual supplemental payment to all ICF/IID providers shall not exceed two percent (2%) of the total reimbursements paid under Section III of this State Plan Amendment.

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

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

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

Q. In order to receive supplemental payment reimbursements an ICF/IID provider shall incur costs and provide DHCF with evidence of training requirements as outlined in Sections II (A) and IV (A-G). Acceptable forms of evidence shall include a copy of any invoice(s) for training costs and cancelled check(s) reflecting the facility's payment of the invoice(s). Within ninety (90) days of receipt of required documents, DHCF shall notify the ICF/IID and process payments.

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

VI. REBASING

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

VII. COST REPORTING AND RECORD MAINTENANCE

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

B. 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, cost report forms and instructions, the treatment and allowability of costs shall be determined in accordance with the Medicare Principles of Reimbursement, 42 C.F.R. Part 413, and the interpretation found in the relevant Provider Reimbursement Manual.

H. A facility reporting expenditures associated with holiday pay within the Direct Service cost center, as described under 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.

VIII. FISCAL ACCOUNTABILITY AND AUDITING

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

B. Beginning in FY 2014, each ICF/IID shall spend one hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid individuals. Facilities expending less than one hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements. Effective January 1, 2014, each ICF/IID shall spend one hundred percent (100%) of the rate associated with the Capital cost center. A facility that fails to expend one hundred percent (100%) on Capital shall be subject to repayment requirements.

C. 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.

D. 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 §47-1270 et seq), and implementing regulations.

E. 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.

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

IX. NOTICE OF RATES AND RIGHT TO APPEAL

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

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

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

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

X. UTILIZATION REVIEW REQUIREMENTS

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