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State Name: District of Columbia

State Plan Amendment (SPA)#: 18-0008

This file contains the following documents in the order listed:

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

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

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

Financial Management Group

Angelique Martin, Acting Medicaid Director
Department of Health Care Finance
441 4th St. N.W., Suite 900 South
Washington, DC 20001

October 4, 2018

RE: State Plan Amendment 18-0008

Dear Ms. Martin:

We have reviewed the proposed amendment to Attachment 4.19-D of the District of Columbia State plan submitted under transmittal number (TN) 18-0008. This amendment modifies the State's methods and standards for setting intermediate care facility (ICFIID) payment rates. Specifically, this amendment clarifies the three-year rate rebasing process and resets it beginning October 1, 2018.

We conducted our review of your submittal according to the statutory requirements at Sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving District of Columbia State plan amendment 18-0008 with an effective date of October 1, 2018. The approved HCFA-179 and the amended state plan pages are enclosed.

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

Sincerely,

/S/

Kristin Fan
Director

Enclosures
cc: Alice Weiss, Health Care Policy and Research Administration

bcc: Francis McCullough, ARA, RO3
Teia Miller, Manager, FMB RO3
Sabrina Tillman-Boyd, Manager, POB RO3
Frankeena Wright, DC State Lead
Lisa Carroll, CO NIRT
Official NIRT File

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: **18-008**

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: **October 1, 2018**

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902(a)(31) of the Social Security Act (421 USC § 1396a(31)); and 42 CFR Part 483, Subpart I

7. FEDERAL BUDGET IMPACT:

FFY19: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Part II: pages 9A and 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, Part II: pages 9A and 18

10. SUBJECT OF AMENDMENT:

Intermediate Care Facilities for Individuals with Intellectual Disabilities Rate Rebasing

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:
D.C. Act: 22-104

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/

13. TYPED NAME
Angelique Martin

14. TITLE **Deputy Director- Medicaid Finance**
Interim Senior Deputy Director/Medicaid Director

15. DATE SUBMITTED
AUG 2 0 2018

16. RETURN TO

Angelique Martin
Deputy Director- Medicaid Finance
Interim Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
OCT 0 4 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
OCT 0 1 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/S/

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

e. All adjustments described in section III.E shall be limited to fiscal years when rebasing does not occur.

f. For purposes of section III.E, the following definitions shall apply:

i. "Operational Adjustment" shall refer to an adjustment made to any cost center based on information reflected in an ICF/IID's cost report (i.e., actual reported costs). These reported costs will be compared to the actual reported aggregate costs for all ICFs/IID. An operational adjustment provides a mechanism for DHCF to address under- or over-payments that are identified after comparing the projections used to determine the rate with the provider's actual costs.

ii. "Outlier Adjustment" shall refer to an adjustment made after the ICF/IID submits a cost report and the actual reported costs reflect uncharacteristically low or high costs. In order to qualify for an outlier adjustment, the unexpected expense must impact all of the District's ICFs/IID.

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

F. Reimbursement rates shall be rebased in accordance with Section IV.

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

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

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

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

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

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

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

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

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

IV. REBASING

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

V. COST REPORTING AND RECORD MAINTENANCE

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

B. A cost report that is not completed in accordance with the requirements of this Section shall be considered an incomplete filing, and DHCF shall notify the ICF/IID within thirty (30) days of the date on which DHCF received the incomplete cost report.

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